HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. 904 **DATE:** April 6, 2003

Version: First Engrossment

Authors: Bradley

Subject: Governor's Health and Human Services Budget Proposal

Analyst: Randy Chun, 651-296-8639 (Articles 2, 3)

Peg Hicks, 651-296-8079 (Articles 5, 6, 7)
Jeanne LeFevre, 651-296-5043 (Articles 8, 9)
Danyell Punelli, 651-296-5058 (Articles 1, 4, 10)

Table of Contents

Article 1: Welfare Reform Public Assistance Modifications

Overview

This article encompasses the governor's welfare proposal. 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.

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

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

3 Emergency need. Amends § 256D.06, subd. 2. Strikes obsolete language, clarifies that emergency general assistance grants may be made to the extent that funds are available, limits grant availability to a recipient to not more than once in any 12-month period. Limits funding for emergency general assistance to 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.

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

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

6 Payment amount. Amends § 256D.46, subd. 3. Limits grant availability to recipients to not more than once in any 12-month period. Limits funding for emergency supplemental aid grants to 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.

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

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

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

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

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

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

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

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

50 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.

51 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.

52 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.

53 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.

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

55 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.

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

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

58 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.

59 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.

60 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.

61 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.

62 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.

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

64 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.

65 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.

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

67 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.

68 Supported work. Amends § 256J.49, by adding subd. 14. 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 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.

70 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.

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

72 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.

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

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

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

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

77 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.

78 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.

79 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.

80 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.

81 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.

82 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.

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

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

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

86 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.

87 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.

88 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.

89 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.

90 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.

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

92 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.

93 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.

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

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

96 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.

97 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.

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

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

100 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.

101 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.

102 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.

103 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.

104 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.

105 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.

106 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.

107 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.

108 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, subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 8, and 9 (assessments; plans); 256J.55, subdivision 5 (option to utilize existing plan); 256J.62, subdivisions 1, 2a, 3a, 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, establishes 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 Specific powers. Amends § 256.01, subd. 2. Requires rebates for the prescription drug program to be equal to the rebate as defined under the federal Medicaid rebate program. (Current law requires the rebate to be equal to the "basic" rebate of that program.)

3 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).

4 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.

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

6 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.

7 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.

8 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.

9 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.

10 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.

11 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).

12 Employed persons with disabilities. Amends § 256B.057, subd. 9. Modifies premium scales and makes other 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 the premium calculated under the sliding scale as provided in current law. (This premium ranges from one percent of gross earned and unearned income at 100 percent of FPG to 7.5 percent of income for those with incomes at or above 300 percent of FPG. Under current law, individuals with incomes less than 100 percent of FPG pay no premium.) Effective November 1, 2003, requires all enrollees who receive unearned income to pay five percent of unearned income in addition to the premium amount. Effective November 1, 2003, requires the commissioner to reduce reimbursement for cost-effective Medicare part B premiums to enrollees with incomes equal to or greater than 120 percent of FPG based on a sliding scale under which the enrollee obligation increases to the full amount of part B premiums for individuals with incomes equal to or greater than 300 percent of FPG.

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

13 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.

14 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.

15 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.

16 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 April 1, 2005, effective date if the HealthMatch system is operational, and a July

1, 2005, effective date if the system is not operational.

17 Drugs. Amends § 256B.0625, subd. 13. Modifies MA reimbursement and coverage of prescription drugs.

The amendment to paragraph (b) excludes coverage of all drugs used for weight loss (current law excludes only anorectics).

The amendment to paragraph (c):

- limits dispensed quantities of prescription drugs to a 30-day supply
- requires the commissioner to estimate the acquisition cost used in setting pharmacy reimbursement rates at AWP-14 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)
- allows payment for generic drugs to be based on the actual acquisition cost or the maximum allowable cost set by the commissioner
- allows the commissioner to require prior authorization for brand-name drugs whenever a generic drug is available, even if the prescriber indicates "dispense as written - brand necessary," and also directs the formulary committee to establish general criteria for requiring prior authorization of brand-name drugs for which a generic drug is available

The amendment to paragraph (d) strikes a definition of multisource drugs that had the effect of required two or more generic versions before a maximum allowable cost could be established.

18 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

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. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment. Requires providers to accept an assertion from the recipient that they are unable to pay.

19 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.

20 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.

21 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.

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

23 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.

24 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.

25 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.

26 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.

27 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.

28 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.

29 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.

30 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.

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

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

33 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.

