Sec. 34. **EFFECTIVE DATE.**

Sections 13, 17, 18, and 31 are effective the day following final enactment.

Presented to the governor May 30, 2003

Signed by the governor June 12, 2003, 8:33 a.m.

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## CHAPTER 14—H.F.No. 6

*An act relating to state government; making changes to public assistance programs, long-term care, continuing care for persons with disabilities, children's services, occupational licenses, human services licensing, county initiatives, local public health grants, child care provisions, child support provisions, and health care; establishing the Community Services Act; establishing alternative care liens; modifying petroleum product specifications; conveying land in Cass county; making forecast adjustments; appropriating money; amending Minnesota Statutes 2002, sections 13.69, subdivision 1; 41A.09, subdivision 2a; 61A.072, subdivision 6; 62A.31, subdivisions 1f, 1u, by adding a subdivision; 62A.315; 62A.316; 62A.48, by adding a subdivision; 62A.49, by adding a subdivision; 62A.65, subdivision 7; 62D.095, subdivision 2, by adding a subdivision; 62E.06, subdivision 1; 62J.17, subdivision 2; 62J.23, by adding a subdivision; 62J.52, subdivisions 1, 2; 62J.692, subdivisions 3, 4, 5, 7, 8; 62J.694, by adding a subdivision; 62L.05, subdivision 4; 62Q.19, subdivisions 1, 2; 62S.22, subdivision 1; 69.021, subdivision 11; 119B.011, subdivisions 5, 6, 15, 19, 20, 21, by adding a subdivision; 119B.02, subdivision 1; 119B.03, subdivisions 4, 9; 119B.05, subdivision 1; 119B.08, subdivision 3; 119B.09, subdivisions 1, 2, 7, by adding subdivisions; 119B.11, subdivision 2a; 119B.12, subdivision 2; 119B.13, subdivisions 1, 6, by adding a subdivision; 119B.16, subdivision 2, by adding subdivisions; 119B.19, subdivision 7; 119B.21, subdivision 11; 119B.23, subdivision 3; 124D.23, subdivision 1; 144.1222, by adding a subdivision; 144.125; 144.128; 144.1481, subdivision 1; 144.1483; 144.1488, subdivision 4; 144.1491, subdivision 1; 144.1502, subdivision 4; 144.396, subdivisions 1, 5, 7, 10, 11, 12; 144.414, subdivision 3; 144.551, subdivision 1; 144A.04, subdivision 3, by adding a subdivision; 144A.071, subdivision 4c, as added; 144A.10, by adding a subdivision; 144A.4605, subdivision 4; 144E.11, subdivision 6; 144E.50, subdivision 5; 145.88; 145.881, subdivisions 1, 2; 145.882, subdivisions 1, 2, 3, 7, by adding a subdivision; 145.883, subdivisions 1, 9; 145A.02, subdivisions 5, 6, 7; 145A.06, subdivision 1; 145A.09, subdivisions 2, 4, 7; 145A.10, subdivisions 2, 10, by adding a subdivision; 145A.11, subdivisions 2, 4; 145A.12, subdivisions 1, 2, by adding a subdivision; 145A.13, by adding a subdivision; 145A.14, subdivision 2, by adding a subdivision; 147A.08; 148.5194, subdivisions 1, 2, 3, by adding a subdivision; 148.6445, subdivision 7; 148C.01, subdivisions 2, 12, by adding subdivisions; 148C.03, subdivision 1; 148C.0351, subdivision 1, by adding a subdivision; 148C.04; 148C.05, subdivision 1, by adding subdivisions; 148C.07; 148C.10, subdivisions 1, 2; 148C.11; 153A.17; 171.06, subdivision 3; 171.07, by adding a subdivision; 174.30, subdivision 1; 239.761, subdivisions 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13; 239.792; 245.0312; 245.4874; 245.493, subdivision 1a; 245A.035, subdivision 3; 245A.04, subdivisions 3, 3b, 3d; 245A.09, subdivision 7; 245A.10; 245A.11, subdivisions 2a, 2b, by adding a subdivision; 245B.03, subdivision 2, by adding a subdivision; 245B.04, subdivision 2; 245B.06, subdivisions 2, 5, 8; 245B.07, subdivisions 6, 9, 11; 245B.08, subdivision 1; 246.014; 246.015, subdivision 3; 246.018, subdivisions 2, 3, 4; 246.13; 246.15; 246.16; 246.54; 246.57, subdivisions 1, 4, 6; 246.71, subdivisions 4, 5; 246B.02; 246B.03; 246B.04; 252.025, subdivision 7; 252.06; 252.27, subdivision 2a; 252.32, subdivisions*

