Except as provided in section 14.29, subdivision 3, no agency may adopt an emergency or temporary rule pursuant to any temporary rulemaking authority granted in a statute enacted prior to March 1, 1984, later than 180 days after the effective date of this section.

Sec. 31. **TERMS CONSTRUED.**

All grants of temporary rulemaking authority made prior to or during the 1984 legislative session shall be construed to be grants of emergency rulemaking authority.

Sec. 32. **INSTRUCTION TO THE REVISOR.**

The revisor of statutes shall change the term "temporary rule," "temporary rulemaking," or similar terms to "emergency rule," "emergency rulemaking," or similar terms wherever those terms appear in Minnesota Statutes 1984.

The revisor of statutes shall change the term "hearing examiner" or similar terms to "administrative law judge" or similar terms and the term "chief hearing examiner" or similar terms to "chief administrative law judge" or similar terms wherever those terms appear in Minnesota Statutes 1984 with reference to personnel of the office of administrative hearings.

Sec. 33. **REPEALER.**

Minnesota Statutes 1982, section 14.13; and Minnesota Statutes 1983 Supplement, sections 14.07, subdivision 5; 14.17; and 14.21, are repealed.

Sec. 34. **EFFECTIVE DATE, APPLICATION.**

Sections 1 to 25, 28, and 30 to 33 are effective the day following final enactment and shall apply to all rulemaking proceedings for which the notice under section 14.14, subdivision 1a, 14.22, or 14.30 is thereafter published. Sections 26 and 27 are effective the day following final enactment.

Approved May 2, 1984

CHAPTER 641 — H.F.No. 2098

An act relating to public welfare; requiring financial statements by providers of continuing care facilities; allowing residents to form associations; revising procedures for determining operating cost payment rates for nursing homes; providing for a study; limiting control of waivered services; regulating continuing care facilities; appropriating money; amending Minnesota Statutes 1982, sections 62D.12, subdivision 1; 62D.17, subdivision 4;

144.072; 256B.25; 256D.06, by adding a subdivision; Minnesota Statutes 1983 Supplement, sections 45.16, subdivision 2; 62D.03, subdivision 4; 144A.31, subdivision 4; 256B.421, subdivisions 2, 5, and 8; 256B.431, subdivisions 1, 2, 4, 5, and by adding a subdivision; 256.48, subdivision 1; and 256B.50; proposing new law coded in Minnesota Statutes, chapters 62D; 80D; 144; and 256B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1983 Supplement, section 45.16, subdivision 2, is amended to read:

Subd. 2. **DUTIES.** The attorney general shall:

(a) enforce the provisions of law relating to consumer fraud and unlawful practices in connection therewith as set forth in sections 325F.68 and 325F.69;

(b) enforce the provisions of law set forth in sections 2 to 4;

(c) make recommendations to the governor and the legislature for statutory needs that exist in adequately protecting the consumer.

Sec. 2. Minnesota Statutes 1983 Supplement, section 62D.03, subdivision 4, if amended by H.F. No. 1561 at the 1984 regular session, is amended to read:

Subd. 4. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, and shall be in a form prescribed by the commissioner of health. Each application shall include the following:

(a) a copy of the basic organizational document, if any, of the applicant and of each major participating entity; such as the articles of incorporation, or other applicable documents, and all amendments thereto;

(b) a copy of the bylaws, rules and regulations, or similar document, if any, and all amendments thereto which regulate the conduct of the affairs of the applicant and of each major participating entity;

(c) a list of the names, addresses, and official positions of the following:

(1) all members of the board of directors, or governing body of the local government unit, and the principal officers and ~~controlling~~ shareholders of the applicant organization; and

(2) all members of the board of directors, or governing body of the local government unit, and the principal officers of the major participating entity and ~~controlling shareholders of~~ each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

The commissioner may by rule identify persons included in the ~~terms~~ term "principal officers" ~~and "controlling shareholders"~~;

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

(d) a full disclosure of the extent and nature of any contract or financial arrangements between the following:

(1) the health maintenance organization and the persons listed in clause (c)(1);

(2) the health maintenance organization and the persons listed in clause (c)(2);

(3) each major participating entity and the persons listed in clause (c)(1) concerning any financial relationship with the health maintenance organization; and

(4) each major participating entity and the persons listed in clause (c)(2) concerning any financial relationship with the health maintenance organization;

(e) the name and address of each participating entity and the agreed upon duration of each contract or agreement;

(f) a copy of the form of each contract binding the participating entities and the health maintenance organization. Contractual provisions shall be consistent with the purposes of sections 62D.01 to 62D.29, in regard to the services to be performed under the contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health maintenance organization, the nature and extent of risk sharing permissible, and contractual termination provisions~~.~~;

(g) a copy of each contract binding major participating entities and the health maintenance organization. Contract information filed with the commissioner shall be confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon the request of the health maintenance organization.

