HOUSE RESEARCH

Bill Summary

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Article 1: Welfare Reform; Public Assistance Modifications

Overview

This article modifies welfare provisions. Significant changes are proposed including a greater focus on work, creation of a new diversionary work component, reduction of the income exit level, modification of sanctions, and limitations on post-secondary education.

Funeral expenses. Amends § 256.935, subd. 1. Removes language regarding state responsibility for funeral costs.

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

Emergency need. Amends § 256D.06, subd. 2. Strikes obsolete language, clarifies that emergency general assistance grants may be made to the extent that funds are available, limits grant availability to a recipient to not more than once in any 12-month period. Limits funding for emergency general assistance to an amount equal to the 2002 actual state expenditures. Creates an allocation formula for counties to receive emergency general assistance funds and requires that county expenditures above the county allocation be made with county funds.

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

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

Payment amount. Amends § 256D.46, subd. 3. Limits grant availability to recipients to not more than once in any 12-month period. Limits funding for emergency supplemental aid grants to an amount equal to the 2002 actual state expenditures. Creates an allocation formula for counties to receive emergency Minnesota supplemental aid funds and requires that county expenditures above the county allocation be made with county funds.

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

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

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

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

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

Diversionary work program or DWP. Amends § 256J.08, by adding subd. 24b. Defines "diversionary work program" or "DWP".

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

14 Family violence. Amends § 256J.08, by adding subd. 34a. Defines "family violence" if committed against a family or household member by a family or household member, as:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 Screening. Amends § 256J.09, subd. 3a. Makes technical and conforming changes. Eliminates references to the diversionary assistance program and the emergency assistance

program. Requires counties to make referrals to other appropriate programs, if applicants appear to be eligible for other programs.

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

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

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

31 Eligibility for parenting or pregnant minors. Amends § 256J.14. Makes a technical change adding a reference to school attendance requirements. Includes a new option for employment if the caregiver chooses.

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

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

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

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

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

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

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

39 Changes that must be reported. Amends § 256J.30, subd. 9. Makes technical and conforming changes. Adds a requirement to report changes that affect the number of hours participants are able to work per week or the type of activity participants are able to perform. Eliminates a change in health care coverage from the list of changes that must be reported to the county agency.

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

41 Factors to be verified. Amends § 256J.32, subd. 4. Makes technical and conforming changes.

Eliminates medical insurance from the list of factors to be verified.

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

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

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

44 Rental subsidies; unearned income. Amends § 256J.37, by adding subd. 3a. Requires counties to count $100 of the value of public and assisted rental subsidies provided through HUD as unearned income to the cash portion of the MFIP grant. Requires the full amount of the subsidy to be counted as unearned income when the subsidy is less than $100. Excludes certain assistance units that include a participant who is:

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

Prohibits this provision from applying to an MFIP assistance unit where the parental caregiver is an SSI recipient.

45 Treatment of supplemental security income. Amends § 256J.37, by adding subd. 3b. Requires counties to reduce the cash portion of the MFIP grant by $175 per SSI recipient who resides in the household, and who would otherwise be included in the MFIP assistance unit, but is excluded solely due to the SSI recipient status. Requires that only the amount received be used in calculating the MFIP cash assistance payment if the SSI recipient receives less than $175 in SSI payments.

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

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

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

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

50 Victims of family violence. Amends § 256J.42, subd. 4. Requires cash assistance received by

an assistance unit that is the victim of family violence to comply with an employment plan in order to be exempt from the 60-month time limit. Currently, an assistance unit that is the victim of family violence must comply with a safety plan or an alternative employment plan.

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

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

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

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

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

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

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

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

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

60 General information. Amends § 256J.45, subd. 2. Makes technical and conforming changes. Changes the language referring to health care eligibility after an MFIP case closes. Reflects changes due to de-linking and updates terminology.

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

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

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

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

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

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

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

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

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

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

71 County duty to ensure employment and training choices for participants. Amends § 256J.50, subd. 8. Excludes DWP participants from the right to choose a provider when there are multiple providers.

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

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

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

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

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

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

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

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

Subd. 2. Employment plan; contents. Requires the job counselor and the participant to develop an employment plan that includes participation in activities and hours that meet the MFIP requirements. States the purpose of the employment plan. Lists activities and other items that may be included in the employment plan. Allows activities and hourly requirements in the employment plan to be adjusted as necessary to accommodate the personal and family circumstances of participants. Requires employment plans to be reviewed every three months.

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

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

Subd. 5. Transition from the diversionary work program. Requires participants who become eligible for MFIP assistance after completing the diversionary work program, or who are deemed unable to benefit from the diversionary work program, to meet all assessment and employment plan requirements.

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

79 Length of program. Amends § 256J.53, subd. 1. Requires a post-secondary education or training program to last 12 months or less in order for it to be an approved work activity. Allows the 12 months of allowable post-secondary education or training to be used to complete the final 12 months of a longer program.

80 Approval of post-secondary education or training. Amends § 256J.53, subd. 2. Makes technical changes. Requires participants to be working in unsubsidized employment at least 25 hours per week in order for a post-secondary education or training program to be an approved activity. Lists documentation that participants seeking approval of post-secondary education or training must provide. Allows current MFIP participants with an approved employment plan in place that includes more than 12 months of post-secondary education or training to complete that plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2. Participation requirements. Requires all caregivers, with certain exceptions, to

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

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

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

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

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

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

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

- short-term, nonrecurring shelter and utility needs;
- transportation needed to obtain or retain employment or to participate in other approved work activities; and
- supported work.

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

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

Subd. 4. County and tribal biennial service agreements. Requires each county and tribe to have in place an approved biennial service agreement, beginning January 1, 2004. Allows counties to collaborate to develop multicounty, multitribal, or regional service agreements. Lists information the agreement must include. Requires the commissioner to provide each county and tribe with the information needed to complete an agreement. Requires counties to allow a period of not less than 30 days prior to submission of the agreement to solicit public comments on the contents of the agreement. Requires the commissioner to inform the county of service agreement approval within 60 days of receiving each agreement.

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

Subd. 6. Base allocation to counties and tribes. Defines "2002 historic spending base," "initial allocation," "final allocation," and "base programs." Creates a new allocation formula based on 2002 historic spending and average caseload.

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

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

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

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

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

97 Establishing the community work experience program. Amends § 256J.67, subd. 1. Eliminates language prohibiting the county from requiring a caregiver to participate in the community work experience program unless the caregiver has been given an opportunity to participate in other work acitivities.

98 Employment options. Amends § 256J.67, subd. 3. Eliminates the requirement that counties first provide the caregiver the opportunity for placement in suitable employment through participation in on-the-job training.

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

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

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

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

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

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

Subd. 1. Establishing a diversionary work program (DWP). Establishes the DWP program on July 1, 2003, to provide short-term diversionary benefits to eligible recipients that lead to unsubsidized employment, increase economic stability, and

reduce the risk of families needing longer term assistance. Prohibits families meeting the DWP eligibility requirements from receiving MFIP assistance. Limits eligibility for DWP to a maximum of four months once in a 12-month period. Requires family maintenance needs to be vendor paid up to the cash portion of the MFIP standard of need for the same size household. Allows for a personal needs allowance of up to $70 per DWP recipient in the family. Allows counties to provide supportive and other allowable services funded by the MFIP consolidated fund to eligible participants.

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

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

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

Subd. 5. Submitting application form. Establishes the date of eligibility for DWP. Lists items that counties must inform applicants of. Allows applicants to withdraw an application at any time prior to approval by giving written or oral notice to the county agency.

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

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

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

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

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

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

reduced hours when approved by the job counselor.

Subd. 12. Conversion or referral to MFIP. Requires counties to convert or refer participants to MFIP if it is determined that a participant is unlikely to benefit from DWP. Lists reasons a participant would be determined to be unlikely to benefit from DWP.

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

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

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

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

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

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

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

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

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

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

107 Ineligibility for state funded programs. Amends Laws 2001, First Special Session chapter 9, article 10, section 62. Eliminates the expiration of eligibility of legal noncitizens for MFIP assistance funded entirely with state money.

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

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

Article 2: Health Care

Overview

This article modifies eligibility requirements, payment rates, and covered services for health care programs administered by DHS, authorizes prescription drug initiatives and sets copayments for certain MA services, modifies procedures related to estate recoveries and prohibited transfers, sunsets the health care access fund, and makes other related changes.

1. 1 Health care access fund. Amends § 16A.724. Sunsets the health care access fund on June 30, 2005, and deposits all remaining funds in the general fund. Beginning July 1, 2005, funds all activities that would otherwise be funded out of the health care access fund from the general fund.

2 Gifts to practitioners prohibited. Amends § 151.461. For purposes of the prohibition on gifts from manufacturers, wholesale drug distributors, or agents to practitioners, modifies the definition of exempt gift to require all drugs from a manufacturer and for each independent practitioner or practice group to meet the $50 threshhold. Also prohibits giving prescription pads to prescribers and requires manufacturers, distributors, or agents to report the value of exempt gifts and payments to the commissioner of human services.

3 Purchase of prescriber practice data prohibited. Adds § 151.4611. Prohibits a manufacturer or wholesale drug distributor from purchasing or otherwise obtaining data related to the prescribing or dispensing practices or patterns of practitioners.

4 Specific powers. Amends § 256.01, subd. 2. Requires rebates for the prescription drug program to be equal to the rebate as defined under the federal Medicaid rebate program.

(Current law requires the rebate to be equal to the "basic" rebate of that program.)

5 Hearing authority. Amends § 256.046, subd. 1. Adds GAMC, MinnesotaCare for adults without children and, upon federal approval, all categories of MA and the remaining categories of MinnesotaCare except children under age 18, to a list of programs for which a local agency must initiate administrative fraud disqualification hearings.

6 Prescription drug discount program. Adds § 256.954. Establishes a prescription drug discount program within the department of human services.

Subd. 1. Establishment; administration. Requires the commissioner of human services to establish and administer the prescription drug discount program, effective January 1, 2004.

Subd. 2. Commissioner's authority. Directs the commissioner to administer a rebate program for drugs purchased through the prescription drug discount program, using the terms and conditions of the federal Medicaid rebate program.

Subd. 3. Definitions. Defines terms. Exempts multisource drugs for which there are three or more drug products from the requirements of this section, unless they are innovator multi-source drugs.

Subd. 4. Eligible persons. In order to be eligible, requires an applicant to:

- be a permanent resident of Minnesota;
- not be enrolled in a state health care program or the prescription drug program;
- not be enrolled in and have available prescription drug coverage through a health plan;
- not be enrolled in and have available prescription drug coverage through a Medicare supplement plan; and
- have a gross household income that does not exceed 250 percent of the federal poverty guidelines.

Subd. 5. Application procedure. Requires applications to be available at specified sites. Requires individuals to submit applications to the commissioner, and requires the commissioner to determine eligibility within 30 days. Specifies that eligibility begins the month after approval. Requires the commissioner to develop an application form that does not exceed one page in length.

Subd. 6. Participating pharmacy. Requires participating pharmacies to sell prescription drugs to enrolled individuals at the pharmacy's usual and customary retail price, minus the rebate amount and plus any administrative fee and switch fee. Also requires pharmacies to provide the commissioner with information necessary to administer the program.

Subd. 7. Notification of rebate amount. Requires the commissioner to notify each drug manufacturer, each calendar quarter or according to a schedule established by the commissioner, of the amount of rebate owed on prescription drugs sold to enrolled individuals.

Subd. 8. Provision of rebate. Requires manufacturers to provide a rebate equal to the MA rebate, for any prescription drug purchased by an enrolled individual at a participating pharmacy. Requires full payment within 30 days of the state invoice, or according to a schedule established by the commissioner, and also requires manufacturers to provide the commissioner with information to verify the rebate

determined per drug. Requires the commissioner to deposit rebates into the Minnesota prescription drug dedicated fund.

Subd. 9. Payment to pharmacies. Requires the commissioner to distribute to pharmacies, on a biweekly basis, the rebate amount obtained for prescription drugs sold by the pharmacy, minus the administrative fee.

Subd. 10. Administrative fee; switch fee. Requires the commissioner to establish an administrative fee that covers expenses for enrollment, claims processing, repaying the start-up appropriation over a seven-year period, and distributing rebates. Requires the commissioner to establish a switch fee to cover expenses incurred by pharmacies in formatting claims for electronic submission.

Subd. 11. Dedicated fund; creation; use of fund. Establishes the Minnesota prescription drug dedicated fund in the state treasury. Requires the commissioner of finance to credit to the fund all rebates paid, any federal funds received, and any designated appropriations or allocations. Specifies that money in the fund is appropriated to the commissioner of human services to reimburse participating pharmacies, pay expenses related to administration of the prescription drug program, and repay the appropriation provided. Requires the commissioner to administer the program so that costs do not exceed the funds appropriated plus drug rebate proceeds.

7 Eligibility. Amends § 256.955, subd. 2a. Strikes language that would have expanded the prescription drug program income limit for the elderly to 135 percent of FPG effective July 1, 2003 (this maintains the current law income limit of 120 percent of FPG).