*1, 1a, 3, 3c; 252.41, subdivision 3; 252.46, subdivision 1; 253.015, subdivision 1; 253.017; 253.20; 253.26; 253B.02, subdivision 18a; 253B.04, subdivision 1; 253B.05, subdivision 3; 253B.09, subdivision 1; 256.01, subdivision 2; 256.012; 256.046, subdivision 1; 256.0471, subdivision 1; 256.476, subdivisions 1, 3, 4, 5, 11; 256.482, subdivision 8; 256.955, subdivisions 2a, 3, by adding a subdivision; 256.9657, subdivisions 1, 4, by adding a subdivision; 256.969, subdivisions 2b, 3a, by adding a subdivision; 256.975, by adding a subdivision; 256.98, subdivisions 3, 4, 8; 256.984, subdivision 1; 256B.055, by adding a subdivision; 256B.056, subdivisions 1a, 1c, 3c, 6; 256B.057, subdivisions 1, 2, 3b, 9, 10; 256B.0595, subdivisions 1, 2, by adding subdivisions; 256B.06, subdivision 4; 256B.061; 256B.0621, subdivisions 4, 7; 256B.0623, subdivisions 2, 4, 5, 6, 8; 256B.0625, subdivisions 5a, 9, 13, 17, 19c, 23, by adding subdivisions; 256B.0627, subdivisions 1, 4, 9; 256B.0635, subdivisions 1, 2; 256B.064, subdivision 2; 256B.0911, subdivision 4d; 256B.0913, subdivisions 2, 4, 5, 6, 7, 8, 10, 12; 256B.0915, subdivision 3, by adding a subdivision; 256B.092, subdivisions 1a, 5, by adding a subdivision; 256B.0945, subdivisions 2, 4; 256B.095; 256B.0951, subdivisions 1, 2, 3, 5, 7, 9; 256B.0952, subdivision 1; 256B.0953, subdivision 2; 256B.0955; 256B.15, subdivisions 1, 1a, 2, 3, 4, by adding subdivisions; 256B.19, subdivision 1; 256B.195, subdivisions 3, 5; 256B.32, subdivision 1; 256B.431, subdivisions 2r, 32, 36, by adding subdivisions; 256B.434, subdivisions 4, 10; 256B.47, subdivision 2; 256B.49, subdivision 15; 256B.501, subdivision 1, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.5013, by adding a subdivision; 256B.5015; 256B.69, subdivisions 2, 4, 5, 5a, 5c, 6a, 6b, 8, by adding subdivisions; 256B.75; 256B.76; 256B.761; 256B.82; 256D.03, subdivisions 3, 3a, 4; 256D.06, subdivision 2; 256D.44, subdivision 5; 256D.46, subdivisions 1, 3; 256D.48, subdivision 1; 256G.05, subdivision 2; 256I.02; 256I.04, subdivision 3; 256I.05, subdivisions 1, 1a, 7c; 256J.01, subdivision 5; 256J.02, subdivision 2; 256J.021; 256J.08, subdivisions 35, 65, 82, 85, by adding subdivisions; 256J.09, subdivisions 2, 3, 3a, 3b, 8, 10; 256J.14; 256J.20, subdivision 3; 256J.21, subdivisions 1, 2; 256J.24, subdivisions 3, 5, 6, 7, 10; 256J.30, subdivision 9; 256J.32, subdivisions 2, 4, 5a, by adding a subdivision; 256J.37, subdivision 9, by adding subdivisions; 256J.38, subdivisions 3, 4; 256J.40; 256J.42, subdivisions 4, 5, 6; 256J.425, subdivisions 1, 1a, 2, 3, 4, 6, 7; 256J.45, subdivision 2; 256J.46, subdivisions 1, 2, 2a; 256J.49, subdivisions 4, 5, 9, 13, by adding subdivisions; 256J.50, subdivisions 1, 9, 10; 256J.51, subdivisions 1, 2, 3, 4; 256J.53, subdivisions 1, 2, 5; 256J.54, subdivisions 1, 2, 3, 5; 256J.55, subdivisions 1, 2; 256J.56; 256J.57; 256J.62, subdivision 9; 256J.645, subdivision 3; 256J.66, subdivision 2; 256J.69, subdivision 2; 256J.75, subdivision 3; 256J.751, subdivisions 1, 2, 5; 256L.03, subdivision 1; 256L.04, subdivisions 1, 10; 256L.05, subdivisions 3a, 4; 256L.06, subdivision 3; 256L.07, subdivisions 1, 3; 256L.12, subdivisions 6, 9, by adding a subdivision; 256L.15, subdivisions 1, 2, 3; 256L.17, subdivision 2; 257.05; 257.0769; 259.21, subdivision 6; 259.67, subdivisions 4, 7; 260B.157, subdivision 1; 260B.176, subdivision 2; 260B.178, subdivision 1; 260B.193, subdivision 2; 260B.235, subdivision 6; 260C.141, subdivision 2; 261.063; 295.53, subdivision 1; 295.55, subdivision 2; 296A.01, subdivisions 2, 7, 8, 14, 19, 20, 22, 23, 24, 25, 26, 28, by adding a subdivision; 297I.15, subdivisions 1, 4; 326.42; 393.07, subdivisions 1, 5, 10; 471.59, subdivision 1; 514.981, subdivision 6; 518.167, subdivision 1; 518.551, subdivisions 7, 12, 13; 518.6111, subdivisions 2, 3, 4, 16; 524.3-805; 626.559, subdivision 5; 641.15, subdivision 2; Laws 1997, chapter 203, article 9, section 21, as amended; Laws 1997, chapter 245, article 2, section 11; 2003 S.F. No. 1019, sections 2, 3, 7, if enacted; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 62S; 97A; 119B; 144; 144A; 145; 145A; 148C; 245; 246; 256; 256B; 256I; 256J; 256L; 514; proposing coding for new law as Minnesota Statutes, chapter 256M; repealing Minnesota Statutes 2002, sections 62J.15; 62J.152; 62J.451; 62J.452; 62J.66; 62J.68; 119B.061; 119B.13, subdivision 2; 144.126; 144.1484; 144.1494; 144.1495; 144.1496; 144.1497; 144.401; 144A.071, subdivision 5; 144A.35; 144A.36; 144A.38; 145.882, subdivisions*

*4, 5; 6, 8; 145.883, subdivisions 4, 7; 145.884; 145.885; 145.886; 145.888; 145.889; 145.890; 145A.02, subdivisions 9, 10, 11, 12, 13, 14; 145A.09, subdivision 6; 145A.10, subdivisions 5, 6, 8; 145A.11, subdivision 3; 145A.12, subdivisions 3, 4, 5; 145A.14, subdivisions 3, 4; 145A.17, subdivision 2; 148.5194, subdivision 3a; 148.6445, subdivision 9; 148C.0351, subdivision 2; 148C.05, subdivisions 2, 3, 4; 148C.06; 148C.10, subdivision 1a; 245.478; 245.4886; 245.4888; 245.496; 246.017, subdivision 2; 246.022; 246.06; 246.07; 246.08; 246.11; 246.19; 246.42; 252.025, subdivisions 1, 2, 4, 5, 6; 252.032; 252.10; 252.32, subdivision 2; 253.015, subdivisions 2, 3; 253.10; 253.19; 253.201; 253.202; 253.25; 253.27; 254A.17; 256.05; 256.06; 256.08; 256.09; 256.10; 256.955, subdivision 8; 256.973; 256.9772; 256B.055, subdivision 10a; 256B.057, subdivision 1b; 256B.0625, subdivisions 35, 36; 256B.0945, subdivision 10; 256B.437, subdivision 2; 256B.5013, subdivision 4; 256E.01; 256E.02; 256E.03; 256E.04; 256E.05; 256E.06; 256E.07; 256E.08; 256E.081; 256E.09; 256E.10; 256E.11; 256E.115; 256E.13; 256E.14; 256E.15; 256F.01; 256F.02; 256F.03; 256F.04; 256F.05; 256F.06; 256F.07; 256F.08; 256F.11; 256F.12; 256F.14; 256J.02, subdivision 3; 256J.08, subdivisions 28, 70; 256J.24, subdivision 8; 256J.30, subdivision 10; 256J.462; 256J.47; 256J.48; 256J.49, subdivisions 1a, 2, 6, 7; 256J.50, subdivisions 2, 3, 3a, 5, 7; 256J.52; 256J.55, subdivision 5; 256J.62, subdivisions 1, 2a, 4, 6, 7, 8; 256J.625; 256J.655; 256J.74, subdivision 3; 256J.751, subdivisions 3, 4; 256J.76; 256K.30; 257.075; 257.81; 260.152; 268A.08; 626.562; Laws 1998, chapter 407, article 4, section 63; Laws 2000, chapter 488, article 10, section 29; Laws 2000, chapter 489, article 1, section 36; Laws 2001, First Special Session chapter 3, article 1, section 16; Laws 2001, First Special Session chapter 9, article 13, section 24; Laws 2002, chapter 374, article 9, section 8; Laws 2003, chapter 55, sections 1, 4; Minnesota Rules, parts 4705.0100; 4705.0200; 4705.0300; 4705.0400; 4705.0500; 4705.0600; 4705.0700; 4705.0800; 4705.0900; 4705.1000; 4705.1100; 4705.1200; 4705.1300; 4705.1400; 4705.1500; 4705.1600; 4736.0010; 4736.0020; 4736.0030; 4736.0040; 4736.0050; 4736.0060; 4736.0070; 4736.0080; 4736.0090; 4736.0120; 4736.0130; 4747.0030, subparts 25, 28, 30; 4747.0040, subpart 3, item A; 4747.0060, subpart 1, items A, B, D; 4747.0070, subparts 4, 5; 4747.0080; 4747.0090; 4747.0100; 4747.0300; 4747.0400, subparts 2, 3; 4747.0500; 4747.0600; 4747.1000; 4747.1100, subpart 3; 4747.1600; 4763.0100; 4763.0110; 4763.0125; 4763.0135; 4763.0140; 4763.0150; 4763.0160; 4763.0170; 4763.0180; 4763.0190; 4763.0205; 4763.0215; 4763.0220; 4763.0230; 4763.0240; 4763.0250; 4763.0260; 4763.0270; 4763.0285; 4763.0295; 4763.0300; 9505.0324; 9505.0326; 9505.0327; 9505.3045; 9505.3050; 9505.3055; 9505.3060; 9505.3068; 9505.3070; 9505.3075; 9505.3080; 9505.3090; 9505.3095; 9505.3100; 9505.3105; 9505.3107; 9505.3110; 9505.3115; 9505.3120; 9505.3125; 9505.3130; 9505.3138; 9505.3139; 9505.3140; 9505.3680; 9505.3690; 9505.3700; 9545.2000; 9545.2010; 9545.2020; 9545.2030; 9545.2040; 9550.0010; 9550.0020; 9550.0030; 9550.0040; 9550.0050; 9550.0060; 9550.0070; 9550.0080; 9550.0090; 9550.0091; 9550.0092; 9550.0093.*