34 Adjustments permitted. Amends § 256B.195, subd. 4. Requires the increase in intergovernmental transfers resulting from the reduction in inpatient hospital payment rates to be paid to the general fund. Eliminates references to a provision that is repealed in this article.

35 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.

36 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.

37 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.

38 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.

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

40 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.

41 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.

42 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.

43 General assistance medical care; services. Amends § 256D.03, subd. 4. Eliminates a provision that allows GAMC enrollees who fail to submit income reports or recertification forms in a timely manner to continue to receive GAMC services from a prepaid health plan through the last day of the month in which the enrollee became ineligible. Removes the restriction on requiring GAMC enrollees to pay copayments.

44 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:

- $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

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. Requires providers to accept an assertion from the recipient that they are unable to pay.

45 Non-Minnesota residents. Amends § 256G.05, subd. 2. Makes a conforming change related

to the elimination of emergency GAMC.

46 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.

47 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.

48 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

Effective October 1, 2004, exempts single adults and households without children with incomes that do not exceed 75 percent of FPG from the ten percent coinsurance requirement for inpatient hospital services.

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. Requires providers to accept an assertion from the recipient that they are unable to pay.

49 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.

50 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.

51 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.

52 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.)

53 Retroactive coverage. Amends § 256L.05, subd. 3c. Eliminates references to GAMC. (This is

a conforming change related to the elimination of the GAMC program.)

54 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 April 1, 2005, if the HealthMatch system is operational, and an effective date of July 1, 2005, if the system is not operational.

55 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.

56 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.

57 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.)

58 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.

59 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.

60 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.

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

62 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.

63 Sliding fee scale to determine percentage of gross individual or family income. Amends § 256L.15, subd. 2. 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.

64 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

65 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.

66 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.

67 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.

68 Repealer. (a) Repeals sections 256.955, subd. 8 (annual report on the prescription drug program); 256B.0625, subd. 5a (intensive early intervention therapy for autism spectrum disorders); 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 for long-term care facilities, increases nursing home surcharges, phases-out rate equalization, modifies administration of the alternative care program, eliminates various long-term care grant programs, and makes other related changes.

1. 1 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.

2 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.

3 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.)

4 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.

5 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.)

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

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

8 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.

9 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.

10 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.

11 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.

12 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.

13 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.

14 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.

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

16 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.

17 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.

18 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.

19 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.

20 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.

21 Payment limitation. Amends § 256B.431, by adding subd. 2t. Beginning July 1, 2003, limits MA payments to nursing homes for Medicare copayments to an amount that does not result in total payment to the facility from Medicare and Medicaid being greater than the Medicaid RUG-III case-mix payment rate.

22 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.

23 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.

24 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.

25 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.

26 Nursing facility rate adjustment. Amends § 256B.431, by adding subd. 39. (a) For the rate year beginning July 1, 2003, requires the commissioner to reduce nursing facility rates by an

amount equal to four percent of the total payment rate in effect on June 30, 2003.

(b) Allows nursing facilities to elect to reduce their licensed capacity as an alternative to the rate adjustment. Facilities must request this election from the commissioner within 60 days of the effective date of the section, and must agree to reduce their licensed capacity in stages, as follows: (1) by October 1, 2003, to 95 percent of the number of beds occupied on January 1, 2003; (2) by January 1, 2004, to 90 percent of the number of beds occupied on January 1, 2003; (3) by April 1, 2004, to 85 percent of the number of beds occupied on January 1, 2003; and (4) to not remove beds from layaway until after June 30, 2007. Specifies additional criteria for implementing the reductions.

(c) Requires the commissioner to reduce retroactively, to July 1, 2003, the payments rates of nursing facilities that fail to reduce capacity according to paragraph (b). Allows the commissioner to grant facilities extensions of up to 90 days and specifies criteria for granting extensions.

Provides an immediate effective date.

27 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.

28 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, and classifies as discrimination requiring an individual eligible for public assistance to accept a transfer from a single to a multiple bed room.

A new paragraph (g) specifies procedures for the commissioner to follow upon determination that a facility is not in compliance with this section. These procedures include withholding and stopping payments.

29 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.")

30 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.

31 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.

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

33 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).

34 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.

35 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.)

36 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.

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

38 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.

39 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.

40 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.

41 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.

42 Repealer. (a) Repeals sections 256.973 (home sharing grant program), 256.9752 (senior nutrition programs), 256.9753 (retired senior volunteer program), 256.976 (foster grandparents program), 256.977 (senior companion program), 256.9772 (health care consumer assistance grant program), 256B.0917 (SAIL projects), 256B.0928 (caregiver support and respite care project), and 256B.437, subd. 2 (planning and development of community-based services), effective July 1, 2003.