8 Prescription drug coverage. Amends § 256.955, subd. 3. Eliminates prescription drug program coverage, for specific enrollees, of drugs that are available under an assistance program offered by a pharmaceutical manufacturer. Provides that the section is effective 30 days after the board on aging implements a prescription drug assistance program.

9 Referrals to prescription drug assistance program. Amends § 256.955, by adding subd. 4a. Requires county social services agencies, in coordination with the commissioner and the board on aging, to refer applicants and enrollees to the prescription drug assistance program for all drugs that are covered under an assistance program offered by a pharmaceutical manufacturer. Provides that the section is effective 30 days after the board on aging implements a prescription drug assistance program.

10 Operating payment rates. Amends § 256.969, subd. 2b. Eliminates the rebasing of MA and GAMC inpatient hospital rates scheduled to take effect January 1, 2005.

11 Payments. Amends § 256.969, subd. 3a. Reduces MA and GAMC inpatient hospital fee-for-service payment rates by 2.5 percent, for admissions occurring on or after July 1, 2003. Excludes certain mental health services and Indian health service facilities from this reduction.

12 Prescription drug assistance. Amends § 256.975, by adding subd. 9. (a) Requires the Minnesota board on aging to establish and administer a program to assist individuals in accessing programs by pharmaceutical manufacturers that provide free or discounted prescription drugs, or provide coverage for prescription drugs. Requires the board to use computer software programs to link individuals to appropriate programs. Also requires the board to make information on the program available and to coordinate the program with the Senior LinkAge line.

(b) Requires the board to work with the commissioner and county social services agencies to coordinate the enrollment of individuals referred from the prescription drug program.

13 Amount of assistance incorrectly paid. Amends § 256.98, subd. 3. In a section allowing

recovery or sentencing for wrongfully obtaining assistance, specifies that the amount of assistance incorrectly paid is equal to all payments for health care services, including capitation payments, under MinnesotaCare, MA, or GAMC, for which the person was not entitled due to concealment or misrepresentation of facts.

14 Recovery of assistance. Amends § 256.98, subd. 4. In a section allowing recovery of assistance incorrectly paid, allows MinnesotaCare participants who have wrongfully obtained assistance but otherwise remain eligible for the program to have their premiums increased by 10 percent or $10/month, whichever is greater, until the debt is satisfied.

15 Disqualification from program. Amends § 256.98, subd. 8. Requires disqualification of persons found to be guilty of wrongfully obtaining GAMC, MinnesotaCare for adults without children, and upon federal approval, all categories of MA and the remaining categories of MinnesotaCare except children under age 18. Sets the period of disqualification at one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. Specifies other requirements for disqualification.

16 Residents of institutions for mental diseases. Amends § 256B.055, by adding subd. 13. Beginning October 1, 2003, provides that persons who would be eligible for MA except for residence in an institution for mental diseases are eligible for MA without federal financial participation.

17 Income and assets generally. Amends § 256B.056, subd. 1a. Makes a conforming change related to the modification of the earned income disregards and deductions for families and children.

18 Families with children income methodology. Amends § 256B.056, subd. 1c. Sunsets the current earned income disregard for children one to five of 21 percent of earned income for four months on July 1, 2003. Effective October 1, 2003, applies a $90 work expense deduction to income for children age one through 18 and clarifies that deductions for dependent care and child support paid under a court order continue. For parents in MA families, children 19 to 21, and children and families on a spend-down, retains the 17 percent earned income disregard of four months and clarifies that deductions for dependent care and child support paid under court order continue.

19 Pregnant women and infants. Amends § 256B.057, subd. 1. Reduces the MA income limit for pregnant women from 275 percent of FPG to 200 percent of FPG, effective February 1, 2004. Provides a July 1, 2003, expiration date for the special work expense deduction for pregnant women, and requires dependent care and child support paid to be deducted from countable income, effective February 1, 2004.

20 Children. Amends § 256B.057, subd. 2. Effective October 1, 2003, reduces the MA income limit for children one through 18 from 170 percent of FPG to 150 percent of FPG.

21 Qualifying individuals. Amends § 256B.057, subd. 3b. Makes MA funding for Medicare beneficiaries who are qualifying individuals contingent upon federal funding (current law provides funding to the extent of the federal allocation, which is time-limited).

22 Prohibited transfers. Amends § 256B.0595, subd. 1. Clarifies that the current prohibition on asset transfers at less than fair market value applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse if determined eligible for MA. Extends the lookback period for transfers of assets from 36 to 72 months, and extends the lookback period for transfers of trusts from 60 to 72 months, effective July 1, 2003, or upon receipt of federal approval, whichever is later. Requires the commissioner to seek federal approval to extend the lookback period to 72 months.

Provides a July 1, 2003, effective date and requires the commissioner to seek waivers and the necessary authority if the amendments are not effective due to federal law. Provides that provisions become effective upon federal approval, notification to the revisor, and

publication of a notice in the State Register.

23 Period of ineligibility. Amends § 256B.0595, subd. 2. Provides that periods of ineligibility due to uncompensated transfers begin the first day of the month after the month in which the transfer occurred. (Under current law, the period of ineligibility begins with the month the transfer occurred.)

Effective upon federal approval, provides that the period of ineligibility begins on the first day of the month the applicant would otherwise be eligible for long-term care services, or for persons receiving long-term care services, the first day of the month after the month the local agency learns of the uncompensated transfer. Requires the commissioner to seek federal approval for this provision.

Allows a cause of action if an applicant receives MA services during what would have been a period of ineligibility if an improper transfer had been reported, regardless of when there was a failure to report.

Provides a July 1, 2003, effective date and requires the commissioner to seek waivers and the necessary authority if the amendments are not effective due to federal law. Provides that provisions become effective upon federal approval, notification to the revisor, and publication of a notice in the State Register.

24 Citizenship requirements. Amends § 256B.06, subd. 4. Effective July 1, 2003, eliminates coverage of care and services through the period of pregnancy and 60 days postpartum, under MA without federal financial participation, for pregnant noncitizens who are undocumented or nonimmigrants.

Beginning October 1, 2003, makes persons receiving services from the center for victims of torture who are otherwise ineligible for MA or GAMC eligible for MA without federal financial participation, for the period they are receiving services from the center. Exempts these individuals from participation in PMAP.

Strikes obsolete provisions and makes conforming changes.

25 Eligibility; retroactive effect; restrictions. Amends § 256B.061. Strikes a delayed verification provision that allows MA applicants meeting specified criteria (gross income and assets less than 90 percent of program limits; do not reside in a long-term care facility; meet all other eligibility requirements) to be determined eligible in the month of application, subject to providing all required verifications within 30 days. Provides an effective date of July 1, 2003.

26 Intensive early intervention behavior therapy services. Amends § 256B.0625, subd. 5a. Delays implementation of MA coverage of intensive early intervention behavior therapy for children with autism spectrum disorders until July 1, 2007, and makes a conforming change in the submittal date for a study on the effectiveness of the services.

27 Dental services. Amends § 256B.0625, subd. 9. Limits MA coverage of dental services for adults over age 21 who are not pregnant to diagnostic and preventative services, basic restorative services, and emergency services, subject to a $500 annual benefit limit.

28 Drugs. Amends § 256B.0625, subd. 13.

A new (b) limits the quantity of dispensed drugs to a 34-day supply, unless prior authorization is obtained.

A new (c) provides MA coverage for specified over-the-counter drugs, when prescribed by a

licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy. Requires licensed pharmacists, when prescribing over-the-counter drugs, to consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed.

A new (d) allows the commissioner to contract with a pharmacy benefit administrator to administer the MA prescription drug benefit. Requires the entity under contract to transfer to the state all direct and indirect payments from pharmaceutical manufacturers. Provides a definition of pharmacy benefit administrator.

Subd. 13c. Limits on the number of brand name prescriptions. L imits coverage for brand name drugs to four products per recipient per month, unless prior authorization is obtained. Exempts antiretroviral agents and brand name drugs from the limit and defines "brand name drugs."

Subd. 13d. Pharmaceutical and therapeutics committee. Replaces the formulary committee with a pharmaceutical and therapeutics committee and requires the committee to develop, and assist the commissioner in implementing, a preferred drug list and to review and recommend drugs for prior authorization. Requires the committee to meet at least quarterly and allows the commissioner to designate the Medicaid drug utilization review board as the committee. Makes other related changes.

Subd. 13e. Drug formulary. Prohibits the MA formulary from covering drugs used for weight loss (current law prohibits inclusion of anorectics). Also makes various conforming changes.

Subd. 13f. Payment rates. Requires the commissioner to estimate the acquisition cost used in setting pharmacy reimbursement rates at AWP-11.5 percent (the formula in current law is AWP-9 percent). Allows the commissioner to set maximum allowable costs for multisource drugs that are on the federal upper limit list (this is done by striking language that limits the commissioner to setting maximum allowable costs for drugs not on the federal upper payment list). Requires licensed pharmacists who meet the standards established by the commissioner to be paid a fee for each consultation provided when authorizing over-the-counter drugs. A new (e) reinstates payment rate language stricken elsewhere in the section.

Subd. 13g. Prior authorization. The amendments to (a) assign prior authorization duties to the pharmaceutical and therapeutics committee and exempts antipsychotic drugs prescribed to individuals before July 1, 2003, from prior authorization. A new (b) sets standards for accessing prior authorization procedures. A new (c) prohibits prior authorization from being required for certain antipsychotic drugs and requires prescriptions for antipsychotic drugs issued after June 30, 2003 to have an ICD-9 code and to be subject to the preferred drug list and any step therapy guidelines established. A new (e) directs the commissioner to require prior authorization for all "dispense as written - brand medically necessary" brand name prescriptions, when a generic product is available. The subdivision also makes conforming or related changes.

Subd. 13h. Step therapy. Directs the commissioner, in consultation with the pharmaceutical and therapeutics committee, to develop and implement a step therapy program. Provides a definition of step therapy.

Subd. 13i. Preferred drug list. Requires the commissioner to adopt and implement a

preferred drug list by January 1, 2004. Allows the commissioner to contract with a vendor or one or more states. Establishes procedures for administration and modification of the preferred drug list. Requires the preferred drug list to be administered as part of the supplemental drug rebate program.

29 **Transportation costs.** Amends § 256B.0625, subd. 17. Sets the following reimbursement rates for MA special transportation services:

(1) for trips originating within a major metropolitan area, flat rates of $28.50 per trip for persons who need a wheelchair-accessible van and $21.00 per trip for persons who do not need a wheelchair-accessible van or stretcher-accessible vehicle;

(2) for trips originating outside of a major metropolitan area, a base rate of $18.00 per trip and $1.20 per mile for persons who need a wheelchair-accessible van and a base rate of $12.00 per trip and $1.40 per mile for persons who do not need a wheelchair-accessible van or stretcher-accessible vehicle; and

(3) for all trips, a base rate of $36.00 and $1.40 per mile, and an attendant rate of $9.00 per trip, for persons who need a stretcher-accessible vehicle.

Defines a major metropolitan area as a standard metropolitan statistical area with a population of more than 2,000,000 people.

30 Access to medical services. Limits MA payments for meals to travel involving lodging, and allows MA coverage for lodging only if the local agency determines that the needed medical services are not available at a location that does not require lodging.

31 Medical assistance copayments. Adds § 256B.0631. Establishes copayments for certain MA services.

Subd. 1. Co-payments. Establishes the following copayments, effective for services provided on or after October 1, 2003:

- $3 per nonpreventive visit
- $3 for eyeglasses
- $6 for nonemergency visits to a hospital-based emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $20 per month maximum

Subd. 2. Exceptions. Exempts the following individuals or services from copayments: children under age 21, pregnant women for services that relate to pregnancy or any other condition that may complicate a pregnancy, recipients expected to reside for 30 days in an institution, recipients receiving hospice care, 100 percent federally funded services provided by an Indian health service, emergency services, family planning, services paid for by Medicare for which MA pays the coinsurance and deductible, and copayments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. Collection. Reduces MA reimbursement to providers by the amount of the copayment except when an individual has reached the $20 per month maximum for prescription drug copayments. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in subdivision 4.

Subd. 4. Uncollected debt. Allows providers to refuse services to individuals with

uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

32 Increased employment. Amends § 256B.0635, subd. 1. Makes the provision of extended MA to persons who lose eligibility due to an increase in hours of employment or employment income, or the loss of an earned income disregard, contingent upon federal funding.

33 Increased child or spousal support. Amends § 256B.0635, subd. 2. Makes the provision of extended MA to persons who lose eligibility due to the collection of child or spousal support contingent upon federal funding.

34 Policy, applicability, purpose, and construction; definition. Amends § 256B.15, subd. 1. Provides a statement of policy and applicability related to sections that follow dealing with estate recovery.

35 Estates subject to claims. Amends § 256B.15, subd. 1a. Makes a conforming change to refer to additional grounds for claims against estates.