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

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## ARTICLE 1

## WELFARE REFORM

Section 1. Minnesota Statutes 2002, section 119B.03, subdivision 4, is amended to read:

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

Subd. 4. **FUNDING PRIORITY.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or work first transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

Sec. 2. Minnesota Statutes 2002, section 256.984, subdivision 1, is amended to read:

Subdivision 1. **DECLARATION.** Every application for public assistance under this chapter ~~and/or~~ or chapters 256B, 256D, ~~256K,~~ ~~MFIP~~ ~~program~~ 256J, and food stamps or food support under chapter 393 shall be in writing or reduced to writing as prescribed by the state agency and shall contain the following declaration which shall be signed by the applicant:

"I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than $10,000, or both."

Sec. 3. Minnesota Statutes 2002, section 256D.06, subdivision 2, is amended to read:

Subd. 2. **EMERGENCY NEED.** Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need, as defined in rules promulgated by the commissioner, where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist and ~~(a) until March 31, 1998, the individual is ineligible for the program of emergency assistance under aid to families with dependent children and is not a recipient of aid to families with dependent children at the time of application; or (b)~~ the individual or family is ~~(i)~~ ineligible for MFIP or DWP or is not a participant of MFIP~~; and (ii) is ineligible for emergency assistance under section 256J.48~~ or DWP. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an

emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision. An emergency general assistance grant is available to a recipient not more than once in any 12-month period. Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency general assistance expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

Sec. 4. Minnesota Statutes 2002, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **SPECIAL NEEDS.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets ~~payable under the Minnesota family investment program~~ if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

Sec. 5. Minnesota Statutes 2002, section 256D.46, subdivision 1, is amended to read:

Subdivision 1. **ELIGIBILITY.** A county agency must grant emergency Minnesota supplemental aid ~~must be granted~~, to the extent funds are available, if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.

Sec. 6. Minnesota Statutes 2002, section 256D.46, subdivision 3, is amended to read:

Subd. 3. **PAYMENT AMOUNT.** The amount of assistance granted under emergency Minnesota supplemental aid is limited to the amount necessary to resolve the emergency. An emergency Minnesota supplemental aid grant is available to a recipient no more than once in any 12-month period. Funding for emergency Minnesota supplemental aid is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency Minnesota supplemental aid grants based on each county agency's average share of state's emergency Minnesota supplemental aid expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency Minnesota supplemental aid expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

Sec. 7. Minnesota Statutes 2002, section 256D.48, subdivision 1, is amended to read:

Subdivision 1. **NEED FOR PROTECTIVE PAYEE.** The county agency shall determine whether a recipient needs a protective payee when a physical or mental condition renders the recipient unable to manage funds and when payments to the recipient would be contrary to the recipient's welfare. Protective payments must be issued when there is evidence of: (1) repeated inability to plan the use of income to meet necessary expenditures; (2) repeated observation that the recipient is not properly fed or clothed; (3) repeated failure to meet obligations for rent, utilities, food, and other essentials; (4) evictions or a repeated incurrence of debts; or (5) lost or stolen checks~~; or (6) use of emergency Minnesota supplemental aid more than twice in a calendar year~~. The determination of representative payment by the Social Security Administration for the recipient is sufficient reason for protective payment of Minnesota supplemental aid payments.

Sec. 8. Minnesota Statutes 2002, section 256J.01, subdivision 5, is amended to read:

Subd. 5. **COMPLIANCE SYSTEM.** The commissioner shall administer a compliance system for the state's temporary assistance for needy families (TANF) program, the food stamp program, ~~emergency assistance,~~ general assistance, medical assistance, general assistance medical care, emergency general assistance, Minnesota supplemental aid, preadmission screening, child support program, and alternative care grants under the powers and authorities named in section 256.01, subdivision 2. The purpose of the compliance system is to permit the commissioner to supervise the administration of public assistance programs and to enforce timely and accurate distribution of benefits, completeness of service and efficient and effective program management and operations, to increase uniformity and consistency in the administration and delivery of public assistance programs throughout the state, and to reduce the possibility of sanction and fiscal disallowances for noncompliance with federal regulations and state statutes.

Sec. 9. Minnesota Statutes 2002, section 256J.02, subdivision 2, is amended to read:

Subd. 2. **USE OF MONEY.** State money appropriated for purposes of this section and TANF block grant money must be used for:

(1) financial assistance to or on behalf of any minor child who is a resident of this state under section 256J.12;

~~(2) employment and training services under this chapter or chapter 256K;~~

~~(3) emergency financial assistance and services under section 256J.48;~~

~~(4) diversionary assistance under section 256J.47;~~

~~(5)~~ the health care and human services training and retention program under chapter 116L, for costs associated with families with children with incomes below 200 percent of the federal poverty guidelines;

~~(6)~~ (3) the pathways program under section 116L.04, subdivision 1a;

~~(7) welfare-to-work extended employment services for MFIP participants with severe impairment to employment as defined in section 268A.15, subdivision 1a;~~

~~(8) the family homeless prevention and assistance program under section 462A.204;~~

~~(9) the rent assistance for family stabilization demonstration project under section 462A.205;~~

~~(10)~~ (4) welfare to work transportation authorized under Public Law ~~Number~~ 105-178;

~~(11)~~ (5) reimbursements for the federal share of child support collections passed through to the custodial parent;

~~(12)~~ (6) reimbursements for the working family credit under section 290.0671;

~~(13) intensive ESL grants under Laws 2000, chapter 489, article 1;~~

~~(14) transitional housing programs under section 119A.43;~~

~~(15) programs and pilot projects under chapter 256K; and~~

~~(16)~~ (7) program administration under this chapter;

(8) the diversionary work program under section 256J.95;

(9) the MFIP consolidated fund under section 256J.626; and

(10) the Minnesota department of health consolidated fund under Laws 2001, First Special Session chapter 9, article 17, section 3, subdivision 2.