(b) Repeals Laws 1988, chapter 689, article 2, section 251 (independent living demonstration project for persons with epilepsy) effective July 1, 2003.

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, and proposes new intensive rehabilitative mental health services.

1. 1 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.

2 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.

3 Rates. Amends § 252.46, subd. 1. Allows the commissioner to authorize county 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. Requires the commissioner to establish procedures for determining the structure of individualized rates to ensure there is no additional cost to the state. Strikes language authorizing an hourly job coach rate.

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

5 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.

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

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

8 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.

9 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.

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

11 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).

12 Definitions. Amends § 256B.501, subd. 1. Adds a definition of "services during the day" to law governing ICF/MR reimbursement rates.

13 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 active treatment requirements for persons residing in an ICF/MR.

14 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.

15 Pass-through of other services costs. Amends § 256B.5015, by adding subd. 2. Requires services during the day to be paid as a pass-through payment no later than January 1, 2004. Requires the commissioner to establish rates for these services at levels that do not exceed 75 percent of a recipient's day training and habilitation costs prior to the service change. Lists factors for the commissioner to consider when establishing rates. Allows pass-through payments to be paid separately or included in a facility's total payment rate.

16 Identification of services to be provided. Amends § 256E.081, subd. 3. Eliminates the requirement that county social services plans specify how day training and habilitation services are to be provided.

17 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.

18 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.

19 Repealer. Repeals § 254A.17, subd. 3 (statewide detoxification transportation program), 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), and 256B.5013, subd. 4 (ICF/MR temporary rate adjustments to address occupancy) effective July 1, 2003. Repeals § 245.4712, subd. 2 (requirement that counties provide day treatment services to adults with mental illness) effective July 1, 2005. Repeals Laws 2001, First Special Session chapter 9, article 13, section 24 (public guardianship alternatives) effective July 1, 2003.

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; require mental health screening for children in the child welfare or juvenile justice systems; modify the children's mental health medical assistance benefit; 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 Duties of county board. Amends § 245.4874. Requires county boards to use the counties' share of mental health and Community Social Services Act funds to arrange for or provide children's mental health screening to a child:

- receiving child protective services or a child in out-of-home placement;
- for whom parental rights have been terminated;
- alleged or found to be delinquent; and
- found to have committed a juvenile petty offense for the third or subsequent time.

Screening is not required if the child has been screened within the previous 180 days or the child is currently under a mental health professional's care. Requires the county conduct to the screening with a screening instrument approved by the commissioner. Also requires that a mental health practitioner or probation officer or local social services agency staff person who is trained in using the screening instrument conduct the screening. If the screening indicates a need for assessment, the child's family or the local social services agency, if the family lacks mental health insurance, must have a diagnostic assessment conducted.

3 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.

4 Day treatment services. Amends § 256B.0625, subd. 23. Clarifies that medical assistance covers day treatment services for adults as specified in section 245.462, subd. 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 8 of this article). Makes this section effective July 1, 2004.

5 Children's mental health crisis response services. Amends § 256B.0625, by adding subd. 35a. Provides that medical assistance covers children's mental health crisis response services under section 256B.0944 (section 9 of this article). Makes this section effective July 1, 2004.

6 Children's therapeutic services and supports. Amends § 256B.0625, by adding subd. 35b. Provides that medical assistance covers children's therapeutic services and supports under section 256B.0943 (section 8 of this article).

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

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

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

Subd. 1. Scope. Provides that children's therapeutic services and supports are an array of mental health services for children who require different therapeutic and rehabilitative intervention levels.

Subd. 2. Definitions. Defines the following terms for purposes of this section: children's therapeutic services and supports; clinical supervision; county board; crisis assistance; cultural competence or culturally competent; culturally competent provider; culturally specific provider; day treatment program for children; diagnostic assessment; direction of mental health behavioral aide; emotional disturbance; face-to-face time; individual behavioral plan; individual treatment plan; mental health professional; preschool program; residence; and skills training.

Subd. 3. 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 certain providers to eligible clients. Defines the service components for children's therapeutic services.

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

Subd. 4. Diagnosis of emotional disturbance or mental illness. Bases a client's eligibility for mental health services under this section on a diagnostic assessment performed within 180 days that documents an emotional disturbance or mental illness diagnosis. Requires that a diagnostic assessment meeting certain requirements be used in developing a client's individualized treatment plan. Requires that a new diagnostic assessment be completed yearly until the client reaches age 18. For individuals between age 18 and 21, requires that a diagnostic assessment be performed within 180 days and updated annually for continuing services. Defines updating for purposes of this subdivision. Requires the client's record to include the initial diagnostic assessment and all subsequent written update or diagnostic assessments.