36 Notice of potential claim. Amends § 256B.15, by adding subd. 1c. Allows a state agency to file a notice of potential claim anytime before or after an MA recipient dies. Specifies procedures for filing a notice.

37 Effect of notice. Amends § 256B.15, by adding subd. 1d. Provides that once it takes effect, a notice shall be a notice that life estates and joint tenancy interests continue to exist, and are subject to liens and claims, and may be included in the recipient's estate.

38 Full or partial release of notice. Amends § 256B.15, by adding subd. 1e. Allows the claimant to fully or partially release a notice, and also modify or amend the recorded notice and related lien.

39 Agency lien. Amends § 256B.15, by adding subd. 1f. Provides that the notice constitutes a lien in favor of the department for a period of 20 years from the date of filing or the recipient's death, whichever is later. Provides that a recipient's life estate and joint tenancy interests shall not end upon the recipient's death. Specifies procedures for releasing liens, requesting hearings, and filing claims in cases of probate.

40 Estate property. Amends § 256B.15, by adding subd. 1g. Provides that if a claim is presented, interests or the proceeds of interests in real property a decedent owned as a life or joint tenant shall become part of the estate.

41 Estates of specific persons receiving medical assistance. Amends § 256B.15, by adding subd. 1h. Defines the estate and specifies other procedures for recipients who died single, or are the surviving spouse of a couple, and who are not survived by individuals from whom estate recovery is limited. Provides that the person's life estate or joint tenancy interest does not end at death but continues.

42 Estates of persons receiving medical assistance and survived by others. Amends § 256B.15, by adding subd. 1i. Specifies lien and claim procedures for recipients who are survived by individuals from whom no estate recovery is possible. Provides that a person's life estate or joint tenancy interests for property not subject to a lien do not end upon death and shall continue.

43 Claims in estates of decedents survived by other survivors. Amends § 256B.15, by adding subd. 1j. Specifies lien and claim procedures for recipients who are survived by individuals from whom only non-homestead recovery is possible.

44 Filing. Amends § 256B.15, by adding subd. 1k. Specifies filing procedures for notices, liens, releases, and other documents.

45 Surviving spouse, minor, blind, or disabled children. Amends § 256B.15, subd. 3. Makes a conforming change.

46 Other survivors. Amends § 256B.15, subd. 4. Specifies procedures for delivering liens to the county agency against homestead property, if there is an unpaid balance to a claim and a

claim is limited to nonhomestead property due to a decedent being survived by certain individuals.

47 Adjustments permitted. Amends § 256B.195, subd. 4. Eliminates references to a provision that is repealed in this article.

48 Continued hospital care for long-term polio patient. Amends § 256B.31. Modifies the payment rate that a hospital receives for providing care to a long-term polio patient, from a rate based on the facility's 1981 costs, indexed by the MA hospital cost index, to the average MA per day rate for disabled individuals receiving services at hospitals located outside of a metropolitan statistical area.

49 Facility fee payment. Amends § 256B.32, subd. 1. Reduces MA and GAMC fee-for-service facility fee payments to hospitals for outpatient hospital facility services by five percent, effective for services provided on or after July 1, 2003. Exempts services provided by Indian health service facilities from this reduction.

50 Definitions. Amends § 256B.69, subd.2. Strikes a provision that allows MA enrollees who fail to submit income reports or recertification forms in a timely manner to continue to receive MA services from a prepaid health plan through the last day of the month in which the enrollee became ineligible.

51 Limitation of choice. Amends § 256B.69, subd. 4. Requires the commissioner to exempt from PMAP persons with access to cost-effective employer-sponsored insurance or persons enrolled in an individual health plan determined to be cost-effective.

52 Managed care contracts. Amends § 256B.69, subd. 5a. Allows the commissioner to exempt a managed care plan from the five percent performance target withhold from MA payment rates, if the plan's contract with the commissioner is the initial contract and was entered into after January 1, 2000. Specifies that this exemption applies for the first five years of operation of the managed care plan.

53 Medical education and research fund. Amends § 256B.69, subd. 5c. Effective July 1, 2003, requires that portion of GAMC capitation payments that would otherwise be transferred to the medical education and research fund to be transferred to the general fund.

54 Payment reduction. Amends § 256B.69, by adding subd. 5h. Reduces MA payments to managed care plans by 0.5 percent for services provided on or after October 1, 2003, and an additional 0.5percent for services provided on or after January 1, 2004. Excludes payments for nursing home services, home and community-based waivers, and payments to demonstration projects for persons with disabilities.

55 Hospital outpatient reimbursement. Amends § 256B.75. Reduces MA and GAMC fee-for-service facility fee payments to hospitals for outpatient hospital facility services by five percent, effective for services provided on or after July 1, 2003. Exempts services provided by Indian health service facilities from this reduction.

56 Physician and dental reimbursement. Amends § 256B.76. Requires the commissioner, for services provided on or after January 1, 2007, to make payments for physician and professional services based on Medicare relative value units. Requires the change to be budget neutral and that the cost of implementing relative value units be incorporated in the conversion factor.

57 General assistance medical care; eligibility. Amends § 256D.03, subd. 3. Modifies eligibility for GAMC and eliminates the program effective October 1, 2004.

The amendment to (a) limits GAMC eligibility, effective October 1, 2003, to Minnesota residents with gross incomes that do not exceed 75 percent of FPG in effect on October 1, 2003, and assets that do not exceed the MA asset limit for families and children. Effective October 1, 2003, eliminates automatic GAMC eligibility for GA enrollees and GRH recipients, and eliminates GAMC eligibility for individuals who spend-down to the GAMC

level, reside in institutions for mental diseases, or are served by the center for victims of torture.

The amendment to (b) makes a conforming change related to paragraph (a).

The amendment to (c) provides that for applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application (one-month retroactive coverage is eliminated).

The amendment to (d) eliminates delayed verification, by striking language allowing eligibility to be granted to certain individuals, subject to the provision of all required verifications within 30 days. This provision is effective April 1 or July 1, 2005, depending on whether the HealthMatch system is operational.

The amendment to (g) eliminates emergency GAMC, effective July 1, 2003.

The amendment to (j) eliminates GAMC coverage for undocumented noncitizens and nonimmigrants, effective July 1, 2003, except for individuals receiving services from the center for victims of torture.

The amendment to (k) eliminates the definition of emergency services, effective July 1, 2003.

A new (m) eliminates GAMC emergency services, effective July 1, 2003, and eliminates the GAMC program effective October 1, 2004. States that individuals enrolled in GAMC as of September 30, 2004, will be converted to MinnesotaCare if they meet the eligibility requirements for that program.

58 General assistance medical care; services. Amends § 256D.03, subd. 4. States that GAMC coverage of dental services is subject to the limitations that apply to MA dental coverage for adults who are not pregnant, except that a 25 percent coinsurance requirement applies to basic restorative dental services. Clarifies that GAMC covers dentures.

59 GAMC co-payments and coinsurance. Adds § 256D.031. Establishes copayments for specified GAMC services.

Subd. 1. Co-payments and coinsurance. Establishes the following copayments, effective for services provided on or after October 1, 2003:

- $25 per nonpreventive visit
- $3 for eyeglasses
- $6 for nonemergency visits to a hospital-based emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $20 per month maximum

Subd. 2. Exceptions. Exempts the following individuals or services from copayments: children under age 21, pregnant women for services that relate to pregnancy or any other condition that may complicate a pregnancy, recipients expected to reside for 30 days in an institution, recipients receiving hospice care, 100 percent federally funded services provided by an Indian health service, emergency services, family planning, services paid for by Medicare for which MA pays the coinsurance and deductible, and copayments that exceed one per day per provider for nonpreventive visits, eyeglasses,

and nonemergency visits to a hospital-based emergency room.

Subd. 3. Collection. Reduces GAMC reimbursement to providers by the amount of the copayment. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in subdivision 4.

Subd. 4. Uncollected debt. Allows providers to refuse services to individuals with uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

60 Non-Minnesota residents. Amends § 256G.05, subd. 2. Makes a conforming change related to the elimination of emergency GAMC.

61 Funding source. Amends § 256L.02, by adding subd. 3a. Requires all MinnesotaCare obligations to be paid out of the general fund, beginning July 1, 2005.

62 Covered health services. Amends § 256L.03. Modifies MinnesotaCare coverage of dental services for adults, by setting coverage at the level provided under MA for adults.

63 Inpatient hospital services. Amends § 256L.03, subd. 3. Exempts single adults and households with no children with incomes not exceeding 75 percent of FPG from the $10,000 inpatient hospital annual limit, effective for services provided on or after October 1, 2004.

64 Copayments and coinsurance. Amends § 256L.03, subd. 5. Modifies MinnesotaCare copayment and coinsurance requirements, to more closely resemble those requirements for MA and GAMC, by:

- adding a $3 copayment for nonpreventive visits
- adding a $6 copayment for nonemergency visits to a hospital-based emergency room, except that the copayment is $25 for parents with incomes exceeding 100 percent of poverty
- setting a 25 percent coinsurance requirement for basic restorative dental services for adults who are not pregnant

Provides exemptions from copayments for the following individuals or services: children under age 21, pregnant women for services that relate to pregnancy or any other condition that may complicate a pregnancy, recipients expected to reside for 30 days in an institution, recipients receiving hospice care, 100 percent federally funded services provided by an Indian health service, emergency services, family planning, services paid for by Medicare for which MA pays the coinsurance and deductible, and copayments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. (Current MinnesotaCare law exempts pregnant women and children under the age of 21.)

States that enrollees are responsible for all copayments and coinsurance. Reduces MinnesotaCare reimbursement to providers by the amount of the copayment. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in (h).

A new (h) allows providers to refuse services to individuals with uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

65 Families with children. Amends § 256L.04, subd. 1. Effective February 1, 2004, eliminates dependent siblings as a MinnesotaCare eligibility category. Allows these individuals to apply as a separate household, rather than being counted in the parental household. Effective July 1, 2003, prohibits parents from remaining enrolled in MinnesotaCare if their gross household income exceeds $50,000.

66 Application and information availability. Amends § 256L.05, subd. 1. Beginning October 1, 2004, requires county human service agencies to accept and process applications and renewals for single adults and households without children with incomes not exceeding 75 percent of FPG who choose to have the county administer their case.

67 Effective date of coverage. Amends § 256L.05, subd. 3. Effective October 1, 2004, provides that coverage for single adults and households without children with gross incomes not exceeding 75 percent of FPG begins the first day of the month following approval. Defines the date of application and specifies eligibility procedures for this group of individuals.

68 Renewal of eligibility. Amends § 256L.05, subd. 3a. Beginning October 1, 2004, requires enrollee eligibility to be renewed every six months and specifies procedures for renewals. (Under current law, eligibility is reviewed every 12 months.)

69 Retroactive coverage. Amends § 256L.05, subd. 3c. Eliminates references to GAMC. (This is a conforming change related to the elimination of the GAMC program.)

70 Application processing. Amends § 256L.05, subd. 4. Eliminates a delayed verification provision that allows individuals who appear to meet eligibility requirements to enroll in MinnesotaCare subject to timely payment of premiums, and to remain enrolled if all required verifications are provided within 30 days.

Provides an effective date of July 1, 2003.

71 Commissioner's duties and payment. Amends § 256L.06, subd. 3. Eliminates the option for enrollees to pay MinnesotaCare premiums on an annual basis, but adds the option of paying premiums on a semiannual basis.

72 General requirements. Amends § 256L.07, subd. 1. Eliminates the July 1, 2003 increase, from 175 percent to 150 percent of FPG, in the maximum income limit at which children are exempt from the requirement that they not have access to employer-subsidized insurance, and also provides an exemption from the four-month uninsured requirement for this group. Effective October 1, 2003, limits the MCHA exemption for persons whose income increases above program income limits to families. Effective February 1, 2004, limits the exemption to children, and reduces the notice period from 18 to 12 months.

73 Must not have access to employer-subsidized coverage. Amends § 256L.07, subd. 2. Beginning February 1, 2004, provides that health coverage for single adults and households without children and adults in families with children shall be considered subsidized coverage if the employer contributes any amount towards the cost of coverage. (Under current law, coverage is considered employer-subsidized if the employer contributes 50 percent or more of the cost.)

74 Other health coverage. Amends § 256L.07, subd. 3. Effective July 1, 2003, reduces from 175 percent to 150 percent of FPG the income limit at which children can remain or become eligible for MinnesotaCare while having other health insurance lacking certain types of coverage. Effective October 1, 2003, exempts individuals with cost-effective coverage paid for by MA from the four-month uninsured requirement. Effective October 1, 2004, exempts single adults and households without children who have gross incomes at or below 75 percent of FPG from the four-month uninsured requirement.