Upon initial filing ~~and thereafter on or before the anniversary of the implementation~~ of each contract, the health maintenance organization shall file a separate document detailing the projected annual expenses to the major participating entity in performing the contract and the projected annual revenues received by the entity from the health maintenance organization for such performance. The commissioner shall disapprove any contract with a major participating entity if the contract will result in an unreasonable expense under section 62D.19. The commissioner shall ~~notify a major participating entity~~ approve or disapprove a contract within 30 days ~~if a contract may be disapproved~~ of filing.

Within 120 days of the anniversary of the implementation of each contract, the health maintenance organization shall file a document detailing the actual expenses incurred and reported by the major participating entity in performing the contract in the proceeding year and the actual revenues received from the health maintenance organization by the entity in payment for the

performance. ~~The contract shall be submitted for a reasonableness determination under section 62D.19.~~

Contracts implemented prior to the effective date of this subdivision shall be filed within 90 days of such effective date. These contracts are subject to the provisions of section 62D.19 but are not subject to the prospective review prescribed by this clause unless or until the terms of the contract are modified. Commencing with the next anniversary of the implementation of each of these contracts immediately following filing, the health maintenance organization shall, as otherwise required by this subdivision, file annual ~~projected and~~ actual expenses and revenues ~~which will be subject to review in the manner prescribed by this subdivision~~.

(h) a statement generally describing the health maintenance organization, its health maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

(i) a copy of the form of each evidence of coverage to be issued to the enrollees;

(j) a copy of the form of each individual or group health maintenance contract and each separate health service contract which is to be issued to enrollees or their representatives;

(k) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement may be deemed to satisfy this requirement;

(l) a description of the proposed method of marketng the plan, a schedule of proposed charges, and a financial plan which includes a three year projection of the expenses and income and other sources of future capital;

(m) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

(n) a description of the complaint procedures to be utilized as required under section 62D.11;

(o) a description of the procedures and programs to be implemented to meet the requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the quality of health care provided to enrollees;

(p) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 62D.06;

(q) a copy of any agreement between the health maintenance organization and an insurer or nonprofit health service corporation regarding reinsurance, stop-loss coverage or any other type of coverage for potential costs of health services, as authorized in section 62D.04, subdivision 1, clause (f), and section 62D.13; and

(r) other information as the commissioner of health may reasonably require to be provided.

Sec. 3. **[62D.102] MINIMUM BENEFITS.**

In addition to minimum requirements established in other sections, all group health maintenance contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage for at least ten hours of treatment over a 12-month period with a copayment not to exceed the greater of $10 or 20 percent of the applicable usual and customary charge for mental or nervous disorder consultation, diagnosis and treatment services delivered while the enrollee is not a bed patient in a hospital.

Sec. 4. **[62D.103] SECOND OPINION RELATED TO CHEMICAL DEPENDENCY AND MENTAL HEALTH.**

A health maintenance organization shall promptly evaluate the treatment needs of any enrollee who is seeking treatment for a problem related to chemical dependency or mental health conditions. In the event that the health maintenance organization or a participating provider determines that no type of structured treatment is necessary, the enrollee shall be immediately entitled to a second opinion paid for by the health maintenance organization, by a health care professional qualified in diagnosis and treatment of the problem and not affiliated with the health maintenance organization. The health maintenance organization or participating provider shall consider the second opinion but is not obligated to accept the conclusion of the second opinion. The health maintenance organization or participating provider shall document its consideration of the second opinion.

Sec. 5. Minnesota Statutes 1982, section 62D.12, subdivision 1, if amended by H.F. No. 1561 at the 1984 regular session, is amended to read:

Subdivision 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. ~~Any written advertising is misleading if it fails to disclose that there are limitations on the services of some health care professionals. This general disclosure is not required on billboards.~~ Each health maintenance organization shall be subject to sections 72A.17 to 72A.321, relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of insurance.

Every health maintenance organization shall be subject to sections 325F.69 and 8.31.

Sec. 6. Minnesota Statutes 1982, section 62D.17, subdivision 4, is amended to read:

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.29.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.29 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices involve violation of the reporting requirements of section 62D.08, or if the commissioner of commerce has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, the health maintenance organization may request an expedited hearing on the matter. The hearing shall be held within 15 days of the request. Within ten days thereafter, a hearing examiner shall issue a recommendation on the matter. The commissioner shall make a final determination on the matter within ten days of receipt of the hearing examiner's recommendation.

When a request for a stay accompanies the hearing request, the matter shall be referred to the office of administrative hearings within three working days of receipt of the request. Within ten days thereafter, a hearing examiner shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receipt of the hearing examiner's recommendation.

To the extent the acts or practices alleged do not involve violations of section 62D.08, if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 90 days from the date the hearing is requested or until a final determination is made on the order, whichever is earlier. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the hearing examiner no later than ten days prior to the expiration of the stay.