Subd. 5. 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 documents the medical necessity of the mental health services. Defines an eligible client.

Subd. 6. Determination of provider entity eligibility. (a) To become an eligible children's therapeutic services and supports provider, requires the provider entity to complete the provider application and certification process established by the commissioner. Requires recertification of providers at least every two years. Makes the county, tribe, and commissioner equally responsible and accountable for certification. 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.

(b) Requires a noncounty entity seeking to provide services outside the host county to get additional recommendations for certification in each county in which it will provide services.

(c) Authorizes the commissioner to intervene at any time to decertify providers for cause. Gives providers the right to appeal a decertification. Also requires the commissioner to develop statewide procedures for provider certification.

Subd. 7. Provider entity administrative standards. (a) Requires a provider entity to have written policies and procedures regarding organizational operation and service provision, review and update the policies and procedures every two years, and distribute the policies and procedures to staff.

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

Subd. 8. Provider entity clinical standards. Specifies standards for an effective mental health care system. Also specifies standards for diagnostic assessment, functional assessment, service delivery, and individual treatment plan review. Requires a provider to review and update clinical standards every two years and distribute the standards to staff. Provides that services billed under children's therapeutic services and supports that are not documented under this subdivision are subject to monetary recovery by the commissioner. Also specifies what a provider entity must address in its clinical policies.

Subd. 9. Qualifications of individual and team providers. Specifies the providers and multidisciplinary teams qualified to provide children's therapeutic services and supports under this section.

Subd. 10. Required preservice and ongoing training. (a) Requires a provider entity to establish a plan to provide preservices and continuing education for staff. 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.

(b) 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 and requirements for a provider's annual documentation of the staff's continuing education.

Subd. 11. Service delivery requirements. (a) Defines service delivery. Requires the commissioner to develop procedures for disseminating information on evidence-based practices and for providing technical assistance to counties, tribes, and certified provider entities. Also specifies two service-delivery requirements a provider must satisfy.

(b) Specifies conditions under which up to 35 hours of children's therapeutic services and supports are eligible for medical assistance reimbursement.

(c) Specifies requirements for provider entities that offer site-based programs such as day treatment and therapeutic preschool programs.

(d) Specifies requirements for a structured treatment program offered by a licensed preschool program.

(e) Defines crisis assistance and specifies requirements for crisis assistance services.

(f) Defines medically necessary services provided by a mental health behavioral aide and specifies documentation requirements. Also specifies the activities a mental health behavioral aide may use to implement goals in the treatment plan.

(g) Requires a provider entity's direction of a mental health behavioral aide to be delivered as specified in the provider entity's policies and procedures.

(h) Specifies requirements for a day treatment program.

Subd. 12. 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. 13. Excluded services. Specifies the services that are not eligible for medical assistance payment as children's therapeutic services and supports.

Makes this section effective July 1, 2004.

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

Subd. 1. Scope. Subject to federal approval, provides that medical assistance covers children's mental health crisis response services if the services are provided to an eligible recipient by a qualified provider entity and individual provider, and the services are identified in the recipient's individual crisis treatment plan.

Subd. 2. 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. 3. Eligibility. Provides that an eligible recipient is an individual who is:

- under age 21;
- screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and
- assessed as experiencing a mental health crisis or emergency and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. Provider entity standards. (a) Specifies that a children's mental health crisis response services provider entity must 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) Requires that a children's mental health crisis response service provider entity also meet 17 standards relating to staffing and services provided.

Subd. 5. Mobile crisis intervention staff qualifications. 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. 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 when 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 members 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. Children's crisis stabilization staff qualifications. Specifies the qualifications for individual provider staff who provide children's mental health crisis stabilization services.

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) Specifies the mental health professional's supervisory duties.

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

Subd. 10. Recipient file. Requires a provider of mobile crisis intervention or crisis stabilization services to maintain a file for each recipient and specifies the information a provider must have in the file. Also requires documentation in the file to comply with the commissioner's requirements.

Subd. 11. Treatment plan. (a) Specifies what must be included in an individual crisis stabilization treatment plan.

(b) Requires the recipient and the recipient's legal guardian to participate in the plan.

(c) Requires a mental health professional or practitioner under the clinical supervision of a mental health profession to develop, approve, and sign the treatment plan. Also requires that the mental health professional or practitioner complete the plan within 24 hours of beginning services.