75 Eligibility as Minnesota resident. Amends § 256L.09, subd. 4. Effective October 1, 2004, exempts single adults and households without children with gross incomes not exceeding 75 percent of FPG from demonstrating residence at a verified address other than a place of

public accommodation. Effective October 1, 2004, exempts single adults and households without children with gross incomes not exceeding 75 percent of FPG from the 180-day residency requirement, but requires these individuals to demonstrate residency for 30 days, unless this requirement is waived due to a medical emergency. Effective October 1, 2004, exempts migrant workers who are single adults and adults in households without children with incomes not exceeding 75 percent of FPG from the MinnesotaCare residency requirements, provided that the migrant worker can verify having worked in the state for the past 12 months and having earned at least $1,000 in gross wages.

76 Rate setting; performance withholds. Amends § 256L.12, subd. 9. For services provided on or after January 1, 2004, requires the commissioner to withhold five percent of managed care plan payments, pending completion of performance targets.

A new (d) allows the commissioner to exempt a managed care plan from the 5 percent performance target withhold from MinnesotaCare payment rates, if the plan's contract with the commissioner is the initial contract and was entered into after January 1, 2000. Specifies that this exemption applies for the first five years of operation of the managed care plan.

77 Rate setting; rateable reduction. Reduces total MinnesotaCare payments to managed care plans by 0.5 percent, for services provided on or after October 1, 2003.

78 Premium determination. Amends § 256L.15, subd. 1. Effective October 1, 2004, exempts single adults and households without children with gross income not exceeding 75 percent of FPG from paying MinnesotaCare premiums.

79 Sliding fee scale to determine percentage of gross individual or family income. Amends § 256L.15, subd. 2. Effective October 1, 2003, requires the commissioner to increase each percentage in the sliding scale by 0.5 percentage points for families and children with incomes greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines, and to increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. Effective October 1, 2003, requires single adults and households without children with gross incomes above 75 percent of FPG to pay the maximum premium. Effective February 1, 2004, requires adults in families with gross incomes above 200 percent of FPG to pay the maximum premium.

Effective July 1, 2005, requires these two groups to pay the full cost premium. Defines full cost premium.

80 Exceptions to sliding scale. Amends § 256L.15, subd. 3. Effective July 1, 2003, reduces the income limit for children paying $48 annual premiums, from 175 percent to 150 percent of FPG

81 Limit on total assets. Amends § 256L.17, subd.2. Makes a conforming change to the repeal of the higher MA asset limit for families, by reinstating the asset limit in a section of law governing MinnesotaCare that had cross-referenced the repealed section.

82 Deposit of revenues and payment of refunds. Amends § 295.58. Beginning July 1, 2005, requires the commissioner of revenue to deposit all revenues from the health care provider taxes and the premium tax on nonprofit health plan companies in the general fund. Annually appropriates to the commissioner from the general fund the amount necessary to provide refunds under chapter 295.

83 Time limits; claim limits; liens on life estates and joint tenancies. Amends § 514.981, subd. 6. Modifies provisions related to MA liens, to reflect changes in chapter 256B related to the continuance of a recipient's life estate or joint tenancy interest.

84 Pharmacy plus waiver. Directs the commissioner of human services to seek a pharmacy plus waiver that uses the accumulated savings from the pharmacy and asset transfer provisions of the act, and previously adopted pharmacy savings strategies, as the factor to prove fiscal

neutrality. Requires the commissioner to expand prescription drug program eligibility for seniors and the disabled up to 135 percent of the federal poverty guidelines, to the extent that new federal funding from the waiver allows an expansion without an additional state appropriation.

85 Review of special transportation eligibility criteria and potential cost savings. Requires the commissioner of human services, in consultation with the commissioner of transportation and special transportation service providers, to review eligibility criteria for MA special transportation services and methods for reducing the cost of special transportation services. Requires the commissioner to present recommendations to specified legislative chairs by January 15, 2004. Prohibits the commissioner from using a broker or coordinator to manage special transportation services until the recommendations are presented.

86 Rebates for managed care. Requires the commissioner of human services to develop a proposal to obtain increased pharmacy rebate revenue for recipients served under managed care, and to present this proposal to the chairs and ranking minority members of the relevant legislative committee.

87 Federal approval. Requires the commissioner of human services to seek federal authority and waivers necessary for implementation, if the amendments to sections 256.046, subdivision 1 (fraud disqualification hearings for health care program enrollees) and 256.98, subdivision 8 (authority to disqualify health care program enrollees for wrongfully obtaining benefits) are not effective because of prohibitions in federal law.

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

89 Repealer. (a) Repeals sections 256.955, subd. 8 (annual report on the prescription drug program); 256B.056, subdivision 3c ($15,000/$30,000 MA asset limit for families); 256B.057, subd. 1b (MA eligibility for two years for auto-newborns); and 256B.195, subd. 5 (inclusion of Fairview University Medical Center in intergovernmental transfer), effective July 1, 2003.

(b) Repeals section 256L.04, subd. 9 (prohibition on MinnesotaCare and GAMC coverage in the same month), effective October 1, 2004.

(c) Repeals section 256B.055, subd. 10a (MA eligibility for two years for auto-newborns), effective July 1, 2003, or upon federal approval, whichever is later.

(d) Repeals section 256L.02, subd. 3 (MinnesotaCare program financial management), effective June 30, 2005.

Article 3: Long-Term Care

Overview

This article modifies reimbursement rates and regulatory requirements for long-term care facilities, increases nursing home surcharges and establishes an ICF/MR surcharge, phases-out rate equalization, modifies administration of the alternative care program, eliminates various long-term care grant programs, and makes other changes.

1. 1 Accelerated benefits. Amends § 61A.072, subd. 6. Permits life insurance policies to pay accelerated benefits (paid before death) to policyholders who need long-term care. Current

law is more restrictive on when accelerated benefits may be paid under a life insurance policy.

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

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

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

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

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

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

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

9 Exceptions for replacement beds. Amends § 144A.071, subd. 4a. Provides an exception to the moratorium on nursing home beds, by allowing a 124-bed nursing facility in Hubbard county to license and certify beds as part of a project that involves the construction of a new addition, conversion of existing space to special care and short-term rehabilitation units, expansion of dining and activity facilities, and related remodeling and improvements. Specifies that the total number of licensed and certified beds cannot increase.

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

11 Balancing long-term care: report required. Adds § 144A.351. Requires the commissioners of

health and human services, with the cooperation of counties and regional entities, to report to the legislature on January 15, 2004, and biennially thereafter, on the status of the range of long-term care services for the elderly. Specifies topics that the reports must address.

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

13 Requirements for emergency license. Amends § 245A.035, subd. 3. Corrects a cross-reference.

14 Reconsideration of disqualification. Amends § 245A.04, subd. 3b. Corrects a cross-reference.

15 Disqualification. Amends § 245A.04, subd. 3d. Corrects a cross-reference.

16 Nursing home license surcharge. Amends § 256.9657, subd. 1. Increases the nursing home surcharge from $990 to $2,700 per licensed bed, effective July 15, 2003, and allows the commissioner to reduce, and subsequently restore, the surcharge amount based on the commissioner's determination of a permissible surcharge. Extends by one year the date by which nursing facilities may elect to participate in MA.

17 ICF/MR license surcharge. Amends § 256.9657, by adding subd. 3b. Requires each nonstate-operated ICF/MR to pay to the commissioner an annual surcharge of $4,380 per licensed bed, effective July 1, 2003. Specifies procedures for adjusting the surcharge if the number of licensed beds is reduced. Allows the commissioner to reduce, and later restore, the surcharge based on the commissioner's determination of a permissible surcharge.

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

19 Creation. Amends § 256.9754, subd. 2. Establishes the consolidated ElderCare development grant fund to rebalance the long-term care system and increase home and community-based alternatives. (This is done through modifying the provisions governing the community services development grants program.)

20 Provision of grants. Amends § 256.9754, subd. 3. Lists additional services eligible for funding through the consolidated ElderCare development grant fund, and strikes language directing the commissioner to provide grants to communities and providers to establish older adult services.

21 Eligibility. Amends § 256.9754, subd. 4. Allows ElderCare development grants to also be awarded to for-profits, nonprofits, and governmental units, as well as communities and providers. Requires a local match of 25 percent in the form of cash or in-kind services, and 50 percent for capital costs. (Under current law, the local match for all costs is 50 percent.)

22 Grant preference. Amends § 256.9754, subd. 5. Strikes language placing a $750,000 limit on grants and makes a technical change.

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

24 Certain persons needing treatment for breast or cervical cancer. Amends § 256B.057, subd. 10. Corrects a citation to the definition of creditable coverage in federal law.

25 Imposition of monetary recovery and sanctions. Amends § 256B.064, subd. 2. Allows the commissioner to suspend or terminate a vendor's participation in MA without advance notice and an opportunity for a hearing, when the suspension or termination is required because of

the vendor's exclusion from participation in Medicare. Requires the commissioner to provide notice within five days of taking action, and specifies the information that must be included in the notice.

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

27 Eligibility for funding for services for nonmedical assistance recipients. Amends § 256B.0913, subd. 4. The amendment to (a) replaces statutory language describing the alternative care funding limit for an individual with a cross-reference to the elderly waiver rate limit. Also sets requirements for payment of alternative care premiums.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 Client premiums. Amends § 256B.0913, subd. 12. Modifies premium payments for the alternative care program, to require:

- individuals with incomes less than 150 percent of FPG and assets less than $10,000 to pay 10 percent of the cost of services (under current law, these individuals pay no premium)
- individuals with incomes greater than or equal to 150 percent of FPG, or who have $10,000 or more in assets, pay a fee of 25 percent of the cost of services.

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

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

35 Quality assurance project system established. Amends § 256B.095. Changes the name of the "alternative quality assurance licensing system project" for persons with developmental disabilities (sometimes referred to as the region 10 quality assurance system) to "quality assurance system." Extends the June 30, 2005 sunset for the project to June 30, 2007. Effective July 1, 2003, allows other counties to apply to participate in this system, subject to the agreement of the quality assurance commission. Also gives counties or groups of counties the option of establishing separate quality assurance systems, that would be governed and operate in the same manner as the existing system.

36 Membership. Amends § 256B.0951, subd. 1. Renames the "region 10 quality assurance commission" the "quality assurance commission" and extends the June 30, 2005 sunset for the commission to June 30, 2007. Strikes outdated language related to the initial membership of the commission.

37 Authority to hire staff; charge fees; and provide technical assistance. Amends § 256B.0951, subd. 2. Allows the commission to charge fees for its services and to provide technical assistance to counties and other parties interested in joining the current quality assurance

system or establishing a separate quality assurance system.

38 Commission duties. Amends § 256B.0951, subd. 3. Requires the commission, in consultation with the commissioner, to work with other populations to expand the system (this replaces current law, which requires the commissioner, in consultation with the commission, to examine the feasibility of expansion). Also eliminates obsolete language.

39 Variance of certain standards prohibited. Amends § 256B.0951, subd. 5. Makes conforming changes in terminology.

40 Waiver of rules. Amends § 256B.0951, subd. 7. Makes conforming changes in terminology.

41 Evaluation. Amends § 256B.0951, subd. 9. Makes conforming changes in terminology.

42 Notification. Amends § 256B.0952, subd. 1. Modifies a provision establishing procedures for counties to join the quality assurance system, to allow the possibility of non-region 10 counties joining and to remove specific dates. Also strikes obsolete language and makes conforming changes.

43 Licensure periods. Amends § 256B.0953, subd. 2. Makes conforming changes in terminology.

44 Duties of the commissioner of human services. Amends § 256B.0955. Makes conforming changes in terminology and eliminates the requirement that the commissioner provide technical assistance and support or training to the pilot project.

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

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

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

48 Portion of nonfederal share to be paid by certain counties. Amends § 256B.19, subd. 1d. Requires counties that own and operate nursing homes to transfer an additional $2,230 per licensed bed to the state Medicaid agency, beginning in 2004. Allows the commissioner to reduce these intergovernmental transfers based on the commissioner's determination of payment rates to county nursing homes.

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

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

51 County nursing home payment adjustments. Amends § 256B.431, subd. 23. Beginning in 2004, requires the commissioner to pay nursing homes owned and operated by counties an additional adjustment equal to $6.11 per day multiplied by the number of licensed beds. Allows the commissioner to reduce this payment based on a determination of Medicare upper payment limits.

52 Payment during first 90 days. Amends § 256B.431, subd. 32. For rate years beginning on or after July 1, 2003, limits enhanced payments to 120 percent of the facility's MA rate for each RUG class for the first 30 days, for admissions occurring on or after July 1, 2003. (Under current law, facilities also receive a payment rate of 110 percent of the facility rate for each case mix class for the next 60 days; this enhanced payment is eliminated.) Effective January

1, 2004, prohibits payments of enhanced rates if an individual was a resident of any nursing facility during the previous 30 days.

53 Employee scholarship costs and training in English as a second language. Amends § 256B.431, subd. 36. Strikes language that would have required the commissioner, beginning July 1, 2003, to reimburse nursing facilities through their operating payment rate for the costs of employee scholarships and training related to English as a second language.