Sec. 7. **[80D.19] ANNUAL FINANCIAL STATEMENT REQUIRED.**

A provider shall prepare and distribute an annual financial statement to the residents of a facility. The statement shall be prepared in accordance with generally accepted accounting principles and shall be distributed within four months of the end of the provider's fiscal year. The statement must reflect all of

the income and expense attributable to the facility for the fiscal year covered. The statement must account for all receipts and disbursements from whatever source derived, to whatever source paid, arising from the operation of the facility.

All entrance and maintenance fees, actual interest received and paid, and loan proceeds received, and interest and principal paid thereon, must be accounted for whether or not included in separate accounts because of trust, escrow, or other requirements. Items of income and expense to be allocated between a facility and another accounting entity must be allocated in accordance with generally accepted accounting principles. The allocation must be noted in the statement. The statement must be in sufficient detail to be meaningful but must be easily readable by, and understandable to, a person of average intelligence and education. The statement must include comparable data for the fewer of: each of the last five years; or for each year since the first receipts or disbursements, arising out of the facility project. If comparable data does not exist and cannot be created for a past year, the variation must be noted and explained in the statement.

Sec. 8. **[80D.20] RESIDENTS' REVIEW OF BUDGET; MONTHLY STATEMENTS.**

Subdivision 1. **FORMATION OF ASSOCIATION.** The residents of a facility may form a residents' association to deal with common interests related to their residency. The association may be organized in any way so long as each resident is given an equal opportunity to participate and an equal vote in the association's decisions including those delegating authority to the association's officers, board, and committees, if any.

Subd. 2. **ANNUAL BUDGET REVIEW.** Upon notification to it of the existence of a residents' association, the provider must present its annual budget to the association for comment before its adoption. The budget must be in sufficient detail to be meaningful, but must be readable by, and understandable to, a person of average intelligence and education. The budget must reflect the projected collection and disbursement of receipts of any kind, for any purpose by the provider, or any person related in business to the provider, attributable to residents of the facility, including interest income, and trust assets, during the budget year.

Subd. 3. **REVIEW OF MONTHLY EXPENDITURE STATEMENTS.** Throughout the budget year, the provider must give the association timely monthly statements of current income and expense showing year-to-date relationship to the annual budget, and explanations for a deviation from the budget. The association or its representative may comment on, or raise questions about, the monthly statements, to the provider.

Subd. 4. The penalty provisions of section 80D.16 shall apply to provider actions in sections 2 and 3.

Sec. 9. **TIME OF EFFECT.**

The first reporting fiscal year a provider must comply with section 7 is the first of its fiscal years that ends after the effective date of sections 7 to 9. Comparable data from up to five years earlier than the reporting fiscal year is required to comply with section 7 according to its terms.

Sec. 10. Minnesota Statutes 1982, section 144.072, is amended to read:

144.072 **IMPLEMENTATION OF SOCIAL SECURITY AMENDMENTS OF 1972.**

Subdivision 1. **RULES.** The state commissioner of health shall implement by rule, pursuant to the administrative procedures act, those provisions of the social security amendments of 1972 (P. L. 92-603) required of state health agencies, including rules which:

(a) establish a plan, consistent with regulations prescribed by the secretary of health, education, and welfare, for the review by appropriate professional health personnel, of the appropriateness and quality of care and services furnished to recipients of medical assistance; and

(b) provide for the determination as to whether institutions and agencies meet the requirements for participation in the medical assistance program, and the certification that those requirements, including utilization review, are being met.

Subd. 2. **EXISTING PROCEDURES.** The policies and procedures, including survey forms, reporting forms, and other documents developed by the commissioner of health for the purpose of conducting the inspections of care required under Code of Federal Regulations, title 42, sections 456.600 to 456.614, in effect on March 1, 1984, have the force and effect of law and shall remain in effect and govern inspections of care until June 30, 1986, unless otherwise superseded by rules adopted by the commissioner of health.

Sec. 11. **[144.0721] ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.**

Subdivision 1. The commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted in accordance with section 144.072, with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

Subd. 2. **ACCESS TO DATA.** With the exception of summary data, data on individuals that is collected, maintained, used, or disseminated by the

commissioner of health under subdivision 1 is private data on individuals and shall not be disclosed to others except:

(1) under section 13.05;

(2) under a valid court order;

(3) to the nursing home or boarding care home in which the individual resided at the time the assessment was completed; or

(4) to the commissioner of public welfare.