Subd. 12. Excluded services. (a) Specifies the services excluded from medical assistance reimbursement under this section.

(b) If a provider is eligible to provide more than one type of medical assistance service, requires the recipient to have a choice of provider for each service, unless otherwise provided by law.

Makes this section effective July 1, 2004.

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

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

12 Distribution of new federal revenue. Amends § 256F.10, subd. 6. Removes 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.

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

14 Investigation. Amends § 260B.157, subd. 1. Requires the court to have a children's mental health screening conducted when a child is alleged or found to be delinquent. Requires a mental health practitioner or a probation officer trained in using the required screening instrument to conduct the screening. Specifies that the commissioner of human services must approve the screening instrument. Also requires that the local social services agency, in consultation with the child's family, to have a diagnostic assessment conducted if the screening indicates a need for assessment.

15 Reasons for detention. Amends § 260B.176, subd. 2. If a child is detained in a state-licensed juvenile facility or program, adult jail, or municipal lockup for an alleged delinquent act, requires the facility supervisor to have a children's mental health screening conducted with a screening instrument approved by the commissioner of human services. Provides that the screening is not required if the child was screened within the previous 180 days or the child is currently under a mental health professional's care. Requires a mental health practitioner or probation officer trained in the use of the screening instrument to conduct the screening. Also requires the screening to occur after the child is taken into custody, but before any later detention hearing and requires the court to consider the screening results at the hearing. Also requires that the local social services agency or probation officer, in consultation with the child's family, to have a diagnostic assessment conducted if the screening indicates a need for

assessment

16 Hearing and release requirements. Amends § 260B.178, subd. 1. Adds a children's mental health screening to the list of possible conditions for the release of a detained child to the child's parent, guardian, custodian, or other suitable person.

17 Consideration of reports. Amends § 260B.193, subd. 2. Permits the court to consider the results of a children's mental health screening before making a disposition in a delinquency case.

18 Alternative disposition. Amends § 260B.235, subd. 6. In a case of a third or subsequent finding by a court that a child has committed any juvenile petty offense, requires the court to order that the child have a children's mental health screening and, if indicated by the screening, undergo a diagnostic assessment.

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

20 Conflicts. Provides that the amendments in section 12 of this article prevail over any conflicting law that amends or repeals it, regardless of the order or date of enactment.

21 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.

22 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) 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 young 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 young 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.

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; human services board; and young adult.

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

Subd. 1. General supervision. Requires the commissioner to allocate funds to each county each year 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 . Species 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 multicounty 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 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 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 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 five 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 funds to projects of regional significance. Requires the commissioner to publish a request to solicit proposals from groups of counties by region. Provides that the funds must support:

- cooperative regional projects between governments, schools, and nonprofit providers to put in place comprehensive health and developmental screening for all children under six years old;
- efforts that lead to simplifying and improving outcomes through regional administration of human services; and
- innovative regional projects designed to improve outcomes and reduce costs through innovative delivery or service design strategies, test alternative incentives within a support strategy, or develop new strategies to engage communities in caring for at-risk populations.

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

Subd. 3. Contracts for services. Permits a county board to contract with certain boards, political subdivisions, collaboratives, or private organizations to discharge its duties.

Subd. 4. 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, if a county meets the reasonable efforts requirements in subdivision 2 and requirements for denying, reducing, or terminating services due to fiscal limitations in subdivision 4, 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 the 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 does not have a 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 Miscellaneous

Overview

This article makes changes to various human services-related statutes. Provisions in this article increase human services licensing fees; restructure parental fees; and require the public authority to charge a cost recovery fee for providing child support and maintenance collection services. 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 Fees. Amends § 245A.10. Makes various changes to human services licensing fees.

Subd. 1. Application or license fee required, programs exempt from fee. Provides that the commissioner of human services shall charge a fee for evaluating applications and inspecting programs licensed under chapter 245A. Provides that no application fee shall be charged for family child care, 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).

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.

3 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 percents 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.

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

5 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.

(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 one percent of the amount collected if an obligee applies for full IV-D services. The public authority must deduct this amount from the amount of child support and maintenance collected before disbursement to the obligee. Specifies that the fee applies to an obligee who:

- has never received public assistance under the state's federal Title IV-A (MFIP), Title IV-E foster care, medical assistance, or MinnesotaCare programs;
- has received medical assistance or assistance under the MinnesotaCare program; or
- has received assistance under the state's Title IV-A (MFIP) or IV-E foster care program. Requires that the fee not be charged until the person has not received assistance for 24 consecutive months.