54 Nursing home rate increases effective in fiscal year 2004. Amends § 256B.431, by adding subd. 38. Effective June 1, 2003, requires the commissioner to provide each nursing home with an increase in each case mix payment rate equal to the increase in the surcharge, divided by 365, and further divided by .90. Provides that this increase is not subject to annual percentage increases and that the 30-day advance notice requirement for private pay residents does not apply. Prohibits the commissioner from adjusting this rate increase unless an adjustment due to a determination of a permissible surcharge is greater than 1.5 percent of the surcharge amount.

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

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

57 Planning and development of community-based services. Amends § 256B.437, subd. 2. Eliminates the requirement that the commissioners of health and human services report biennially to the legislature on the development of community-based services, transition or closure of nursing facilities, and gaps in services.

58 Prohibited practices. Amends § 256B.48, subd. 1. Phases out the current equalization law for nursing home rates, makes related changes, and recodifies existing language.

The amendment to paragraph (a) allows facilities, effective July 1, 2003, to charge private paying residents up to two percent higher than the June 30, 2003, rate, plus an adjustment equal to any other rate increase provided in law, for a resident's RUGs group. Effective July 1, 2004, this percentage is four percent; effective July 1, 2005, this percentage is six percent; and effective July 1, 2006, this percentage is eight percent. Defines allowable payment rate.

A new paragraph (b) specifies that effective July 1, 2007, limits on private pay rates do not apply, except that special services, if offered, must be available to all residents in all areas, charged at the same rate, and must not include services that must be provided by a facility to meet licensure or certification standards and which would result in a deficiency or violation for the facility if not provided.

The amendment to paragraph (c) requires MA payments to be accepted as payment in full for MA residents.

The amendment to paragraph (f) makes related changes to language specifying what constitutes discrimination in admissions, services offered, or room assignment.

59 Rate increase effective July 1, 2003. Amends § 256B.5012, subd. 5. For rate periods beginning on or after July 1, 2003, requires the commissioner to increase the total operating payment rate of each ICF/MR by $12 per day. Specifies that this increase is not subject to

any annual percentage increase.

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

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

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

63 Copayments and benefit limits. Amends § 256L.12, subd. 6. Corrects cross-reference.

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

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

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

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

68 Monthly rates; exemptions. Amends § 256I.05, subd. 2. Exempts a facility reimbursed by group residential housing at the nursing home rate from the reductions in nursing home rates required under § 256B.431, subd. 39, paragraph (a).

69 Demonstration project. Amends § 256I.05, subd. 7c. Requires the commissioner to seek federal approval by January 1, 2004, for a demonstration project to obtain federal reimbursement of food and nutritional costs currently paid by GRH. Specifies that any reimbursement received is nondedicated revenue to the general fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79 Reports; potential savings to state from certain long-term care insurance purchase incentives.

Subd. 1. Long-term care insurance partnerships. Provides for a study by the DHS commissioner of the possible savings to the state of enacting a "long-term care partnership" program, similar to those in effect in a few other states. Partnership programs involve the state permitting disregard of assets of persons who buy long-

term care insurance and later use up their benefits and need to apply for medical assistance. This is an indirect subsidy to provide an incentive to purchase long-term care insurance.

Subd. 2. Use of medical assistance funds to subsidize purchase of long-term care insurance. Provides for a study by the DHS commissioner of the idea of providing a direct subsidy, from state MA funds, for the purchase of long-term care insurance, targeted at persons who would be unlikely to buy it without the subsidy. The goal would be to reduce MA spending in the long run.

Subd. 3. Nursing facility benefits in Medicare supplement coverage. Provides for a study by the DHS commissioner of the costs and savings to the state of requiring a nursing facility benefit in Medicare supplement coverage.

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

81 Repealer. (a) Repeals sections 256.973 (home sharing grant program); 256.9772 (health care consumer assistance grant program); 256B.0928 (caregiver support and respite care project); and 256B.437, subdivision 2 (planning and development of community-based services), effective July 1, 2003.

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

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

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

Article 4: Continuing Care for Persons with Disabilities

Overview

This article makes changes to ICF/MRs, day training and habilitation programs, eliminates exceptions in the consumer support grant program, modifies family support grants, modifies the home and community-based waivered services, and proposes new intensive rehabilitative mental health services.

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

2 Leaving the residence. Amends § 245B.06, subd. 8. No longer requires ICF/MR residents to leave their residence to participate in regular education, employment, or community activities.

3 Travel time to and from a day training and habilitation site. Amends § 245B.07, subd. 11. Allows providers licensed under chapter 245B to serve persons with developmental disabilities to transport consumers to day training and habilitation sites for up to 90 minutes

per one-way trip (current law limits trips to one hour).

4 Liability of county; reimbursement. Amends § 246.54.

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

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

Makes this section effective January 1, 2004.

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

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

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

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

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

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

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

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

11 Purpose and goals. Amends § 256.476, subd. 1. Eliminates the exceptions in the consumer support grant program.

12 Eligibility to apply for grants. Amends § 256.476, subd. 3. Makes individuals receiving home and community-based waivers ineligible for the consumer support grant. Current law limits the participation of individuals receiving home and community-based waivers.

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

14 Reimbursement, allocations, and reporting. Amends § 256.476, subd. 5. Makes technical and conforming changes.

15 Consumer support grant program after July 1, 2001. Amends § 256.476, subd. 11. Eliminates exceptions in the consumer support grant program so that all recipients are treated equitably. The 2001 Legislature made statutory clarifications that provided a standard method by which consumer support grant amounts were to be calculated. The grant amounts for about 200 recipients exceeded the amount that was allowed under the new methodology. Exceptions in the 2001 law allowed these recipients to be "grandfathered" in at the higher levels.

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

17 Employed persons with disabilities. Amends § 256B.057, subd. 9. Makes a number of changes related to the MA employed persons with disabilities eligibility category.

The amendment to (a) allows individuals who lose employment for reasons not attributable to the enrollee to retain eligibility for up to four consecutive months after the month of job loss, effective January 1, 2004, and makes conforming changes.

A new (c), effective January 1, 2004, provides an earned income disregard of $65 and requires applicants to have earned income above this disregard level. Also requires Medicare, social security, and applicable state and federal income taxes to be withheld.

The amendment to (d) requires all enrollees, effective January 1, 2004, to pay a premium that is the greater of $35 or a premium based on a sliding scale that starts at one percent of gross earned and unearned income for persons with incomes equal to or greater than 100 percent of FPG and increases to 7.5 percent of income for persons with incomes at or above 300 percent of FPG. Also requires enrollees with unearned income to pay one-half of one percent of unearned income in addition to the premium, effective November 1, 2003.

The amendment to (f) requires premiums to be redetermined at six-month income reviews, rather than annually at certification. Requires enrollees to report changes in income or household size within ten days and specifies when premium changes take effect.

The amendment to (h) clarifies that individuals disenrolled for nonpayment of premiums must pay any past due premiums as well as current premiums, prior to being reenrolled, except when an installment agreement is accepted by the commissioner.

18 Relocation targeted case management provider qualifications. Amends § 256B.0621, subd. 4. Makes technical changes.

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

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

Subd. 2. Definitions. Defines "intensive nonresidential rehabilitative mental health services," "intensive residential rehabilitative mental health services," "evidence-based

practices," "overnight staff," and "treatment team."

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

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

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

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

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

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

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

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

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

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

22 Qualifications of provider staff. Amends § 256B.0623, subd. 5. Modifies a component of the definition of mental health rehabilitation worker requiring fluency in the non-English language or competency in the culture of the ethnic group to which at least 20 percent (reduced from 50 percent) of the mental health rehabilitation worker's clients belong.

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

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

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

26 Day treatment services. Amends § 256B.0625, subd. 23. Eliminates MA coverage for day treatment for adults on June 30, 2005.

27 Definition. Amends § 256B.0627, subd. 1. Modifies the definition of "responsible party." Requires responsible parties to be accessible to the recipient and the personal care assistant when personal care services are being provided, monitor the services at least weekly, be

identified at the time of assessment, and be listed on the recipient's service agreement and care plan. Allows responsible parties to delegate the responsibility to another adult who is not the personal care assistant. Strikes the requirement of the responsible party to reside with a recipient of personal care assistant services.

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

29 Flexible use of personal care assistant hours. Amends § 256B.0627, subd. 9. Strikes language requiring the recipient or responsible party to determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party. Strikes references to developing a written month-to-month plan of the projected use of services. Strikes language allowing the recipient or responsible party to revoke the authorization for flexible use of hours. Strikes language requiring the commissioner to deny, revoke, or suspend authorization to use authorized hours flexibly if certain requirements have not been met.

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

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

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

33 Federal waivers. Amends § 256B.092, subd. 5. Requires the individualized service plan to address the appropriateness of receiving habilitative services outside the residence on weekdays.

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

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

36 Regional management of home and community-based waiver services. Proposes coding for new law § 256B.492.

Subd. 1. Region. Defines "region" for the purposes of this section as a county or group of counties with a population of 100,000 or more.

Subd. 2. Purpose. Allows counties to form joint powers agreements for the purpose of regionally managing the home and community-based waiver services. Encourages counties with a population of less than 100,000 to form joint powers agreements with other counties to regionally manage the home and community-based waiver services.

Subd. 3. Regional waiver authority. Requires one of the parties to the joint powers agreement to be designated the regional waiver authority and to monitor regional authorizations and expenditures. Requires the joint powers agreement to specify how decisions are made on authorizations and expenditures from the home and community-based waiver allocation.

Subd. 4. Fiscal management. Allows a region to reserve up to 2 percent of its home and community-based waiver allocation in a given fiscal year.

Subd. 5. Alternative method. Allows the commissioner to (1) require a joint powers agreement; (2) contract with a public or private agency; or (3) require both to administer the waiver program when waiver resources are distributed to a group of counties. Makes the commissioner responsible for assuring that funds are used properly within the amount allocated.

37 Cost management of home and community-based waivered services. Proposes coding for new law, § 256B.493. Requires the commissioner to efficiently allocate and manage limited home and community-based waiver services program resources to achieve certain outcomes. Requires the commissioner to monitor the costs of home and community-based services and allows the commissioner to adjust allocations as necessary to assure that program costs are managed within available funding. Requires the commissioner to give consideration to offsets that may occur in other programs as a result of the availability and use of home and community-based services. Requires the commissioner to make certain considerations when allocating home and community-based resources to local or regional entities.

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

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

40 Payment rate reduction. Amends § 256B.5012, by adding subd. 5. Effective July 1, 2003, requires the commissioner to reduce operating payment rates for each ICF/MR by four percent. Provides the methodology for the adjustment and provides that facilities whose rates are governed by closure or receivership agreements, or rules governing newly established facilities, are not subject to adjustments under the subdivision.

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

42 Pass-through of other services costs. Amends § 256B.5015. Requires services during the day to be paid as a pass-through payment no later than January 1, 2004. Requires the commissioner to establish rates for these services at levels that do not exceed 60 percent of a recipient's day training and habilitation costs prior to the service change. Lists factors the commissioner must consider when establishing a rate and requires pass-through payments for

services during the day to be paid separately by the commissioner.

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

44 Home and community-based waivered service priorities. Requires the commissioner to monitor all available home and community-based waiver resources to support certain priorities for service for eligible individuals during the 2004-2005 biennium.

45 Home and community-based waiver for persons with mental retardation or a related condition; resource management statewide. Requires the commissioner to manage MR/RC waiver resources, during the 2004-2005 biennium, to assure that all available funds are allocated to meet the service priority needs and maintain a reserve statewide of no more than 3 percent of available funds. Requires the commissioner to enable counties to manage resources on a regional basis.

46 Denial, reduction, or termination of waiver services. For the 2004-2005 biennium, before a county denies, reduces, or terminates services under a home and community-based waiver for persons with disabilities, requires the case manager to meet with the individual or guardian and prioritize service needs based on the ISP. Prohibits the reduction in the services authorized for an individual due to funding changes from exceeding the amount necessary to meet the individual's health, safety, and welfare.

47 Direction to the commissioner; home and community-based services resource allocation method development. Requires the commissioner to consult with representatives of persons with disabilities, their families and guardians, counties, service providers, and advocacy organizations to develop recommendations for a statewide method of allocating resources sufficient to meet the identified needs of persons eligible for home and community-based waiver services. Requires the recommendations to include provisions that address the feasibility of offering incentives to persons with less urgent service needs who are receiving services or on the waiting list to postpone their access to home and community-based service options. Requires the recommendations to be provided to the legislative committees with jurisdiction over health and human services issues by January 15, 2005. Requires a status report to be provided by January 15, 2004.

48 Home and community-based services funding methodology. Beginning July 1, 2003, requires the commissioner to consult with representatives of counties, service providers, and persons with disabilities and their families before making significant changes in the funding methodology for the home and community-based waiver for persons with MR/RC.

49 Case management access for home and community-based waiver recipients. Requires the county to determine whether a person qualifies for case management services under the home and community-based waiver services and to begin the screening process and ISP development within ten working days and to provide case management services to those eligible within a reasonable time. Requires the county to contract for case management services if the county is unable to provide case management services.