Sec. 12. Minnesota Statutes 1983 Supplement, section 144A.31, subdivision 4, is amended to read:

Subd. 4. **ENFORCEMENT.** The board shall develop and recommend for implementation effective methods of enforcing quality of care standards. When it deems necessary, and when all other methods of enforcement are not appropriate, the board shall recommend to the commissioner of health closure of all or part of a nursing home or certified boarding care home and revocation of the license. The board shall develop, and the commissioner of public welfare shall implement, a resident relocation plan that instructs the county in which the nursing home or certified boarding care home is located of procedures to ensure that the needs of residents in nursing homes or certified boarding care homes about to be closed are met. The duties of a county under the relocation plan also apply when residents are to be discharged from a nursing home or certified boarding care home as a result of a change in certification, closure, or loss or termination of the facility's medical assistance provider agreement. The county shall ensure placement in swing beds in hospitals, placement in unoccupied beds in other nursing homes, utilization of home health care on a temporary basis, foster care placement, or other appropriate alternative care. In preparing for relocation, the board shall ensure that residents and their families or guardians are involved in planning the relocation.

Sec. 13. Minnesota Statutes 1982, section 256B.25, is amended to read:

256B.25 **PAYMENTS TO ~~LICENSED~~ CERTIFIED FACILITIES.**

Subdivision 1. Payments may not be made hereunder for care in any private or public institution, including but not limited to hospitals and nursing homes, unless licensed by an appropriate licensing authority of this state, any other state, or a Canadian province and if applicable, certified by an appropriate authority under United States Code, title 42, sections 1396-1396p.

Subd. 2. The payment of state or county funds to nursing homes, boarding care homes, and supervised living facilities, except payments to state operated institutions, for the care of persons who are eligible for medical assistance, shall be made only through the medical assistance program, except as provided in subdivision 3.

Subd. 3. The limitation in subdivision 2 shall not apply to:

(a) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(b) payment or grants to a boarding care home or supervised living facility licensed by the department of public welfare under 12 MCAR 2.036, 12 MCAR 2.035, 12 MCAR 2.005, or 12 MCAR 2.008, or payment to recipients who reside in these facilities;

(c) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(d) payments or grants otherwise specifically authorized by statute or rule.

Sec. 14. Minnesota Statutes 1983 Supplement, section 256B.421, subdivision 2, is amended to read:

Subd. 2. **ACTUAL ALLOWABLE HISTORICAL OPERATING COST PER DIEM.** "Actual allowable historical operating cost per diem" means the per diem ~~payment for actual~~ operating costs~~, including operating costs,~~ allowed by the commissioner for the most recent reporting year.

Sec. 15. Minnesota Statutes 1983 Supplement, section 256B.421, subdivision 5, is amended to read:

Subd. 5. **GENERAL AND ADMINISTRATIVE COSTS.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, ~~medical directors,~~ accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dieticians required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; ~~licenses and permits;~~ membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars. These costs shall be included in general and administrative costs in total, without direct or indirect allocation to other cost categories.

In a nursing home of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social

services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home.

Sec. 16. Minnesota Statutes 1983 Supplement, section 256B.421, subdivision 8, is amended to read:

Subd. 8. **OPERATING COSTS.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; medical directors; licenses and permits; general and administration; payroll taxes; real estate taxes and actual special assessments paid; and fringe benefits, including clerical training; and travel necessary for training programs for nursing personnel and dieticians required to maintain licensure, certification, or professional standards requirements.

Sec. 17. Minnesota Statutes 1983 Supplement, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **IN GENERAL.** The commissioner shall determine prospective payment rates for resident care costs. In determining the rates, the commissioner shall group nursing homes according to different levels of care and geographic location until July 1, 1985~~, and after that date, mix of resident needs, and geographic location, as defined by the commissioner~~. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. Until ~~groups are established according to mix of resident needs~~ the commissioner establishes procedures for determining operating cost payment rates, the commissioner shall group all convalescent and nursing care units attached to hospitals into one group for purposes of determining reimbursement for operating costs. On or before June 15, 1983, the commissioner shall mail notices to each nursing home of the rates to be effective from July 1 of that year to June 30 of the following year. In subsequent years, the commissioner shall provide notice to each nursing home on or before May 1 of the rates effective for the following rate year. If a statute enacted after May 1 affects the rates, the commissioner shall provide a revised notice to each nursing home as soon as possible.

The commissioner shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. For rate years beginning July 1, 1985, the commissioner shall not provide, by rule, limitations

on top management personnel. Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category. The commissioner shall also establish, by rule, limitations on allowable nursing hours for each level of care for the rate years beginning July 1, 1983 and July 1, 1984. For the rate year beginning July 1, 1984, nursing homes in which the nursing hours exceeded 2.9 hours per day for skilled nursing care or 2.3 hours per day for intermediate care for the reporting year ending on September 30, 1983, shall be limited to a maximum of 3.2 hours per day for skilled nursing care and 2.6 hours per day for intermediate care.