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

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

(h) Authorizes the commissioner to establish a special revenue account to receive child support cost recovery fees. Requires the commissioner to retain and transfer to the child

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

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

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

7 Order. Amends § 518.6111, subd. 3. Makes support orders subject to income withholding from the obligor's income. 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.

8 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.

9 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.

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. 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 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.

2 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 1 and 2 is dependent upon passage of amendments to the dedicated cigarette tax proposed in H.F. 751, article 8, section 3.

3 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.

4 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.

5 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.

6 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.

7 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.

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

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

10 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.

11 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.

12 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.

13 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.

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

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

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

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

18 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.

19 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.

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

21 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.

22 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.

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

24 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.

25 Revisor's instruction. Allows revisor to amend and delete references where appropriate and to correct punctuation, grammar and structure.

26 Repealer.

Statutes repealed: Repeals all aspects of the Medical Education Endowment Fund except the sunset section. Repeals inborn errors of metabolism testing program. Repeals Rural Hospital

Financial Assistance Grant program. Repeals rural physician education account for loan forgiveness for certain medical residents. Repeals mid-level practitioner loan forgiveness program. Repeals nurses loan forgiveness program. Repeals grant program for nurse-practitioner education. Repeals all aspects of tobacco use prevention and local public health endowment fund except the sunset section. Repeals nursing home transition planning grant program. Repeals nursing home innovations in quality demonstration grant program. Repeals the $25 surcharge for applicants for registration as speech-language pathologists and audiologists. Repeals surcharges for occupational therapists and occupational therapy assistants' license and renewal fees.

Minnesota Rules repealed: Repeals rules implementing the rural and urban primary care physician loan forgiveness program. Repeals rules implementing the mid-level practitioner education account program. Repeals rules implementing the nursing home or intermediate care facility nurses' education account.

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 appropriates money for the Department of Human Services, Department of Health, the health-related boards, and other councils and boards.

1. 1 Health and Human Services Appropriations. Appropriates general revenue, state government special revenue, health care access, federal TANF, and lottery prize funds to the agencies and for the purposes specified for fiscal years 2004 and 2005.

2 Commissioner of Human Services.

Subd. 1. Total appropriation. Appropriates general revenue, state government special revenue, health care access, federal TANF, and lottery prize funds to the commissioner in fiscal years 2004 and 2005.

- Requires appropriations and federal receipts for information systems for MAXIS, PRISM, MMIS, and SSIS to be deposited in the state system account. Allows money appropriated for computer projects to be transferred from one project to another and from development to operations as the commissioner considers necessary. Makes any unexpended balance in these appropriations available for ongoing development and operations.
- Allows the commissioner to accept gifts on behalf of the state for the purpose of financing the cost of assistance program grants or nongrant administration.
- Allows the nonfederal share of activities for which federal administrative reimbursement is appropriated to be transferred to the special revenue fund.
- Requires any expenditures from the TANF block grant to be expended in accordance with the requirements and limitations of any applicable federal laws or requirements. Cancels any unexpended TANF funds appropriated to any state, local, or nonprofit entity at the end of the fiscal year, unless appropriating language permits otherwise.
- Requires the commissioner to authorize transfers from TANF to other federal block grants. Requires the commissioner to preserve the future potential transfer capacity from TANF to other block grants.
- Limits the allowable activities that may be reported as fulfilling the nonfederal TANF maintenance of effort (MOE). Lists the allowable activities. Requires the commissioner to ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF MOE requirements. Makes this clause expire June 20, 2007.
- Requires the commissioner to make up to 100 percent of the calendar year 2005 payments to counties for developmental disabilities semi-independent living services grants, developmental disabilities family support grants, and adult mental health grants from fiscal year 2006 appropriations. Clarifies that this is a one-time shift. Makes this clause expire June 30, 2006.
- Requires that fiscal year 2004 and 2005 health care access fund appropriations to the University of Minnesota be used to increase MA capitation payments.

Subd. 2. Agency management. Appropriates general revenue, state government special revenue, health care access, and federal TANF, for agency management in fiscal years

2004 and 2005.

Subd. 3. Revenue and pass-through.

- Transfers federal TANF funds to the Social Services Block Grant in fiscal year 2005 to provide services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines.
- Makes available to the commissioner federal TANF funds in fiscal years 2006 and 2007 to replace general funds.
- Reduces transfers to the child care development fund in fiscal years 2004 and 2005 for the purposes of MFIP child care.

Subd. 4. Children's services grants. Appropriates general funds and federal TANF funds in fiscal years 2004 and 2005 for adoption assistance incentive grants. Permits commissioner to transfer unencumbered balances for adoption assistance and relative custody assistance between fiscal years and programs.