Sec. 10. Minnesota Statutes 2002, section 256J.021, is amended to read:

256J.021 **SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.**

Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat ~~financial assistance~~ MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 11. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 11a. **CHILD ONLY CASE.** "Child only case" means a case that would be part of the child only TANF program under section 256J.88.

Sec. 12. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 24b. **DIVERSIONARY WORK PROGRAM OR DWP.** "Diversionary work program" or "DWP" has the meaning given in section 256J.95.

Sec. 13. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 28b. **EMPLOYABLE.** "Employable" means a person is capable of performing existing positions in the local labor market, regardless of the current availability of openings for those positions.

Sec. 14. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 34a. **FAMILY VIOLENCE.** (a) "Family violence" means the following, if committed against a family or household member by a family or household member:

(1) physical harm, bodily injury, or assault;

(2) the infliction of fear of imminent physical harm, bodily injury, or assault; or

(3) terroristic threats, within the meaning of section 609.713, subdivision 1; criminal sexual conduct, within the meaning of section 609.342, 609.343, 609.344, 609.345, or 609.3451; or interference with an emergency call within the meaning of section 609.78, subdivision 2.

(b) For the purposes of family violence, "family or household member" means:

(1) spouses and former spouses;

(2) parents and children;

(3) persons related by blood;

(4) persons who are residing together or who have resided together in the past;

(5) persons who have a child in common regardless of whether they have been married or have lived together at any time;

(6) a man and woman if the woman is pregnant and the man is alleged to be the father, regardless of whether they have been married or have lived together at anytime; and

(7) persons involved in a current or past significant romantic or sexual relationship.

Sec. 15. Minnesota Statutes, section 256J.08, is amended by adding a subdivision to read:

Subd. 34b. **FAMILY VIOLENCE WAIVER.** "Family violence waiver" means a waiver of the 60-month time limit for victims of family violence who meet the criteria in section 256J.545 and are complying with an employment plan in section 256J.521, subdivision 3.

Sec. 16. Minnesota Statutes 2002, section 256J.08, subdivision 35, is amended to read:

Subd. 35. **FAMILY WAGE LEVEL.** "Family wage level" means 110 percent of the transitional standard as specified in section 256J.24, subdivision 7.

Sec. 17. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 51b. **LEARNING DISABLED.** "Learning disabled," for purposes of an extension to the 60-month time limit under section 256J.425, subdivision 3, clause (3), means the person has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. Learning disabled does not include 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.

Sec. 18. Minnesota Statutes 2002, section 256J.08, subdivision 65, is amended to read:

Subd. 65. **PARTICIPANT.** "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP ~~as funded by TANF and the food stamp program~~. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the

minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the ~~person~~ case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant.

Sec. 19. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 65a. **PARTICIPATION REQUIREMENTS OF TANF.** "Participation requirements of TANF" means activities and hourly requirements allowed under title IV-A of the federal Social Security Act.

Sec. 20. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 73a. **QUALIFIED PROFESSIONAL.** (a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, a physician's assistant, a nurse practitioner, or a licensed chiropractor.

(b) For mental retardation and intelligence testing, a "qualified professional" means an individual qualified by training and experience to administer the tests necessary to make determinations, such as tests of intellectual functioning, assessments of adaptive behavior, adaptive skills, and developmental functioning. These professionals include licensed psychologists, certified school psychologists, or certified psychometrists working under the supervision of a licensed psychologist.

(c) For learning disabilities, a "qualified professional" means a licensed psychologist or school psychologist with experience determining learning disabilities.

(d) For mental health, a "qualified professional" means a licensed physician or a qualified mental health professional. A "qualified mental health professional" means:

(1) for children, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) for adults, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in clinical social work, a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(4) in psychology, an individual licensed by the board of psychology under sections 148.88 to 148.98, who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(5) in psychiatry, a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; and

(6) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 21. Minnesota Statutes 2002, section 256J.08, subdivision 82, is amended to read:

Subd. 82. **SANCTION.** "Sanction" means the reduction of a family's assistance payment by a specified percentage of the MFIP standard of need because: a nonexempt participant fails to comply with the requirements of sections ~~256J.52~~ 256J.515 to ~~256J.55~~ 256J.57; a parental caregiver fails without good cause to cooperate with the child support enforcement requirements; or a participant fails to comply with ~~the insurance, tort liability, or~~ other requirements of this chapter.

Sec. 22. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 84a. **SSI RECIPIENT.** "SSI recipient" means a person who receives at least $1 in SSI benefits, 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.

Sec. 23. Minnesota Statutes 2002, section 256J.08, subdivision 85, is amended to read:

Subd. 85. **TRANSITIONAL STANDARD.** "Transitional standard" means the basic standard for a family ~~with no other income or a nonworking family~~ without earned income and is a combination of the cash ~~assistance needs~~ portion and food ~~assistance needs for a family of that size~~ portion as specified in section 256J.24, subdivision 5.

Sec. 24. Minnesota Statutes 2002, section 256J.08, is amended by adding a subdivision to read:

Subd. 90. **SEVERE FORMS OF TRAFFICKING IN PERSONS.** "Severe forms of trafficking in persons" means: (1) sex trafficking in which a commercial sex

act is induced by force, fraud, or coercion, or in which the person induced to perform the act has not attained 18 years of age; or (2) 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.

Sec. 25. Minnesota Statutes 2002, section 256J.09, subdivision 2, is amended to read:

Subd. 2. **COUNTY AGENCY RESPONSIBILITY TO PROVIDE INFORMATION.** When a person inquires about assistance, a county agency must:

(1) explain the eligibility requirements of, and how to apply for~~, diversionary assistance as provided in section 256J.47; emergency assistance as provided in section 256J.48; MFIP as provided in section 256J.10; or~~ any ~~other~~ assistance for which the person may be eligible; and

(2) offer the person brochures developed or approved by the commissioner that describe how to apply for assistance.