Sec. 18. Minnesota Statutes 1983 Supplement, section 256B.431, subdivision 2, is amended to read:

Subd. 2. **OPERATING COSTS, 1984-1985.** (a) For the rate year beginning July 1, 1984, the commissioner shall establish, by rule, procedures for determining per diem reimbursement for operating costs based on actual resident days. The commissioner shall disallow any portion of the general and administration cost category, exclusive of fringe benefits and payroll taxes, that exceeds:

~~10 percent~~ (1) for nursing homes with more than 100 certified beds in total, the greater of ten percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care;

~~12 percent~~ (2) for nursing homes with fewer than 101 but more than 40 certified beds in total, the greater of 12 percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care;

~~14 percent~~ (3) for nursing homes with 40 or fewer certified beds in total, the greater of 14 percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care; and

(4) 15 percent for convalescent and nursing care units attached to hospitals for the rate year beginning July 1, ~~1983~~ 1984, of the expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administration.

~~(b)~~ Subd. 2a. **OPERATING COSTS, 1983-1984.** For the rate year beginning July 1, 1983, and ending June 30, 1984, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on the allowed historical operating costs as reported in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs allowed. To determine the allowed historical operating cost, the commissioner shall update the historical per diem shown in those cost reports to June 30, 1983, using a nine percent annual rate of increase after applying the general and administrative cost limitation described in ~~paragraph (a)~~ subdivision 2. The commissioner shall calculate the 60th percen-

tile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

~~(1)~~ (a) Within each group, each nursing home whose actual allowable historical operating cost per diem as determined under this ~~paragraph~~ ~~(b)~~ subdivision is above the 60th percentile shall receive the 60th percentile increased by six percent plus 80 percent of the difference between its actual allowable operating cost per diem and the 60th percentile.

~~(2)~~ (b) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased by six percent.

For the rate year beginning July 1, 1984, and ending June 30, 1985, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on actual allowable historical operating costs incurred during the reporting year preceding the rate year. The commissioner shall analyze and evaluate each nursing home's report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year. The actual allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the number of actual resident days to compute the actual allowable historical operating cost per diems. The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

~~(3)~~ (c) Within each group, each nursing home whose actual allowable historical operating cost per diem is above the 60th percentile of payment rates shall receive the 60th percentile increased at an annual rate of six percent plus 75 percent of the difference between its actual allowable historical operating cost per diem and the 60th percentile.

~~(4)~~ (d) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased at an annual rate of six percent.

~~(c)~~ Subd. 2b. **OPERATING COSTS, AFTER JULY 1, 1985.** (a) For ~~subsequent years~~ rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

~~(1)~~ (b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate~~;~~ .

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

~~(2) Establish the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year.~~ (c) The commissioner shall analyze and evaluate each nursing home's cost report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective. ~~The allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the actual number of resident days in order to compute the actual allowable historical operating cost per diem;~~

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, age, size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing home payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing home is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories.

~~(3)~~ (e) The commissioner shall establish a composite index ~~for each group~~ or indices by determining the ~~weighted average of all~~ appropriate economic change indicators to be applied to ~~the~~ specific operating cost categories ~~in that group;~~ or combination of operating cost categories.

~~(4) Within each group, each nursing home shall receive the 60th percentile increased by the composite index calculated in paragraph (c)(3). The historical base for determining the prospective payment rate shall not exceed the operating cost payment rates during that reporting year.~~

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

(f) Each nursing home shall receive an operating cost payment rate equal to the sum of the nursing home's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing home's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability of each proprietary nursing home as an operating cost of that nursing home. The commissioner shall include a reported actual special assessment for each nursing home as an operating cost of that nursing home. Total real estate tax liability and actual special assessments paid for each nursing home ~~(i)~~ (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, ~~but (ii) shall not be used to compute the 60th percentile~~ (2) shall not be used to compute the 60th percentile or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e).

Subd. 2c. **OPERATING COSTS AFTER JULY 1, 1986.** For rate years beginning on or after July 1, 1986, the commissioner may allow a one time adjustment to historical operating costs of a nursing home that has been found by the commissioner of health to be significantly below care related minimum standards appropriate to the mix of resident needs in that nursing home when it is determined by the commissioners of health and public welfare that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the commissioner shall specify the terms and conditions governing any additional payments made to a nursing home as a result of the adjustment. The commissioner shall establish procedures to recover amounts paid under this subdivision, in whole or in part, and to adjust current and future rates, for nursing homes that fail to use the adjustment to satisfy care related minimum standards.

~~(d) The commissioner shall allow the nursing home to keep, as an efficiency incentive, the difference between the nursing home's operating cost payment rate established for that rate year and the actual historical operating costs incurred for that rate year, if the latter amount is smaller. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up.~~

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

Subd. 2d. If an annual cost report or field audit indicates that ~~the~~ expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency board for quality assurance. If a field audit reveals that unallowable expenditures have been included in the nursing home's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270.75 on any outstanding balance resulting from an overpayment or underpayment.