- Appropriates federal funds available during fiscal years 2004 and 2005 for adoption incentive grants.
- Allows the commissioner to transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and programs.

Subd. 5. Children's services management. Appropriates general funds in fiscal years 2004 and 2005 for children's services management.

Subd. 6. Basic health care grants. Appropriates general funds and health care access funds in fiscal years 2004 and 2005 for MinnesotaCare grants, MA basic health care grants, GAMC grants, other health care grants, and for the prescription drug program.

- Makes annual updates to the federal poverty guidelines effective each July 1.
- Allows the commissioner to expend money from the health care access fund for MinnesotaCare in either fiscal year of the biennium.
- Delays the last payment to providers for medical assistance and general assistance medical care services in fiscal year 2005. Requires this payment to be included in the first payment in fiscal year 2006.

Subd. 7. Health care management. Appropriates general funds and health care access funds in fiscal years 2004 and 2005 for health care policy administration and health care options.

- Appropriates federal administrative reimbursements.
- Eliminates state funding for the nonfederal share of prepaid medical assistance program administration costs for county managed care advocacy and enrollment operations for counties in which this program has been operation for 12 or more months.

Subd. 8. State-operated-services. Appropriates general funds for fiscal years 2004 and 2005 for state-operated-services.

- Allows money appropriated to finance mitigation expenses related to restructuring state-operated services to be transferred between fiscal years.
- Requires any state-operated services position reduction to be accomplished through mitigation, attrition, transfer, and other methods, provided there is no

conflict with any collective bargaining agreement.

- Allows the commissioner to transfer unencumbered appropriation balances between fiscal years for the state residential facilities repairs and betterment account and special equipment.

Subd. 9. Continuing care grants. Appropriates general funds and lottery prize funds for aging and adult service grants, deaf and hard-of-hearing service grants, mental health grants, community support grants, MA long-term care waivers and home care grants, MA long-term care facilities grants, alternative care grants, group residential housing grants, and chemical dependency entitlement grants.

- Requires the commissioner to decrease reimbursement rates or reduce allocations for the home and community-based waivered services for the elderly, day training and habilitation services for adults with mental retardation or related conditions, group residential housing supplemental service rate, chemical dependency residential and nonresidential service rates, consumer support grants, home and community-based services for alternative care services, home health services, personal care services, private duty nursing services, persons with mental retardation or related services, community alternatives for disabled individuals services, community alternative care waivered services, traumatic brain injury waivered services, and deaf and hard-of-hearing grants.
- Requires the commissioner to reduce the growth in the MF/RC waiver by not allocating the 300 additional diversion allocations that are included in the February 2003 forecast for fiscal years 2004 and 2005.
- Requires the commissioner to allocate money for the TBI waiver so that the caseload growth for this program does not exceed 150 in each year of the biennium. Sets priorities for the allocation of funds.
- Delays targeted case management benefits for home care recipients until July 1, 2005.
- Delays implementation of the common service menu option within the home and community-based waivers until July 1, 2005.
- Transfers any money that is not spent in the alternative care program to the medical assistance account. Gives the commissioner carry forward authority for the funds appropriated for the alternative care program. Changes premiums and eligibility for alternative care.
- Increases the home and community-based service rates and county allocations provided to group residential housing effective July 1, 2004.

Subd. 10. Continuing care management. Appropriates general funds, state government special revenue funds, and lottery prize funds for fiscal years 2004 and 2005 for continuing care management.

Subd. 11. Economic support grants. Appropriates general funds and federal TANF funds for fiscal years 2004 and 2005 for the MFIP program, work grants, other economic support grants, child support enforcement grants, general assistance grants, and Minnesota supplemental aid grants. Sets the monthly standard of assistance for general assistance units at $203. Allows the commissioner to reduce this amount. Creates an allocation formula for FY 2004-2005 for the consolidated MFIP support

services grant.

Subd. 12. Economic support management. Appropriates general fund, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 for economic support policy administration and economic support operations.

- Requires the commissioner to deposit payments received for services performed by the child support payment center in the state systems account. Appropriates these payments for the operation of the child support payment center.
- Requires the commissioner to transfer $247,000 of child support cost recovery fees collected in FY 2005 to the PRISM special revenue account.
- Authorizes the commissioner to allocate up to $310,000 in each fiscal year 2004-2005 from the PRISM special revenue account to financial institutions for performing data matches.

3 Commissioner of Health.

Subd. 1. Total appropriation. Appropriates general funds, state government special revenue funds, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 to the commissioner of health.