50 Case management services redesign. Requires the commissioner to develop proposed legislation for case management changes in consultation with consumers, consumer advocates, counties, and service providers. Requires the proposed legislation to be provided to the legislative committees with jurisdiction over health and human services issues by January 15, 2005.

51 SILS and family support grants. Requires the commissioner to require a 20 percent county contribution for the SILS and family support grants by January 1, 2004.

52 Vacancy listings. Requires the commissioner of human services to work with interested stakeholders to provide useful information to consumers on bed vacancies for group

residential and ICF/MR providers.

53 Homeless services; state contracts. Allows the commissioner to contract directly with nonprofit organizations providing homeless services in two or more counties. Prohibits more than 2 percent of the Children's and Community Social Services Act funds from being set aside for this purpose.

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

55 Governor's council on developmental disability. Requires the council to submit an annual report to the legislature by February 1 of each year.

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

57 Repealer. (a) Repeals sections 245.4886 (children's community-based mental health fund); 245.496 (implementation); 252.32, subdivision 2 (individual service plan); 254A.17, subdivision 3 (statewide detoxification transportation program); 256B.0945, subdivisions 6 to 10 (federal earnings, maintenance of effort, reports, sanctions, and recommendations); 256B.095 (quality assurance project established); 256B.0951 (quality assurance commission); 256B.0952 (county duties; quality assurance teams); 256B.0953 (quality assurance process); 256B.0954 (certain persons defined as mandated reporters); 256B.0955 (duties of the commissioner of human services); 256B.5013, subdivision 4 (ICF/MR temporary rate adjustments to address occupancy); 256E.01, 256E.02, 256E.03, 256E.04, 256E.05, 256E.06, 256E.07, 256E.09, 256E.10, 256E.11, 256E.115, 256E.12, 256E.13, 256E.14, 256E.15, (community social services); 256F.01, 256F.02, 256F.03, 256F.04, 256F.05, 256F.06, 256E.07, 256E.08, 256F.11, 256F.12, 256F.14 (Minnesota family preservation act); 257.075 (grants for support services); 257.81 (training for interviewers of maltreated children); 260.152 (mental health screening of children); and 626.562 (child abuse professional consultation telephone line); effective July 1, 2003.

(b) Repeals § 245.4712, subd. 2 (requirement that counties provide day treatment services to adults with mental illness) effective July 1, 2005.

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

(d) Repeals Minnesota Rules related to community social services.

Article 5: Children's Services

Overview

This article makes changes to various human services statutes related to children's services. Provisions in this article authorize medical assistance reimbursement for an adolescent mental health crisis facility; modify the children's mental health medical assistance benefit; modify certification requirements for prospective adoptive homes in international adoptions; and modify the adoption and relative custody assistance programs.

1. 1 Restricted construction or modification. Amends § 144.551, subd. 1. Adds an exception to the moratorium on hospital construction or modification. Authorizes a project to construct or relocate up to 20 hospital beds to operate up to two psychiatric facilities or units for children if the commissioner of human services approves the operation of the facilities or units.

2 Mental health case management. Amends § 256B.0625, subd. 20. Removes the county or tribal maintenance of effort requirements for medical assistance mental health case management services.

3 Day treatment services. Amends § 256B.0625, subd. 23. Clarifies that medical assistance covers day treatment services for adults as specified in section 245.462, subdivision 8 (the definition of day treatment services in the Adult Mental Health Act). Provides that medical assistance covers day treatment services for children as specified under section 256B.0943 (section 7 of this article). Makes this section effective July 1, 2004.

4 Children's mental health crisis response services. Amends § 256B.0625, by adding subd. 35a. Provides that medical assistance covers children's mental health crisis response services under section 256B.0944 (section 8 of this article). Makes this section effective July 1, 2004.

5 Children's therapeutic services and supports. Amends § 256B.0625, by adding subd. 35b. Provides that medical assistance covers children's therapeutic services and supports under section 256B.0943 (section 7 of this article). Makes this section effective July 1, 2004.

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

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

Makes this section effective July 1, 2004.

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

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

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

necessary children's therapeutic services and supports provided by eligible providers to eligible clients.

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

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

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

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

(b) Specifies that a provider entity must be:

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

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

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

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

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

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

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

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

(c) Requires a mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. Specifies the topics that must be covered in the training.

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

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

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

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

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

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

Makes this section effective July 1, 2004.

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

Subd. 1. Definitions. Defines the following terms for purposes of this section: mental health crisis; mental health emergency; mental health crisis assessment; mental health mobile crisis intervention services; and mental health crisis stabilization services.

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

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

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

Subd. 4. Provider entity standards. (a) Specifies that a children's mental health crisis response services provider entity must meet the administrative and clinical standards under this section and be:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Makes this section effective July 1, 2004.

9 Covered services. Amends § 256B.0945, subd. 2. Removes requirements from current law regulating medical assistance reimbursement for facilities that are institutions for mental diseases or other approved facilities. Medical assistance coverage for subacute psychiatric care for persons under age 21 is provided under section 6 of this article.

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

11 Distribution of new federal revenue. Amends § 256F.10, subd. 6. Removes a provision from current law requiring counties to use federal medical assistance funds earned for child welfare targeted case management services to expand preventive child welfare services. Gives counties flexibility regarding use of these funds.

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

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

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

15 Conflicts. Provides that the amendments in section 11 of this article prevail over any conflicting law that amends or repeals it, regardless of the order or date of enactment.

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

17 Repealer. (a) Repeals section 256B.0945, subdivision 10 (requiring the commissioner to provide recommendations to the legislature by January 15, 2000, regarding amendments necessary before implementing the residential services for children with severe emotional disturbance section) and 256F.10, subdivision 7 (requirements for county and tribal social services expenditures for child welfare preventive services).

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

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

Article 6: Community Services Act

Overview

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

1. 1 Citation. Adds § 256M.01. Provides that sections 1 to 9 of this article may be cited as the "Children and Community Services Act." Also provides that the act establishes a fund to address the needs of children, adolescents, and adults in each county in accordance with a service agreement between the county and the commissioner of human services. Requires that the service agreement specify outcomes, strategies, and state and county roles. Also requires the service agreement to be reviewed and updated every two years, or sooner if necessary. Specifies that nothing in this article is intended to limit the ability of counties to provide services to adults over age 25.

2 Definitions. Adds § 256M.10. Defines the following terms for purposes of sections 1 to 9 of this article: children and community services; commissioner; county board; former children's services and community service grants; and human services board.

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

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

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

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

(b) Authorizes the commissioner to require a county to enter into a joint powers agreement with counties in good standing if the commissioner determines the county has failed to reach the targets identified in its approved service agreement over a four-year period for the core outcomes established for all counties.

Subd. 4. Corrective action procedure. Specifies the procedures the commissioner must comply with when reducing a county's funds or requiring a joint powers agreement. The procedures include the commissioner providing notice to the county of

noncompliance, a 30-day opportunity for the county to demonstrate compliance, and an opportunity for the county to develop and implement a corrective action plan.

4 Service agreement. Adds § 265M.30.

Subd. 1. Approval required by commissioner. Effective January 1, 2004, in order to receive funds under this act, requires each county to have a biennial service agreement approved by the commissioner. Permits counties to submit multi-county or regional service agreements.

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

Subd. 3. Information. Requires the commissioner to provide each county with certain information and technical assistance needed to complete the service agreement.

Subd. 4. Timelines. Requires each county to submit the preliminary service agreement to the commissioner by October 15, 2003, and by October 15 every two years thereafter.

Subd. 5. Public comment. Requires the county to solicit public participation and comments in the development and contents of the service agreement.

Subd. 6. Commissioner responsibilities. Requires the commissioner to notify the county within 60 days of receiving a county service agreement if the agreement is approved or if revisions are necessary before approval.

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

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

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

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

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

Subd. 2. Performance incentive. Beginning with the calendar year 2006 allocation, requires the commissioner to withhold 5 percent of each county's annual allocation and release those funds to the counties based on the county's achievement of positive outcomes as agreed to in the county's service agreement.

Subd. 3. Project of regional significance. Beginning with the calendar year 2006 allocation, dedicates $25,000,000 of the available annual funds to projects of regional significance. Requires the commissioner to publish a request to solicit proposals from groups of counties by region. Specifies the efforts the projects must support.

Subd. 4. Payments. Requires the commissioner to make calendar year allocations of state funds appropriated for children and community services grants and performance

incentive payments to counties on or before July 10 each year. Requires the commissioner to pay funds awarded to projects of regional significance according to requirements in the contract between the commissioner and the contracting entities.

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

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

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

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

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

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

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

8 Fiscal limitations. Adds § 256M.70.

Subd. 1. Service limitation. Provides that the county is not required to provide children and community services beyond federal or state requirements.

Subd. 2. Demonstration of reasonable efforts. Requires the county to make reasonable efforts to comply with all children and community services requirements, within available funding, including efforts to identify and apply for commonly available state and federal funding.

Subd. 3. Identification of services to be provided. Specifies what a county must consider in providing services when the county has made reasonable efforts to comply with all administrative rule requirements, but is unable to meet all requirements.

Subd. 4. Denial, reduction, or termination of services due to fiscal limitations. Specifies the county requirements when denying, reducing, or terminating services to an individual due to fiscal limitations.

Subd. 5. Appeal rights. Provides that an individual who is denied services or whose services are reduced or terminated has the right to a fair hearing.

Subd. 6. Right to petition for review. An individual who is denied services or whose services are reduced or terminated under this chapter may petition the commissioner in writing to review the county's performance under the county service agreement. Requires the commissioner to reply in writing to the petition within 60 days of receiving the petition.

9 Program evaluation. Adds § 256M.80.

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

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

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

11 Repealer. (a) Repeals sections 245.478 (adult component of community social services plan); 245.4886 (children's community-based mental health fund); 245.4888 (children's component of community social services plan); 245.496 (start-up funds for local children's mental health collaboratives); 254A.17 (prevention and treatment initiatives); 256B.0945, subdivisions 6 (residential services for children with severe emotional disturbance; federal earnings), 7 (maintenance of effort), 8 (reports), 9 (sanctions), and 10 (recommendations); 256B.83 (maintenance of effort for certain mental health services); 256E.01 to 256E.115 and 256E.13 to 256E.15 (Community Social Services Act, except for grants for community support services programs for persons with serious and persistent mental illness); 256F.01 to 256F.08 (the Minnesota Family Preservation Act, except for child welfare targeted case management); 256F.11 (grant program for crisis nurseries); 256F.12 (grant program for respite care); and 256F.14 (family group decision-making); 257.075 (grants for support services for minority children in out-of-home placements); 257.81 (training for interviewers of maltreated children; commissioner of human services duties); 260.152 (mental health screening of children); and 626.562 (child abuse professional consultation telephone line).

(b) Repeals Minnesota Rules, parts 9550.0010 to 9550.0093 (administration of community social services).

Article 7: Human Services Licensing, County Initiatives, and Miscellaneous

Overview

This article makes changes to various human services-related statutes. Provisions in this article modify the Human Services Licensing Act and the licensing standards for programs serving persons with mental retardation or related conditions; increase human services licensing fees; restructure parental fees; remove certain requirements on counties; modify the voluntary admissions and treatment standards and emergency hold provisions in the Civil Commitment Act; modify the Minnesota merit system; require the public authority to charge a cost recovery fee for providing child support and maintenance collection services; and require the commissioners of health and human services to make certain reports to the legislature. This article also includes a provision reducing the amount appropriated and transferred annually from the excess police state-aid holding account to the ambulance service personnel longevity award and incentive suspense account.

1. 1 Excess police state-aid holding account. Amends § 69.021, subd. 11. Reduces the amount in the excess police state-aid holding account appropriated and annually transferred to the ambulance service personnel longevity award and incentive suspense account from $1,000,000 to $900,000.

2 Duties. Amends § 124D.23, subd. 2. Removes a requirement that family service collaboratives use new or reallocated funds to improve or enhance services provided to children and their families. Requires instead that a collaborative use funds to provide services to children and their families.

3 Restricted construction or modification. Amends § 144.551, subd 1. Exempts, from the moratorium on hospital construction, a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver county serving the southwest suburban metropolitan area.

4 Collaborative responsibilities. Amends § 245.4932, subd. 1. Removes certain requirements related to the authority and responsibilities of the children's mental health collaborative regarding federal revenue enhancement. Removes requirement that the collaborative must use any enhanced revenue attributable to the collaborative's activities "solely" to provide mental health services or expand the target population. Also removes the maintenance of effort requirement related to expenditures for services for children with emotional or behavioral disturbances and their families.

5 Background study of the applicant; definitions. Amends § 245A.04, subd. 3. Clarifies when the commissioner of human services may require the subject of a background study to provide classifiable fingerprints obtained from an authorized law enforcement agency.

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

(e) Clarifies that, if an individual is disqualified for a determination of substantiated maltreatment of children or adults, the person may request a fair hearing if the commissioner

does not set aside the disqualification. Also clarifies that, if a person is disqualified for the conviction or admission to certain crimes, the commissioner's reconsideration decision is the final agency determination for purposes of appeal.