~~(e)~~ Subd. 2e. **NEGOTIATED RATES.** Until procedures for determining operating cost payment rates according to mix of resident needs are established, the commissioner may negotiate, with a nursing home that is eligible to receive medical assistance payments, a payment rate of up to 125 percent of the allowed payment rate to be paid for a period of up to three months for individuals who have been hospitalized for more than 100 days, or who have extensive care needs based on nursing hours actually provided or mental or physical disability, or who need ~~for~~ respite care for a specified and limited time period~~, and~~. In addition, the commissioner shall take into consideration facilities which historically provided nursing hours at or near the maximum limits which were subsequently reduced as a consequence of payment rate reductions. The payment rate shall be based on an assessment of the nursing home's resident mix as determined by the commissioner of health. When circumstances dictate, the commissioner has authority to renegotiate payment rates for an additional period of time. The payment rate negotiated and paid pursuant to this paragraph is specifically exempt from the definition of "rule" and the rule-making procedures required by chapter 14 and section 256B.502.

~~(f)~~ Subd. 2f. **EXCLUSION.** Until ~~groups are established according to mix of resident care needs~~ procedures for determining operating cost payment rates according to mix of resident needs are established, nursing homes licensed on June 1, 1983 by the commissioner to provide residential services for the physically handicapped and nursing homes that have an average length of stay of less than 180 days shall not be included in the calculation of the 60th percentile of any group. For rate year beginning July 1, 1983 and July 1, 1984, each of these nursing homes shall receive their actual allowed historical operating cost per diem increased by six percent. The commissioner shall also apply to these nursing homes the percentage limitation on the general and administrative cost category as provided in subdivision 2~~, paragraph (a)~~.

Sec. 19. Minnesota Statutes 1983 Supplement, section 256B.431, subdivision 4, is amended to read:

Subd. 4. **SPECIAL RATES.** (a) A newly constructed nursing home or one with a capacity increase of 50 percent or more may, upon written application

to the commissioner, receive an interim payment rate for reimbursement for property-related costs calculated pursuant to the statutes and rules in effect on May 1, 1983 and for operating costs negotiated by the commissioner based upon the 60th percentile established for the appropriate group under subdivision 2, paragraph (b) to be effective from the first day a medical assistance recipient resides in the home or for the added beds. For newly constructed nursing homes which are not included in the calculation of the 60th percentile for any group, subdivision 2(f), the commissioner shall establish by rule procedures for determining interim operating cost payment rates and interim property-related cost payment rates. The interim payment rate shall not be in effect for more than 17 months. The commissioner shall establish, by temporary and permanent rules, procedures for determining the interim rate and for making a retroactive cost settle-up after the first year of operation; the cost settled operating cost per diem shall not exceed 110 percent of the 60th percentile established for the appropriate group. Until procedures determining operating cost payment rates according to mix of resident needs are established, the commissioner shall establish by rule procedures for determining payment rates for nursing homes which provide care under a lesser care level than the level for which the nursing home is certified.

(b) For rate years beginning on or after July 1, 1983, the commissioner may exclude from a provision of 12 MCAR S 2.050 any facility that is licensed by the commissioner of health only as a boarding care home, is certified by the commissioner of health as an intermediate care facility, is licensed by the commissioner of public welfare under 12 MCAR S 2.036, and has less than five percent of its licensed boarding care capacity reimbursed by the medical assistance program. Until a permanent rule to establish the payment rates for facilities meeting these criteria is promulgated, the commissioner shall establish the medical assistance payment rate as follows:

(1) The desk audited payment rate in effect on June 30, 1983, remains in effect until the end of the facility's fiscal year. The commissioner shall not allow any amendments to the cost report on which this desk audited payment rate is based.

(2) For each fiscal year beginning between July 1, 1983, and June 30, 1985, the facility's payment rate shall be established by increasing the desk audited operating cost payment rate determined in clause (1) at an annual rate of five percent.

(3) For fiscal years beginning on or after July 1, 1985, the facility's payment rate shall be established by increasing the facility's payment rate in the facility's prior fiscal year by the increase indicated by the consumer price index for Minneapolis and St. Paul.

(4) For the purpose of establishing payment rates under this paragraph, the facility's rate and reporting years coincide with the facility's fiscal year.

A facility that meets the criteria of this paragraph shall submit annual cost reports on forms prescribed by the commissioner.

Sec. 20. Minnesota Statutes 1983 Supplement, section 256B.431, subdivision 5, is amended to read:

Subd. 5. **ADJUSTMENTS.** When resolution of appeals or on-site field audits of the records of nursing homes within a group result in adjustments to the 60th percentile of the payment rates within the group in ~~any~~ the reporting year ending on September 30, 1983, the 60th percentile established for the following rate year for that group shall be increased or decreased by the adjustment amount.