Sec. 26. Minnesota Statutes 2002, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **SUBMITTING THE APPLICATION FORM.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins with the date the signed application is received by the county agency or the date all eligibility criteria are met, whichever is later;

(2) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

(3) inform a person that the person may submit the application before an interview;

(4) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

(5) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

(6) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

(7) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections ~~256J.52~~ 256J.515 to ~~256J.55~~ 256J.57;

(8) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

(9) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and ~~the initial~~ assessment under section ~~256J.52~~ 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 27. Minnesota Statutes 2002, section 256J.09, subdivision 3a, is amended to read:

Subd. 3a. **SCREENING.** The county agency, or at county option, the county's employment and training service provider as defined in section 256J.49, must screen each applicant to determine immediate needs and to determine if the applicant may be eligible for:

~~(1)~~ another program that is not partially funded through the federal temporary assistance to needy families block grant under Title I of Public Law ~~Number~~ 104-193, including the expedited issuance of food stamps under section 256J.28, subdivision 1. ~~If the applicant may be eligible for another program, a county caseworker must provide the appropriate referral to the program;~~

~~(2) the diversionary assistance program under section 256J.47; or~~

~~(3) the emergency assistance program under section 256J.48.~~ If the applicant appears eligible for another program, including any program funded by the MFIP consolidated fund, the county must make a referral to the appropriate program.

Sec. 28. Minnesota Statutes 2002, section 256J.09, subdivision 3b, is amended to read:

Subd. 3b. **INTERVIEW TO DETERMINE REFERRALS AND SERVICES.** If the applicant is not diverted from applying for MFIP, and if the applicant meets the MFIP eligibility requirements, then a county agency must:

(1) identify an applicant who is under the age of 20 without a high school diploma or its equivalent and explain to the applicant the assessment procedures and employment plan requirements ~~for minor parents~~ under section 256J.54;

(2) explain to the applicant the eligibility criteria in section 256J.545 for ~~an exemption under~~ the family violence ~~provisions in section 256J.52, subdivision 6~~ waiver, and ~~explain~~ what an applicant should do to develop an ~~alternative~~ employment plan;

(3) determine if an applicant qualifies for an exemption under section 256J.56 from employment and training services requirements, explain how a person should report to the county agency any status changes, and explain that an applicant who is exempt may volunteer to participate in employment and training services;

(4) for applicants who are not exempt from the requirement to attend orientation, arrange for an orientation under section 256J.45 and an ~~initial~~ assessment under section ~~256J.52~~ 256J.521;

(5) inform an applicant who is not exempt from the requirement to attend orientation that failure to attend the orientation is considered an occurrence of noncompliance with program requirements and will result in an imposition of a sanction under section 256J.46; and

(6) explain how to contact the county agency if an applicant has questions about compliance with program requirements.

Sec. 29. Minnesota Statutes 2002, section 256J.09, subdivision 8, is amended to read:

Subd. 8. **ADDITIONAL APPLICATIONS.** Until a county agency issues notice of approval or denial, additional applications submitted by an applicant are void. However, an application for monthly assistance or other benefits funded under section 256J.626 and an application for ~~emergency assistance or~~ emergency general assistance may exist concurrently. More than one application for monthly assistance~~, emergency assistance,~~ or emergency general assistance may exist concurrently when the county agency decisions on one or more earlier applications have been appealed to the commissioner, and the applicant asserts that a change in circumstances has occurred that would allow eligibility. A county agency must require additional application forms or supplemental forms as prescribed by the commissioner when a payee's name changes, or when a caregiver requests the addition of another person to the assistance unit.

Sec. 30. Minnesota Statutes 2002, section 256J.09, subdivision 10, is amended to read:

Subd. 10. **APPLICANTS WHO DO NOT MEET ELIGIBILITY REQUIREMENTS FOR MFIP OR THE DIVERSIONARY WORK PROGRAM.** When an applicant is not eligible for MFIP or the diversionary work program under section 256J.95 because the applicant does not meet eligibility requirements, the county

agency must determine whether the applicant is eligible for food stamps~~, medical assistance, diversionary assistance, or has a need for emergency assistance when the applicant meets the eligibility requirements for those programs~~ or health care programs. The county must also inform applicants about resources available through the county or other agencies to meet short-term emergency needs.

Sec. 31. Minnesota Statutes 2002, section 256J.14, is amended to read:

256J.14 **ELIGIBILITY FOR PARENTING OR PREGNANT MINORS.**

(a) The definitions in this paragraph only apply to this subdivision.

(1) "Household of a parent, legal guardian, or other adult relative" means the place of residence of:

(i) a natural or adoptive parent;

(ii) a legal guardian according to appointment or acceptance under section 260C.325, 525.615, or 525.6165, and related laws;

(iii) a caregiver as defined in section 256J.08, subdivision 11; or

(iv) an appropriate adult relative designated by a county agency.

(2) "Adult-supervised supportive living arrangement" means a private family setting which assumes responsibility for the care and control of the minor parent and minor child, or other living arrangement, not including a public institution, licensed by the commissioner of human services which ensures that the minor parent receives adult supervision and supportive services, such as counseling, guidance, independent living skills training, or supervision.

(b) A minor parent and the minor child who is in the care of the minor parent must reside in the household of a parent, legal guardian, other adult relative, or in an adult-supervised supportive living arrangement in order to receive MFIP unless:

(1) the minor parent has no living parent, other adult relative, or legal guardian whose whereabouts is known;

(2) no living parent, other adult relative, or legal guardian of the minor parent allows the minor parent to live in the parent's, other adult relative's, or legal guardian's home;

(3) the minor parent lived apart from the minor parent's own parent or legal guardian for a period of at least one year before either the birth of the minor child or the minor parent's application for MFIP;

(4) the physical or emotional health or safety of the minor parent or minor child would be jeopardized if the minor parent and the minor child resided in the same residence with the minor parent's parent, other adult relative, or legal guardian; or

(5) an adult supervised supportive living arrangement is not available for the minor parent and child in the county in which the minor parent and child currently

reside. If an adult supervised supportive living arrangement becomes available within the county, the minor parent and child must reside in that arrangement.

(c) The county agency shall inform minor applicants both orally and in writing about the eligibility requirements, their rights and obligations under the MFIP program, and any other applicable orientation information. The county must advise the minor of the possible exemptions under section 256J.54, subdivision 5, and specifically ask whether one or more of these exemptions is applicable. If the minor alleges one or more of these exemptions, then the county must assist the minor in obtaining the necessary verifications to determine whether or not these exemptions apply.

(d) If the county worker has reason to suspect that the physical or emotional health or safety of the minor parent or minor child would be jeopardized if they resided with the minor parent's parent, other adult relative, or legal guardian, then the county worker must make a referral to child protective services to determine if paragraph (b), clause (4), applies. A new determination by the county worker is not necessary if one has been made within the last six months, unless there has been a significant change in circumstances which justifies a new referral and determination.

(e) If a minor parent is not living with a parent, legal guardian, or other adult relative due to paragraph (b), clause (1), (2), or (4), the minor parent must reside, when possible, in a living arrangement that meets the standards of paragraph (a), clause (2).

(f) Regardless of living arrangement, MFIP must be paid, when possible, in the form of a protective payment on behalf of the minor parent and minor child according to section 256J.39, subdivisions 2 to 4.