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

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

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

(b) Provides that no application fee shall be charged for child foster care, adult foster care, or state-operated programs, unless the state-operated program is an intermediate care facility for persons with mental retardation or related conditions (ICF/MR).

(c) Permits a county agency to charge a fee to an applicant or license holder for criminal background checks in an amount not to exceed the actual cost, but in any case not to exceed $100 annually. Also permits the county agency to charge for conducting licensing inspections of family day care programs in an amount not to exceed the actual cost of licensing, but in any case not to exceed $150 annually.

(d) Provides that a county may elect to reduce or waive the fees in paragraph (c) in cases of financial hardship or if the county has a shortage of providers.

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

Subd. 2. Application fee for initial license or certification. Requires an applicant for initial license or certification to submit a $500 application fee. Also specifies application fee requirements for a license to provide waivered services to persons with developmental disabilities or related conditions; semi-independent living services to persons with developmental disabilities or related conditions; and independent living assistance for youth.

Subd. 3. Annual license or certification fee for programs with licensed capacity. Specifies annual license or certification fees for child care centers and programs with a licensed capacity. Also specifies the license fee requirements for day training and habilitation programs serving persons with developmental disabilities or related conditions.

Subd. 4. Annual license or certification fee for programs without a licensed capacity. Requires a program without a licensed capacity to pay a $400 license or certification fee. Also requires a mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement to pay a $1,000 annual certification fee.

Subd. 5. License not issued until license or certification fee is paid. Prohibits the commissioner from issuing a license or certification until the license or certification fee is paid. Specifies the process the commissioner must use for billing a license holder for the fee and notifying a license holder that the fee is past due. Requires that a program license expire on December 31 unless the license holder pays the fee before December 31. Also provides that, after a license expires, the former license holder must submit a new license application and application fee.

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

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

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

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

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

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

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

12 Relationship to other standards governing services for persons with mental retardation or

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

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

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

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

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

17 Staff training. Amends § 245B.07, subd. 6. Provides that direct service staff who have worked for a license holder for at least 30 hours per week for 24 months or more to annually complete hours of training equal to 1 percent of the number of hours the staff person worked.

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

19 Alternative methods of determining compliance. Amends § 245B.08, subd. 1. Corrects a cross-reference.

20 Contribution amount. Amends § 252.27, subd. 2a. Modifies the amount a parent must contribute to the cost of services provided to a child who has mental retardation or a related

condition, a physical disability, or emotional disturbance, who receives 24-hour care outside the home in a facility licensed by the commissioner.

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

- if adjusted gross income is between 100 percent and 175 percent of federal poverty guidelines, the parental contribution is $4 per month;
- if adjusted gross income is between 175 percent and 375 percent of federal poverty guidelines, the parental contribution is determined using a sliding fee scale established by the commissioner that begins at 1 percent of adjusted gross income and increases to 7.5 percent of adjusted gross income;
- if adjusted gross income is between 375 percent and 675 percent of federal poverty guidelines, the parental contribution is 7.5 percent of adjusted gross income;
- if adjusted gross income is between 675 percent and 975 percent of federal poverty guidelines, the parental contribution is 10 percent of adjusted gross income; and
- if adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution is 12.5 percent of adjusted gross income.

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

Makes this section effective July 1, 2003.

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

- has given informed consent or, if lacking capacity, is a person for whom legally valid consent has been given; and
- is participating in a medically appropriate course of treatment.

Permits the court to commit a person if the court finds, based on the person's recent history, it is unlikely the person will remain in and cooperate with treatment absent commitment. Specifies circumstances in which this paragraph does not apply. Also specifies how legally valid substitute consent may be provided.

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

(a) Provides that a person held under the emergency hold section may be held up to 72 hours based upon a determination that a hold is necessary.

(c) Provides that the examiner or treating physician may discharge a patient if, at any time during the 72 hour hold, the examiner or treating physician determines a patient held in a detoxification facility no longer meets the criteria to be held under this section. The examiner or treating physician must provide a written statement specifying why the patient no longer meets the criteria for an emergency hold. Also states that the county or provider is not liable if a patient is discharged if the requirements of this paragraph are met.

(d) Provides that, if a person is intoxicated in public and held for detoxification, a treatment facility may release the person without providing the required notice as soon as the treatment facility determines the person is no longer intoxicated.

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

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

24 Sunset. Amends § 256.482, subd. 8. Extends from June 30, 2003, to June 30, 2005, the date on which the council on disability sunsets.

25 Burial or cremation expenses. Amends § 256.935, subd. 1. Modifies a requirement that county agencies pay for the funeral expenses of persons receiving public assistance through MFIP. Allows counties to pay for cremation instead of burial expenses. Removes a requirement that freedom of choice be granted in the selection of a funeral director to persons lawfully authorized to make arrangements for the burial of any such deceased recipient.

26 Long-term care consultation team. Amends § 256B.0911, subd. 3. Removes requirement that the long-term care consultation team is responsible for providing consultation services to all persons located in the county who request services

27 Federal revenue enhancement. Amends § 256F.13, subd. 1. Removes certain duties of the commissioner of human services relating to base level expenditures of the family services collaboratives. Also removes certain responsibilities of family services collaboratives relating to base level expenditures. Makes technical changes.

28 Agreements with family services collaboratives. Amends § 256F.13, subd. 2. Modifies the provisions that must be included in the agreement between the commissioner and a family services collaborative.

29 Burial at expense of county. Amends § 261.035. Modifies a requirement that counties provide for a person's funeral or final disposition when a person dies in any county without apparent means to defray the necessary expenses. Changes references to "funeral or final disposition" to "burial or cremation."

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

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

administrative costs to the state while maintaining compliance with federal requirements.

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

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

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

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

(c) Requires the public authority to charge a cost recovery fee of 2 percent of the amount collected if an obligee applies for full IV-D services. The public authority must deduct this amount from the amount of child support and maintenance collected before disbursement to the obligee. Specifies that the fee does not apply to an obligee who:

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

(d) Requires the public authority to charge a cost recovery fee of 2 percent of the monthly court-ordered child support and maintenance obligation if an obligor applies for full IV-D services. Provides that the public authority may collect the fee through income withholding or any other available enforcement remedy.

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

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

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

34 Application. Amends § 518.6111, subd. 2. Broadens the public authority's income

withholding authority. Makes this section effective July 1, 2004.

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

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

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

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

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

Makes this section effective July 1, 2004.

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

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

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

Makes this section effective July 1, 2004.

38 Mandate identification; report to legislature. Requires the commissioners of health and human services to identify required state services or programs in law or rule that are under each agency's respective jurisdictions, the administration of which the state has delegated to the counties. Specifies what the commissioners must describe for each state-mandated service or program. Requires the commissioner to seek the advice of county officials knowledgeable about the state-mandated services and programs, county associations, consumer representatives, and service or program providers. Requires each commissioner to report to the legislature by January 15, 2004. Makes this section effective the day following

final enactment and expire June 30, 2005.

39 State-operated services study. Requires the commissioner to study alternate methods of providing services to persons with developmental disabilities served in state-operated community services, including how the services could be privatized by June 30, 2005. Requires the commissioner to also study the Minnesota extended treatment options, including an analysis of the population served by the program and the effectiveness of the program. Requires the commissioner to report on the results of the study to the chairs of the house and senate committees with jurisdiction over state-operated services by January 15, 2004.

40 Reducing duplicative health and human services licensing activities; report to the legislature. Requires the commissioners of health and human services to submit a report to the legislature by December 15, 2003, regarding how to reduce duplicative licensing activities by the departments of health and human services. Also requires the report to include draft legislation and an analysis of certain issues related to reducing the agencies' duplicative licensing activities for intermediate care facilities for persons with mental retardation or related conditions (ICFs/MR) and residential adult mental illness and chemical dependency treatment programs.

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

42 Repealer. (a) Repeals sections 145A.17, subdivision 9 (no supplanting of existing funds); 245.478 (adult component of community social services plan); 245.4888 (children's component of community social services plan); 245.714 (maintenance of effort); 256B.0945, subdivision 6 (federal earnings), subdivision 7 (maintenance of effort), subdivision 8 (reports), and subdivision 10 (recommendations); 256B.83 (maintenance of effort for certain mental health services); and 256F.10, subdivision 7 (expansion of services and base level of expenditures).

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

Article 8: Miscellaneous Health Provisions

1. 1 Short term coverage. Changes limits on short term health coverage from 185 days in a 365 day period to 555 days in a 730-day period.

2 Distribution of funds. Eliminates reference to repealed Medical Education Endowment Fund. Provides that other specified funds are available for University of Minnesota academic health care.

3 Transfers from University of Minnesota. Provides for $4,850,000 annual transfer from University of Minnesota to commissioner of health from certain dedicated funds.

NOTE: Effect of sections 2 and 3 is dependent upon passage of amendments to the dedicated cigarette tax proposed in H.F. 751, article 8, section 3.

4 Designation. Designates hospitals that would have met criteria for rural hospital assistance grants under section 144.1484 (repealed by this bill) as essential community providers.

5 Fees. Provides a schedule of fees to be charged by the commissioner for plan review and inspection of public pools and spas. Currently, some fees for pool plan review are included in Minnesota Rules 2001, chapter 4717.0310.

6 Testing of infants for heritable and congenital disorders. Changes requirement that specified people test infants for "inborn errors of metabolism" to a requirement for tests for "heritable and congenital disorders." Provides criteria for determination of which tests should be performed. Mandates a $61 per specimen laboratory service fee. Provides that written objection to the tests by parents exempt an infant from these testing requirements and the registration requirements of section 144.128.

7 Advisory committee on heritable and congenital disorders. Provides for an advisory on heritable and congenital disorders to be appointed by the commissioner of health. Identifies groups to be represented in membership of committee. Activities of committee to include collection of information on tests for heritable and congenital conditions, availability and efficacy of treatments for such disorders, and severity of medical conditions caused by such disorders. Committee is also to discuss benefits versus disadvantages of performing tests and ethical considerations surrounding testing. Committee also to make recommendations to the commissioner concerning tests and treatments for heritable and congenital disorders found in newborns. This section is effective the day following final enactment.

8 Commissioner's duties. Changes terminology from "inborn errors of metabolism" to "heritable and congenital disorders." Provides that the commissioner will make referrals for treatment of heritable and congenital disorders when indicated. Prior law required the commissioner to make arrangements for such treatment when the family was unable to pay the cost.

9 Rural health initiatives. Eliminates administration of these grants (program repealed) from the rural health initiative duties of the commissioner.

10 Eligible health professionals. Changes reference to federal Bureau of Primary Health Care to Bureau of Health Professions.

11 Penalties for breach of contract. Conforms statute to federal length of service and financial penalty requirements for breach of contract by health professionals to provide services in shortage areas in exchange for loan repayment.

12 Health professional education loan forgiveness program. Establishes a single health professional education loan forgiveness program similar to three repealed programs for medical residents agreeing to practice in designated rural or underserved urban communities, mid-level practitioners agreeing to practice in designated rural areas, and nurses agreeing to practice in nursing homes or ICF/MR's. Minimum service commitment for new program is three years, compared to current minimums of three years for residents, two years for mid-level practitioners and one year for nurses. Maximum loan repayment based on formula using average educational indebtedness of graduates in the respective professions. Current maximum loan repayments are fixed dollar amounts. Funds available to be distributed proportionally among the covered professions according to the vacancy rate for each. Distribution to be 75 percent for rural and 25 percent for underserved urban areas.

13 Loan forgiveness. Removes the 14-person limitation on annual participation in the dentists loan forgiveness program. Replaces the $10,000 per year and $40,000 total maximum disbursements to participants with a formula-based maximum allowing 15 percent of the average educational debt of a dental graduate.

14 Citation. Provides that the new law may be cited as the "Minnesota Adverse Health Care Events Reporting Act of 2003".

15 Definitions. Defines "commissioner," "facility," "serious disability" and "surgery" for purposes of the act.

16 Facility requirements to report, analyze and correct. Establishes requirement that facilities report adverse health care events to the commissioner as soon as possible and within 15 working days of discovery. Reports are to be in the form specified by commissioner, and are to identify the facility but not to name or otherwise personally identify any individuals

involved. Six categories of reportable events are established:

- Surgical events. Includes surgery performed on the wrong body part or on the wrong patient, performance of the wrong surgical procedure, retention of a foreign body in a patient after surgery or death during or immediately after surgery in normal, healthy patients undergoing certain localized operations.
- Product or device events. Includes certain deaths or serious disabilities resulting from: contaminated drugs, devices or biologics; improper function of a device; or intravascular air embolism.
- Patient protection events. Includes discharge of an infant to the wrong person, death or disability associated with patient disappearance of more than four hours, and suicide or attempted suicide resulting in disability if due to patient actions while in a facility.
- Care managements events. Includes patient death or disability associated with medical error, administration of incompatible blood, labor and delivery in a low-risk pregnancy, hypoglycemia, or failure to treat neonatal hyperbilirubinemia. Also includes stage 3 or 4 ulcers acquired after admission and death or disability from spinal manipulative therapy.
- Environmental events. Includes death or disability from electric shock, burns, falls, or use or lack of restraints or bedrails, as well as any incident in which a line designated for oxygen or other gas contains the wrong gas.
- Criminal events. Includes instances of care provided by someone impersonating a health care provider, abduction of a patient, sexual assault on a patient, or death or injury of a patient or staff member resulting from assault.