Sec. 21. Minnesota Statutes 1983 Supplement, section 256B.50, is amended to read:

256B.50 **APPEALS.**

A nursing home may appeal a decision arising from the application of standards or methods pursuant to sections 256B.41 and 256B.47 if the appeal, if successful, would result in a change to the nursing home's payment rate. The appeal procedures also apply to appeals of payment rates calculated under 12 MCAR S 2.049 filed with the commissioner on or after May 1, 1984. To appeal, the nursing home shall notify the commissioner in writing of its intent to appeal within 30 days and submit a written appeal request within 60 days of receiving notice of the payment rate determination or decision. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the nursing home believes is correct, the authority in statute or rule upon which the nursing home relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner. The appeal shall be heard by a hearing examiner according to sections 14.48 to 14.56, or upon agreement by both parties according to a modified appeals procedure established by the commissioner and the hearing examiner. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary. To challenge the validity of rules established by the commissioner pursuant to sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, a nursing home shall comply with section 14.44.

Sec. 22. Minnesota Statutes 1983 Supplement, section 256B.431, is amended by adding a subdivision to read:

Subd. 6. The commissioners of health and public welfare shall adopt temporary rules necessary for the implementation and enforcement of the reimbursement system established in sections 10 to 20. The commissioner of health may adopt temporary rules relating to the licensure requirements of boarding care homes and nursing homes promulgated under sections 144.56 and 144A.08 if appropriate due to the changes in the reimbursement system. Until June 30, 1986, any temporary rules adopted by the commissioner of health or the commissioner of public welfare under this section shall be adopted in accordance with the provisions contained in sections 14.29 to 14.36 in effect on March 1, 1984. Temporary rules adopted under this subdivision have the force and effect of law and remain in effect until June 30, 1986, unless otherwise superseded by rule. The procedures for the adoption of the temporary rules authorized by this subdivision shall prevail over any other act that amends chapter 14 regardless of the date of final enactment of those amendments. The rules shall be developed in consultation with the interagency board for quality assurance, provider groups and consumers and the board shall conduct public hearings as appropriate. The commissioners of health and public welfare shall consider all comments received and shall not implement the temporary rules until a report on the proposed rules has been presented to the senate health and human services committee and the house of representatives health and welfare committee. The rules are effective five days after publication in the State Register.

Sec. 23. Minnesota Statutes, 1983 Supplement, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **PROHIBITED PRACTICES.** A nursing home is not eligible to receive medical assistance payments unless it refrains from:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be offered to all residents and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing home in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing home. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing home that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions

or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing home may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of a hearing examiner under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The hearing examiner shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance;

(b) Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit in excess of $100, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home;

(c) Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home;

(d) ~~Requiring any applicant to the nursing home, or the applicant's guardian or conservator, as a condition of admission, to assure that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs~~ Providing differential treatment on the basis of status with regard to public assistance;

(e) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance. Admissions discrimination shall include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing home, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs;

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately.

The collection and use by a nursing home of financial information of any applicant pursuant to the pre-admission screening program established by section 256B.091 shall not raise an inference that the nursing home is utilizing that information for any purpose prohibited by this paragraph;

~~(e)~~ (f) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of his fee to the nursing home except as payment for renting or leasing space or equipment of the nursing home or purchasing support services, if those agreements are disclosed to the commissioner; and

~~(f)~~ (g) Refusing, for more than 24 hours, to accept a resident returning to his same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

The prohibitions set forth in clause (b) shall not apply to a retirement home with more than 325 beds including at least 150 licensed nursing home beds and which:

(1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and

(2) accounts for all of the applicant's assets which are required to be assigned to the home so that only expenses for the cost of care of the applicant may be charged against the account; and

(3) agrees in writing at the time of admission to the home to permit the applicant, or his guardian, or conservator, to examine the records relating to the applicant's account upon request, and to receive an audited statement of the expenditures charged against his individual account upon request; and

(4) agrees in writing at the time of admission to the home to permit the applicant to withdraw from the home at any time and to receive, upon withdrawal, the balance of his individual account.

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing home or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing home to correct the violation. The nursing home shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20 day period the commissioner may reduce the payment rate to the nursing home by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation, and shall remain in effect until the violation is corrected. The nursing home or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing home is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing home to receive reimbursement on a

temporary basis until the resident can be relocated to a participating nursing home.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 24. **[256B.491] WAIVERED SERVICES.**

Subdivision 1. **STUDY.** The commissioner of public welfare shall prepare a study on the characteristics of providers who have the potential for offering home and community-based services under federal waivers authorized by United States Code, title 42, sections 1396 to 1396p. The study shall include, but not be limited to:

(a) An analysis of the characteristics of providers presently involved in offering services to the elderly, chronically ill children, disabled persons under age 65, and mentally retarded persons;

(b) The potential for conversion to waivered services of facilities which currently provide services to the disability groups enumerated in clause (a);

(c) Proposals for system redesign to include (1) profiles of the types of providers best able, within reasonable fiscal constraints, to serve the needs of clients and to fulfill public policy goals in provision of waivered services, (2) methods for limiting concentration of facilities providing services under waiver, (3) methods for ensuring that services are provided by the widest array of provider groups.