Sec. 32. Minnesota Statutes 2002, section 256J.20, subdivision 3, is amended to read:

Subd. 3. **OTHER PROPERTY LIMITATIONS.** To be eligible for MFIP, the equity value of all nonexcluded real and personal property of the assistance unit must not exceed $2,000 for applicants and $5,000 for ongoing participants. The value of assets in clauses (1) to (19) must be excluded when determining the equity value of real and personal property:

(1) a licensed vehicle up to a loan value of less than or equal to $7,500. The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the vehicle with the highest loan value and count only the loan value over $7,500, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a handicapped member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. To establish

the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

(2) the value of life insurance policies for members of the assistance unit;

(3) one burial plot per member of an assistance unit;

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

(5) the value of personal property not otherwise specified which is commonly used by household members in day-to-day living such as clothing, necessary household furniture, equipment, and other basic maintenance items essential for daily living;

(6) the value of real and personal property owned by a recipient of Supplemental Security Income or Minnesota supplemental aid;

(7) the value of corrective payments, but only for the month in which the payment is received and for the following month;

(8) a mobile home or other vehicle used by an applicant or participant as the applicant's or participant's home;

(9) money in a separate escrow account that is needed to pay real estate taxes or insurance and that is used for this purpose;

(10) money held in escrow to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, business insurance, property rental, property taxes, and other costs that are paid at least annually, but less often than monthly;

(11) monthly assistance~~, emergency assistance, and diversionary~~ payments for the current month's ~~needs~~ or short-term emergency needs under section 256J.626, subdivision 2;

(12) the value of school loans, grants, or scholarships for the period they are intended to cover;

(13) payments listed in section 256J.21, subdivision 2, clause (9), which are held in escrow for a period not to exceed three months to replace or repair personal or real property;

(14) income received in a budget month through the end of the payment month;

(15) savings from earned income of a minor child or a minor parent that are set aside in a separate account designated specifically for future education or employment costs;

(16) the federal earned income credit, Minnesota working family credit, state and federal income tax refunds, state homeowners and renters credits under chapter 290A, property tax rebates and other federal or state tax rebates in the month received and the following month;

(17) payments excluded under federal law as long as those payments are held in a separate account from any nonexcluded funds;

(18) the assets of children ineligible to receive MFIP benefits because foster care or adoption assistance payments are made on their behalf; and

(19) the assets of persons whose income is excluded under section 256J.21, subdivision 2, clause (43).

Sec. 33. Minnesota Statutes 2002, section 256J.21, subdivision 1, is amended to read:

Subdivision 1. **INCOME INCLUSIONS.** To determine MFIP eligibility, the county agency must evaluate income received by members of an assistance unit, or by other persons whose income is considered available to the assistance unit, and only count income that is available to the member of the assistance unit. Income is available if the individual has legal access to the income. All payments, unless specifically excluded in subdivision 2, must be counted as income. The county agency shall verify the income of all MFIP recipients and applicants.

Sec. 34. Minnesota Statutes 2002, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **INCOME EXCLUSIONS.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9545.0010 to 9545.0260 and 9555.5050 to 9555.6265, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the ~~Job Training Partnership~~ Workforce Investment Act 1998, United States Code, title ~~29~~ 20, chapter ~~19~~ 73, ~~sections 1501 to 1792b~~ section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) ~~emergency assistance~~ payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law ~~Number~~ 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) adoption assistance payments under section 259.67;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with mental retardation or related conditions, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater ~~self-support~~ economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code,

title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law ~~Number~~ 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public ~~Law Numbers~~ Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash; and

(46) the principal portion of a contract for deed payment.

Sec. 35. Minnesota Statutes 2002, section 256J.24, subdivision 3, is amended to read:

Subd. 3. **INDIVIDUALS WHO MUST BE EXCLUDED FROM AN ASSISTANCE UNIT.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

(1) individuals ~~receiving~~ who are recipients of Supplemental Security Income or Minnesota supplemental aid;

(2) individuals disqualified from the food stamp program or MFIP, until the disqualification ends;

(3) children on whose behalf federal, state or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2; and

(4) children receiving ongoing monthly adoption assistance payments under section 259.67.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

Sec. 36. Minnesota Statutes 2002, section 256J.24, subdivision 5, is amended to read:

Subd. 5. **MFIP TRANSITIONAL STANDARD.** The ~~following table represents the~~ MFIP transitional standard ~~table when all members of~~ is based on the number of persons in the assistance unit ~~are~~ eligible for both food and cash assistance unless the restrictions in subdivision 6 on the birth of a child apply. The following table represents the transitional standards effective October 1, 2002.

| Number of Eligible People | Transitional Standard | | Cash Portion | Food Portion |
|---|---|---|---|---|
| 1 | ~~$351~~ | $370: | $250 | $120 |
| 2 | ~~$609~~ | $658: | $437 | $221 |
| 3 | ~~$763~~ | $844: | $532 | $312 |
| 4 | ~~$903~~ | $998: | $621 | $377 |
| 5 | ~~$1,025~~ | $1,135: | $697 | $438 |
| 6 | ~~$1,165~~ | $1,296: | $773 | $523 |
| 7 | ~~$1,273~~ | $1,414: | $850 | $564 |
| 8 | ~~$1,403~~ | $1,558: | $916 | $642 |
| 9 | ~~$1,530~~ | $1,700: | $980 | $720 |
| 10 | ~~$1,653~~ | $1,836: | $1,035 | $801 |
| over 10 | add ~~$121~~ | $136: | $53 | $83 |

per additional member.

The commissioner shall annually publish in the State Register the transitional standard for an assistance unit sizes 1 to 10 including a breakdown of the cash and food portions.

Sec. 37. Minnesota Statutes 2002, section 256J.24, subdivision 6, is amended to read:

Subd. 6. **~~APPLICATION OF ASSISTANCE STANDARDS~~ FAMILY CAP.** ~~The standards apply to the number of eligible persons in the assistance unit.~~ (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of

determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth; or

(5) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

Sec. 38. Minnesota Statutes 2002, section 256J.24, subdivision 7, is amended to read:

Subd. 7. **FAMILY WAGE LEVEL ~~STANDARD~~.** The family wage level ~~standard~~ is 110 percent of the transitional standard under subdivision 5 or 6, when applicable, and is the standard used when there is earned income in the assistance unit. As specified in section 256J.21, earned income is subtracted from the family wage level to determine the amount of the assistance payment. ~~Not including~~ The ~~family wage level standard,~~ assistance ~~payments~~ payment may not exceed the ~~MFIP standard of need~~ transitional standard under subdivision 5 or 6, or the shared household standard under subdivision 9, whichever is applicable, for the assistance unit.