Subd. 2. Health improvement. Appropriates general funds, state government special revenue funds, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 for health improvement.

- Transfers funds from the tobacco use prevention and local public health endowment expendable trust fund to the general fund and the special revenue fund.
- Makes TANF funds available for home visiting and nutritional activities and eliminating health disparities. Authorizes carry forward of unexpended TANF funds from one year of the biennium to the next.

Subd. 3. Health quality and access. Appropriates general funds, state government special revenue funds, and health care access funds for fiscal years 2004 and 2005.

- Transfers money from the special revenue fund to the general fund on July 1, 2003.
- Transfers any unexpended funds in the medical education expendable trust fund to the special revenue fund.

Subd. 4. Health protection. Appropriates general funds and state government special revenue funds for fiscal years 2004 and 2005 for health protection.

Subd. 5. Management and support services. Appropriates general funds for fiscal years 2004 and 2005 for management and support services.

4 Veteran's home board. Appropriates general funds for fiscal years 2004 and 2005 for the veteran's home board.

5 Health related boards.

Subd. 1. Total appropriations. Appropriates funds in fiscal years 2004 and 2005 for the health related boards. Clarifies that these appropriations are from the special revenue fund, except where noted. Prohibits the commissioner from permitting expenditures in

excess of anticipated biennial revenues or accumulated surpluses. Transfers funds from the special revenue fund to the general fund on July 1, 2003.

Subd. 2. Board of chiropractic examiners. Appropriates funds in fiscal years 2004 and 2005.

Subd. 3. Board of dentistry. Appropriates special revenue funds and health care access funds in fiscal years 2004 and 2005.

Subd. 4. Board of dietetic and nutrition practice. Appropriates funds in fiscal years 2004 and 2005.

Subd. 5. Board of marriage and family therapy. Appropriates funds in fiscal years 2004 and 2005.

Subd. 6. Board of medical practice. Appropriates funds in fiscal years 2004 and 2005.

Subd. 7. Board of nursing. Appropriates funds in fiscal years 2004 and 2005.

Subd. 8. Board of nursing home administrators. Appropriates funds in fiscal years 2004 and 2005.

Subd. 9. Board of optometry. Appropriates funds in fiscal years 2004 and 2005.

Subd. 10. Board of pharmacy. Appropriates funds in fiscal years 2004 and 2005.

Subd. 11. Board of physical therapy. Appropriates funds in fiscal years 2004 and 2005.

Subd. 12. Board of podiatry. Appropriates funds in fiscal years 2004 and 2005.

Subd. 13. Board of psychology. Appropriates funds in fiscal years 2004 and 2005.

Subd. 14. Board of social work. Appropriates funds in fiscal years 2004 and 2005.

Subd. 15. Board of veterinary medicine. Appropriates funds in fiscal years 2004 and 2005.

Emergency medical services board.

Subd. 1. Total appropriations. Appropriates general funds and state government special revenue funds for fiscal years 2004 and 2005 for the emergency medical services board.

Council on disability. Appropriates general funds for fiscal years 2004 and 2005 for the Council on Disability.

Ombudsman for mental health and mental retardation. Appropriates general funds for fiscal years 2004 and 2005 for the ombudsman for mental health and mental retardation.

Ombudsman for families. Appropriates general funds for fiscal years 2004 and 2005 for the ombudsman for families.

Transfers.

Subd. 1. Grants. Allows the commissioner of human services to transfer unencumbered appropriation balances for the fiscal year 2004-2005 biennium within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration. Allows positions, salary money, and nonsalary administrative money to be transferred within the departments of human services and health and within the programs operated by the veteran's nursing home board as the

commissioners and the board consider necessary.

Subd. 3. Prohibited transfers. Prohibits grant money from being transferred to operations within the departments of human services and health and within the programs operated by the veteran's nursing home board without approval of the legislature.

11 Indirect costs not to fund programs. Prohibits the commissioners of health and human services from using indirect cost allocations to pay for the operational costs of any program for which they are responsible.

12 Carryover limitation. Prohibits allowed carryovers from fiscal year 2004 to 2005 from becoming part of the base level funding for the 2006-2007 biennial budget, unless specifically directed by the legislature.

13 Sunset of uncodified language. Requires all uncodified language in this article to expire on June 30, 2005, unless a different expiration date is explicit.

14 Repealer. Repeals Laws 2002, chapter 374, article 9, section 8 (fiscal 2003 TANF MOE).

15 Effective date. Makes the provisions of this article effective July 1, 2003, unless a different effective date is specified.