The commissioner shall present the study to the legislature no later than March 15, 1985.

Subd. 2. **CONTROL LIMITED.** Until July 1, 1985, no one person shall control the delivery of waivered services to more than 50 persons receiving waivered services as authorized by section 256B.501. For the purposes of this section the following terms have the meanings given them:

(1) A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, a subsidiary of an organization, and an affiliate. A "person" does not include any governmental authority, agency or body.

(2) An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

(3) "Control" including the terms "controlling," "controlled by," and "under the common control with" is the possession, direct or indirect, or the power to direct or cause the direction of the management, operations or policies

of a person, whether through the ownership of voting securities, by contract, through consultation or otherwise.

Sec. 25. Minnesota Statutes 1982, section 256D.06, is amended by adding a subdivision to read:

Subd. 6. General assistance funds may be paid to cover the room and board needs of persons who are eligible for general assistance and who are placed by the county in a licensed facility for the purpose of receiving physical, mental health, or rehabilitative care.

Sec. 26. **OPERATING COST ADJUSTMENT ALLOWANCE.**

For the rate year beginning July 1, 1984, and ending June 30, 1985, and for the purpose of salary increases for direct-care personnel, the commissioner shall add 24 cents per resident per day to the operating cost payment rate of each nursing home whose allowable historical operating cost per diem is below the 60th percentile of allowable historical operating costs per diems for its respective group and shall add 6 cents per resident per day to the operating cost payment rate of each nursing home whose allowable historical operating cost per diem is at or above the 60th percentile of allowable historical operating costs per diems for its respective group. The groups shall be the groups established under section 256B.431, subdivision 1, based on cost reports of allowable historical operating costs incurred in the previous reporting year. This increase shall not be used for general and administrative costs or property-related costs. Any change in the ranking of nursing homes as a result of amendments, field audits, or appeal settlements shall not affect the calculation in this clause.

Sec. 27. **ACQUISITION LIMITATION STUDY.**

The interagency board for quality assurance in consultation with the state planning agency, the department of public welfare, and the department of health shall study the issues related to concentration of ownership in the nursing home industry and in residential care services for the mentally retarded, including the effect on medical assistance rates paid for resident care. The board shall report to the legislative commission on long-term health care by January 15, 1985.

Sec. 28. **APPROPRIATION.**

Subdivision 1. The sum of $698,000 is appropriated from the general fund to the commissioner of health for purposes of sections 10, 11, and 21 and is available until June 30, 1985. The approved complement of the department of health is increased by 22 positions for the purposes of sections 10, 11, and 21. Five of these positions are temporary to continue only until June 30, 1985.

Subd. 2. There is appropriated to the commissioner of the department of public welfare, $1,170,000 for the purposes of sections 8 to 27.

Subd. 3. There is appropriated to the legislative commission on long-term health care $15,000 for the purposes of nursing home reimbursement rule developments and the state hospital planning study.

Subd. 4. The appropriations in subdivisions 1, 2, and 3, are from the general fund for the biennium ending June 30, 1985.

Sec. 29. **EFFECTIVE DATE.**

Sections 1 to 27 are effective the day following final enactment.

Approved May 2, 1984

CHAPTER 642 — H.F.No. 1991

An act relating to government operations; regulating public employee leave of absences; providing for civil service exams for handicapped persons; authorizing the commissioner of employee relations to negotiate insurance premium rates; providing for unclassified positions; modifying the appeal of court-martial proceedings for employees in the state military forces; amending Minnesota Statutes 1982, sections 15.62, subdivision 2; 192A.325; 192A.345, subdivisions 2 and 8; 192A.612; Minnesota Statutes 1983 Supplement, sections 43A.10, subdivision 8; 43A.23, subdivision 1; and 116L.03, subdivision 6; repealing Minnesota Statutes 1982, section 192A.345, subdivisions 1 and 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1983 Supplement, section 43A.10, subdivision 8, is amended to read:

Subd. 8. **ELIGIBILITY FOR QUALIFIED HANDICAPPED EXAMINATIONS.** The commissioner shall establish examination procedures for candidates whose handicaps are of such a severe nature that the candidates are unable to demonstrate their abilities in competitive examination processes. The examination procedures shall consist of up to 700 hours on-the-job trial work experience which will be in lieu of a competitive examination and for which the ~~employee~~ disabled person will be paid or unpaid at ~~the employee's~~ his or her option. This work experience shall be limited to candidates who ~~are mentally retarded, have severe hearing or visual impairments, have mobility impairments requiring the use of a wheelchair, or have other impairments that comprise serious employment handicaps and who have been referred for employment to a specific suitable vacancy by a vocational rehabilitation, veterans administration, or services for the blind counselor~~ have a physical or mental impairment for which there is no reasonable accommodation in the examination process. Implementation of provisions of this subdivision shall not be deemed a violation of other provisions of Laws 1981, chapter 210 or chapter 363.