Sec. 39. Minnesota Statutes 2002, section 256J.24, subdivision 10, is amended to read:

Subd. 10. **MFIP EXIT LEVEL.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least ~~120~~ 115 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same time as the October food stamp cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

Sec. 40. Minnesota Statutes 2002, section 256J.30, subdivision 9, is amended to read:

Subd. 9. **CHANGES THAT MUST BE REPORTED.** A caregiver must report the changes or anticipated changes specified in clauses (1) to ~~(17)~~ (16) within ten days of the date they occur, at the time of the periodic recertification of eligibility under section 256J.32, subdivision 6, or within eight calendar days of a reporting period as in subdivision 5 or 6, whichever occurs first. A caregiver must report other changes at the time of the periodic recertification of eligibility under section 256J.32, subdivision 6, or at the end of a reporting period under subdivision 5 or 6, as applicable. A caregiver must make these reports in writing to the county agency. When a county agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to ~~(16)~~ (15) had not occurred, the county agency must determine whether a timely notice under section 256J.31, subdivision 4, could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 256J.38. Calculation of overpayments for late reporting under clause ~~(17)~~ (16) is specified in section 256J.09, subdivision 9. Changes in circumstances which must be reported within ten days must also be reported on the MFIP household report form for the reporting period in which those changes occurred. Within ten days, a caregiver must report:

(1) a change in initial employment;

(2) a change in initial receipt of unearned income;

(3) a recurring change in unearned income;

(4) a nonrecurring change of unearned income that exceeds $30;

(5) the receipt of a lump sum;

(6) an increase in assets that may cause the assistance unit to exceed asset limits;

(7) a change in the physical or mental status of an incapacitated member of the assistance unit if the physical or mental status is the basis of exemption from an MFIP employment services program under section 256J.56, or as the basis for reducing the hourly participation requirements under section 256J.55, subdivision 1, or the type of activities included in an employment plan under section 256J.521, subdivision 2;

(8) a change in employment status;

(9) information affecting an exception under section 256J.24, subdivision 9;

(10) ~~a change in health insurance coverage;~~

~~(11)~~ the marriage or divorce of an assistance unit member;

~~(12)~~ (11) the death of a parent, minor child, or financially responsible person;

~~(13)~~ (12) a change in address or living quarters of the assistance unit;

~~(14)~~ (13) the sale, purchase, or other transfer of property;

~~(15)~~ (14) a change in school attendance of a ~~custodial parent~~ caregiver under age 20 or an employed child;

~~(16)~~ (15) filing a lawsuit, a workers' compensation claim, or a monetary claim against a third party; and

~~(17)~~ (16) a change in household composition, including births, returns to and departures from the home of assistance unit members and financially responsible persons, or a change in the custody of a minor child.

Sec. 41. Minnesota Statutes 2002, section 256J.32, subdivision 2, is amended to read:

Subd. 2. **DOCUMENTATION.** The applicant or participant must document the information required under subdivisions 4 to 6 or authorize the county agency to verify the information. The applicant or participant has the burden of providing documentary evidence to verify eligibility. The county agency shall assist the applicant or participant in obtaining required documents when the applicant or participant is unable to do so. ~~When an applicant or participant and the county agency are unable to obtain documents needed to verify information, the county agency may accept an affidavit from an applicant or participant as sufficient documentation.~~ The county agency may accept an affidavit only for factors specified under subdivision 8.

Sec. 42. Minnesota Statutes 2002, section 256J.32, subdivision 4, is amended to read:

Subd. 4. **FACTORS TO BE VERIFIED.** The county agency shall verify the following at application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of a minor child to caregivers in the assistance unit;

(4) age, if necessary to determine MFIP eligibility;

(5) immigration status;

(6) social security number according to the requirements of section 256J.30, subdivision 12;

(7) income;

(8) self-employment expenses used as a deduction;

(9) source and purpose of deposits and withdrawals from business accounts;

(10) spousal support and child support payments made to persons outside the household;

(11) real property;

(12) vehicles;

(13) checking and savings accounts;

(14) savings certificates, savings bonds, stocks, and individual retirement accounts;

(15) pregnancy, if related to eligibility;

(16) inconsistent information, if related to eligibility;

(17) ~~medical insurance;~~

~~(18)~~ burial accounts;

~~(19)~~ (18) school attendance, if related to eligibility;

~~(20)~~ (19) residence;

~~(21)~~ (20) a claim of family violence if used as a basis ~~for~~ a to qualify for the family violence waiver ~~from the 60-month time limit in section 256J.42 and regular employment and training services requirements in section 256J.56~~;

~~(22)~~ (21) disability if used as the basis for an exemption from employment and training services requirements under section 256J.56 or as the basis for reducing the hourly participation requirements under section 256J.55, subdivision 1, or the type of activity included in an employment plan under section 256J.521, subdivision 2; and

~~(23)~~ (22) information needed to establish an exception under section 256J.24, subdivision 9.

Sec. 43. Minnesota Statutes 2002, section 256J.32, subdivision 5a, is amended to read:

Subd. 5a. **INCONSISTENT INFORMATION.** When the county agency verifies inconsistent information under subdivision 4, clause (16), or 6, clause ~~(4)~~ (5), the reason for verifying the information must be documented in the financial case record.

Sec. 44. Minnesota Statutes 2002, section 256J.32, is amended by adding a subdivision to read:

Subd. 8. **AFFIDAVIT.** The county agency may accept an affidavit from the applicant or recipient as sufficient documentation at the time of application or recertification only for the following factors:

(1) a claim of family violence if used as a basis to qualify for the family violence waiver;

(2) information needed to establish an exception under section 256J.24, subdivision 9;

(3) relationship of a minor child to caregivers in the assistance unit; and

(4) citizenship status from a noncitizen who reports to be, or is identified as, a victim of severe forms of trafficking in persons, if the noncitizen reports that the noncitizen's immigration documents are being held by an individual or group of individuals against the noncitizen's will. The noncitizen must follow up with the Office of Refugee Resettlement (ORR) to pursue certification. If verification that certification is being pursued is not received within 30 days, the MFIP case must be closed and the agency shall pursue overpayments. The ORR documents certifying the noncitizen's status as a victim of severe forms of trafficking in persons, or the reason for the delay in processing, must be received within 90 days, or the MFIP case must be closed and the agency shall pursue overpayments.

Sec. 45. Minnesota Statutes 2002, section 256J.37, is amended by adding a subdivision to read:

Subd. 3a. **RENTAL SUBSIDIES; UNEARNED INCOME.** (a) Effective July 1, 2003, the county agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section 256J.34.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) 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

(3) 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 or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI recipient.

(d) Prior to implementing this provision, the commissioner must identify the MFIP participants subject to this provision and provide written notice to these participants at least 30 days before the first grant reduction. The notice must inform the participant of the basis for the potential grant reduction, the exceptions to the provision, if any, and inform the participant of the steps necessary to claim an exception. A person who is found not to meet one of the exceptions to the provision must be notified and informed of the right to a fair hearing under section 256J.40. The notice must also inform the participant that the participant may be eligible for a rent reduction resulting from a reduction in the MFIP grant, and encourage the participant to contact the local housing authority.