Facilities are required to complete a root cause analysis and corrective action plan with regard to each reportable event and file it with the commissioner within 60 days. Commissioner must implement an electronic means for filing these reports. Events reportable under this act are not subject to the reporting requirements of the Vulnerable Adults Act.

17 Commissioner duties and responsibilities. Requires commissioner to establish adverse event reporting system to consist of: mandatory reporting of the events listed in section 4, mandatory root cause analysis and corrective action plans, analysis of reports by commissioner to identify patterns of health care system failure and methods of correction, imposing sanctions for failure to comply with reporting requirements and communications with specified parties to maximize use of reporting system. Reports submitted under this act are considered aggregate data and provided the protections and immunities of section 145.64, subdivision 1, paragraph (b), which allows release of nonpatient-identified trend data without liability. Further requires the commissioner to analyze reports received, communicate conclusions and any recommendations to facilities, and publish an annual report. Commissioner may sanction a facility for failure to file required reports, analysis and corrective action plans. Commissioner may suspend, revoke, place conditions on or fail to renew a facility's license for failure to develop and implement a mandated corrective action plan.

18 Interstate coordination. Requires the commissioner of health to report the list of reportable events included in section 4 to the National Quality Forum. Requires commissioner to monitor the Forum's list of reportable events and recommend changes in Minnesota's list to the legislature as necessary.

19 Exemptions. Replaces references to definitions of "mid-level practitioner," "nurse-midwife"

and "nurse practitioner" in repealed statutes with references to the same definitions in new statutes.

20 Fee proration. Allows proration of registration fee for clinical fellowship registrants and temporary registrants. Currently only first time registrants fees are prorated.

21 Biennial registration fee. Adds clinical fellowship registration to the $200 speech-language pathologists and audiologists registration fee.

22 Biennial registration fee for dual registration. Adds clinical fellowship registration to the $200 speech-language pathologists and audiologists dual registration fee.

23 Verification of credential. Provides for a $25 fee for verification of credentialed status of speech-language pathologists and audiologists.

24 Verification to other states. With regard to occupational therapists and occupational therapy assistants, changes reference to "certification" of licensure to other states to "verification" of licensure.

25 Fees. Provides various fees related to alcohol and drug counselor licensure. Most of these fees are currently provided in Minnesota Rules 2001, chapter 4747.1600. The amounts of some of the fees are changed, and a fee for temporary practice status is included.

26 Expenses; fees. Certain fees payable by hearing aid dispensers amended.

27 Medical education and research fund. Amends formula for calculation of commissioner of human services transfer to the health education and research fund by reducing the amount to be paid from capitation rates beginning July 1, 2002 from $2,537,000 to $2,157,000.

28 Estimated tax; hospitals; surgical centers. The exclusion from payment of estimated gross earnings tax for entities receiving certain grants to at-risk rural hospitals is eliminated. Program from which such grants were made is repealed in this bill.

29 Applications, fees. Provides a schedule of fees for plan reviews and audits of plumbing installations for public, commercial and industrial buildings.

30 Authority to collect certain fees suspended. The certification fee for hearing aid dispensers provided by section 20 is suspended for renewal certifications in fiscal year 2004. The license renewal fee for occupational therapists and occupational therapy assistants is suspended for fiscal years 2004 and 2005.

31 Transition period. Provides for transition to full implementation of the Minnesota Adverse Health Care Events Reporting Act from July 1, 2003 through June 20, 2005

32 Hospital moratorium study. Provides for a study on the moratorium on hospital beds by the commissioner of health in cooperation with the Minnesota Hospital Association and other affected parties. Requires a final report to the legislature by January 15, 2005 and a progress report by March 15, 2004.

33 Repealer, expenditure reporting. Repeals requirement that certain expenditures by health care providers be reported to the commissioner of health. Repeals sunset on statute requiring proceeds of litigation by a state official on behalf of the state to be deposited in the general fund.

Article 9: Local Public Health Grants

Overview

Amends statutes relating to Community Health Service Subsidy and Maternal and Child Health Special Projects to create single Local Public Health Grant program for distribution to community health boards using a single formula. Eliminates references to deleted sections of statute and amends references to amended sections.

1. 1 Review criteria. Eliminates reference to a repealed section in criteria for reviewing ambulance service applications.

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

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

4 Funding. Eliminates review of proportional expenditure of maternal and child health block grants by the maternal and child health advisory task force.

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

6 Allocation to community health. Block grants to be allocated to community health boards on the basis of a new formula (found in section 28) rather than to community health services areas. Eliminates minimum allocations and requirement for proportional decreases among grant recipients.

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

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

9 Accountability. Community health boards receiving block grant money must select two statewide maternal and child health outcomes by December 31, 2005. Provides for monitoring and evaluation of progress towards outcomes selected. From January 1, 2004, until December 31, 2005, all community health boards must work toward goal of reducing number of low birth weight babies to no more than 5%.

10 Scope. References to repealed section eliminated.

11 Community health board. The definition of community health services area is replaced with a definition for community health board.

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

13 Community health services. Eliminates list of program categories of community health services.

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

15 Generally. Amends reference to include newly added subdivision.

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

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

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

19 Preemption. Replaces references to present public health subsidy with proposed public health grant.

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

21 State and local advisory committees. Eliminates per diem for members of public health advisory committees. Eliminates minimum number of members and minimum number of meetings per year. Expands requirements for broad representation on committees. Provides that committee will advise on new duties of community health board provided in section 20.

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

23 Ordinances relating to community health services. Deletes cross-reference to deleted section.

24 Administrative and program support. Assistance to community health boards by commissioner to include standards developed by the state community health advisory committee. Deletes reference to a plan approval that was required by a deleted section.

25 Personnel standards. For purposes of commissioner's standards for community health personnel, eliminates reference to competence in program areas where the definitions of the program areas are repealed by the bill.

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

27 Expiration. Provides that the community health services subsidy program expires on January 1, 2004 (replaced by local public health grant - see section 28).

28 Local public health grant. New program to replace variety of dedicated grant programs. Provides $2 million annually for tribal governments. Allocation of funds to community public health boards shall be as follows: no less than 95% of the board's 2002 community health services subsidy and the board's 2002 maternal and child health special projects grant; $25,000 for every county included on a board; and any available balance distributed on a per capita basis. 50% local match required. Additional funds for specific outcomes may be

distributed in proportion to the basic award. Non-competitive special project grants may be funded through local public health grants. Commissioner is responsible for activities to meet statewide outcomes in geographic areas where the board does not participate in the grant program. Boards must demonstrate progress toward outcomes to remain eligible for grants. Establishes criteria and procedures for commissioner's determination not to distribute funds for failure to make progress.

29 Indian health grants. Amends Indian health grant provisions to eliminate the requirement that such grants be to community health boards pursuant to a community health plan.

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

31 Repealer.

Statutes repealed. Repeals community prevention grant program, grants for temporary lead-safe housing contracts, suicide prevention grant program, formula for distribution of maternal and child health block grants, definitions of "essential services" and "special project" for purposes of the maternal and child health block grant, application procedures for maternal and child health care grants, grants and clinics for fetal alcohol syndrome education and diagnosis, funding for screening and follow-up for tuberculosis for foreign-born persons, certain definitions from the Local Public Health Act, certain planning and reporting obligations of community health boards, certain approval obligations of cities and counties, certain planning and reporting assistance obligations of the commissioner, certain grants to prevent tobacco use and to establish health promotion teams, and allocation of funds to family home visiting programs.

Rules repealed. Repeals all local public health services rules except those relating to Indian Health Grants and personnel standards for community health services administrators.

Article 10: Appropriations

Overview

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

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

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

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

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

5 Registration. Amends § 119B.011, proposing a new subd. Defines "registration" as the process used by a county to determine whether a provider meets the requirements necessary

for payment of child care assistance for care provided by that provider.

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

7 Federal poverty guidelines. Amends § 119B.011, by adding subd. 23. Defines "federal poverty guidelines."

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

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

Subd. 1. Factors which must be verified. Requires counties to verify certain information at all child care applications and recertifications using the universal application.

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

10 Portability pool. Amends § 119B.03, subd. 9. Requires families who have moved from one county to another to notify the new county of residence within 60 days (instead of 30 days) of moving and to submit information to the new county to verify eligibility for the basic sliding fee program.

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

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

13 General eligibility requirements for all applicants of child care assistance. Amends § 119B.09, subd. 1. Modifies income eligibility establishing eligibility at 250 percent or less of the federal poverty guidelines. Currently, income eligibility is 75 percent or less of the state median income.

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

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

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

17 Payment of funds. Amends § 119B.09 by adding a subd. Requires all federal, state, and local child care funds to be paid directly to the child care provider on behalf of the eligible family. Under current law, counties have the option of paying the provider or the family.

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

19 Parent fee. Amends § 119B.12, subd. 2. Increases the parent fee for families with incomes between 75 percent and 100 percent of the federal poverty guidelines from $5 to $10.

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

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

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

Subd. 3. Authorization exception. Allows counties to authorize a person as a provider after the county has initially denied a person authorization as a legal nonlicensed family child care provider if three conditions are met.

Subd. 4. Unsafe care. Allows counties to deny authorization as a child care provider to any applicant or rescind authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. Requires counties to include in their child care fund plan the standards used to determine whether a provider or care arrangement is unsafe.

Subd. 5. Retroactive payment. Allows the county to issue retroactive payment to the provider for child care services provided during the time between the county's receipt of the completed application and final authorization of the provider.

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

21 Subsidy restrictions. Amends § 119B.13, subd. 1. Reduces the maximum rate paid for child care assistance from the 75th percentile to the 60th percentile for like-care arrangements in the county. Requires the commissioner to determine the maximum rate for each type of care on an hourly, full-day, and weekly basis. Prohibits providers from requiring parents to pay the difference between the maximum rate allowed and the provider charge.

22 Child care providers; hourly rates. Amends § 119B.13, by adding subd. 1a. Requires child care assistance payments to be made on an hourly basis when seven hours of care per day or less are authorized. Prohibits the hourly payments from exceeding the maximum full-day rate.

23 Legal nonlicensed family child care provider. Amends § 119B.13. Requires that legal nonlicensed child care providers receiving child care assistance reimbursements be paid in hourly blocks of time. Limits the maximum rate paid to legal nonlicensed family child care providers to 90 percent of the county maximum hourly rate for licensed family child care providers. Allows a rate which includes a provider bonus or a special needs rate to be in excess of the maximum rate allowed under this subdivision. Prohibits legal nonlicensed family child care providers from receiving reimbursement for registration fees for families receiving assistance.

24 Provider rate bonus for accreditation. Amends § 119B.13, subd. 2. Makes a technical and conforming change.

25 Provider payments. Amends § 119B.13, subd. 6. Makes technical and conforming changes.

Strikes a provision allowing counties or the state to pay parents directly for eligible child care expenses. Requires both the parent and the provider to sign the bill for services rendered if the child care center does not keep detailed log sheets. For licensed and legal nonlicensed family child care, both the parent and the provider must sign the bill. Requires providers to submit all bills within 90 days of the last date of service on the bill. Allows counties to pay bills submitted more than 90 days after the last date of service if the provider can show good cause as to why the bill was submitted late. Requires counties to define good cause in their child care fund plan. Prohibits counties from paying bills submitted more than one year after the last date of service on the bill, unless the delay in payment is due to county error. Allows counties to stop payment issued or to refuse to pay a bill under certain circumstances.

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

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

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

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

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

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

32 Fees. Amends § 245A.10. Allows counties to charge a fee of up to $100 to legal nonlicensed child care providers for the cost of conducting a background check. Allows providers to pay the fee on an installment basis over the course of one year.

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

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

35 Disqualification from program. Amends § 256.98, subd. 8. Establishes a disqualification period for providers convicted of wrongfully obtaining public assistance.

36 Licensing and authorization of providers. Amends § 466.03, subd. 6d. Amends a provision protecting counties from liability relating to licensing and authorization of child care providers.

37 Direction to commissioner; provider rates. Requires the provider rates for fiscal years 2003-2004 implemented on July 1, 2003, to be continued in effect through June 30, 2005. Directs the commissioner to evaluate the costs of child care, examine the differences in the cost of

child care in rural and metropolitan areas, and make recommendations to the legislature for containing future cost increases by January 15, 2004. Requires the commissioner to take into consideration the impact any recommendations might have on work incentives for low and middle-income families and possible changes to MFIP child care, basic sliding fee child care, and the dependent care tax credit.

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

Repealer. Repeals the at-home infant child care program and a child care report.