Sec. 46. Minnesota Statutes 2002, section 256J.37, is amended by adding a subdivision to read:

Subd. 3b. **TREATMENT OF SUPPLEMENTAL SECURITY INCOME.** Effective July 1, 2003, the county shall reduce the cash portion of the MFIP grant by $125 per SSI recipient who resides in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but is excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives less than $125 of SSI, only the amount received shall be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

Sec. 47. Minnesota Statutes 2002, section 256J.37, subdivision 9, is amended to read:

Subd. 9. **UNEARNED INCOME.** ~~(a)~~ The county agency must apply unearned income to the MFIP standard of need. When determining the amount of unearned income, the county agency must deduct the costs necessary to secure payments of unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

~~(b) Effective July 1, 2003, the county agency shall count $100 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income. The full amount of the subsidy must~~

~~be counted as unearned income when the subsidy is less than $100.~~

~~(c) The provisions of paragraph (b) shall not apply to MFIP participants who are exempt from the employment and training services component because they are:~~

~~(i) individuals who are age 60 or older;~~

~~(ii) individuals who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment; or~~

~~(iii) caregivers whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household.~~

~~(d) The provisions of paragraph (b) shall not apply to an MFIP assistance unit where the parental caregiver receives supplemental security income.~~

Sec. 48. Minnesota Statutes 2002, section 256J.38, subdivision 3, is amended to read:

Subd. 3. **RECOVERING OVERPAYMENTS ~~FROM FORMER PARTICIPANTS~~.** A county agency must initiate efforts to recover overpayments paid to a former participant or caregiver. ~~Adults~~ Caregivers, both parental and nonparental, and minor caregivers of an assistance unit at the time an overpayment occurs, whether receiving assistance or not, are jointly and individually liable for repayment of the overpayment. The county agency must request repayment from the former participants and caregivers. When an agreement for repayment is not completed within six months of the date of discovery or when there is a default on an agreement for repayment after six months, the county agency must initiate recovery consistent with chapter 270A, or section 541.05. When a person has been convicted of fraud under section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment is less than $35, and is not the result of a fraud conviction under section 256.98, the county agency must not seek recovery under this subdivision. The county agency must retain information about all overpayments regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for assistance, the overpayment must be recouped under subdivision 4.

Sec. 49. Minnesota Statutes 2002, section 256J.38, subdivision 4, is amended to read:

Subd. 4. **RECOUPING OVERPAYMENTS FROM PARTICIPANTS.** A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover from the overpaid assistance unit, including child only cases, ten percent of the applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover from the overpaid assistance unit, including child only cases, three percent of the MFIP standard of need or the amount of the monthly assistance payment, whichever is less.

Sec. 50. Minnesota Statutes 2002, section 256J.40, is amended to read:

256J.40 **FAIR HEARINGS.**

Caregivers receiving a notice of intent to sanction or a notice of adverse action that includes a sanction, reduction in benefits, suspension of benefits, denial of benefits, or termination of benefits may request a fair hearing. A request for a fair hearing must be submitted in writing to the county agency or to the commissioner and must be mailed within 30 days after a participant or former participant receives written notice of the agency's action or within 90 days when a participant or former participant shows good cause for not submitting the request within 30 days. A former participant who receives a notice of adverse action due to an overpayment may appeal the adverse action according to the requirements in this section. Issues that may be appealed are:

(1) the amount of the assistance payment;

(2) a suspension, reduction, denial, or termination of assistance;

(3) the basis for an overpayment, the calculated amount of an overpayment, and the level of recoupment;

(4) the eligibility for an assistance payment; and

(5) the use of protective or vendor payments under section 256J.39, subdivision 2, clauses (1) to (3).

Except for benefits issued under section 256J.95, a county agency must not reduce, suspend, or terminate payment when an aggrieved participant requests a fair hearing prior to the effective date of the adverse action or within ten days of the mailing of the notice of adverse action, whichever is later, unless the participant requests in writing not to receive continued assistance pending a hearing decision. An appeal request cannot extend benefits for the diversionary work program under section 256J.95 beyond the four-month time limit. Assistance issued pending a fair hearing is subject to recovery under section 256J.38 when as a result of the fair hearing decision the participant is determined ineligible for assistance or the amount of the assistance received. A county agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the participant change and are not related to the issue on appeal. The commissioner's order is binding on a county agency. No additional notice is required to enforce the commissioner's order.

A county agency shall reimburse appellants for reasonable and necessary expenses of attendance at the hearing, such as child care and transportation costs and for the transportation expenses of the appellant's witnesses and representatives to and from the hearing. Reasonable and necessary expenses do not include legal fees. Fair hearings must be conducted at a reasonable time and date by an impartial referee employed by the department. The hearing may be conducted by telephone or at a site that is readily accessible to persons with disabilities.

The appellant may introduce new or additional evidence relevant to the issues on appeal. Recommendations of the appeals referee and decisions of the commissioner must be based on evidence in the hearing record and are not limited to a review of the county agency action.

Sec. 51. Minnesota Statutes 2002, section 256J.42, subdivision 4, is amended to read:

Subd. 4. **VICTIMS OF FAMILY VIOLENCE.** Any cash assistance received by an assistance unit in a month when a caregiver complied with a safety plan, an alternative employment plan, or an employment plan ~~or after October 1, 2001, complied or is complying with an alternative employment plan~~ under section ~~256J.49~~ 256J.521, subdivision ~~1a~~ 3, does not count toward the 60-month limitation on assistance.

Sec. 52. Minnesota Statutes 2002, section 256J.42, subdivision 5, is amended to read:

Subd. 5. **EXEMPTION FOR CERTAIN FAMILIES.** (a) Any cash assistance received by an assistance unit does not count toward the 60-month limit on assistance during a month in which the caregiver is ~~in the category~~ in age 60 or older, including months during which the caregiver was exempt under section 256J.56, paragraph (a), clause (1).

(b) From July 1, 1997, until the date MFIP is operative in the caregiver's county of financial responsibility, any cash assistance received by a caregiver who is complying with Minnesota Statutes 1996, section 256.73, subdivision 5a, and Minnesota Statutes 1998, section 256.736, if applicable, does not count toward the 60-month limit on assistance. Thereafter, any cash assistance received by a minor caregiver who is complying with the requirements of sections 256J.14 and 256J.54, if applicable, does not count towards the 60-month limit on assistance.

(c) Any diversionary assistance or emergency assistance received prior to July 1, 2003, does not count toward the 60-month limit.

(d) Any cash assistance received by an 18- or 19-year-old caregiver who is complying with ~~the requirements of~~ an employment plan that includes an education option under section 256J.54 does not count toward the 60-month limit.

(e) Payments provided to meet short-term emergency needs under section 256J.626 and diversionary work program benefits provided under section 256J.95 do not count toward the 60-month time limit.

Sec. 53. Minnesota Statutes 2002, section 256J.42, subdivision 6, is amended to read:

Subd. 6. **CASE REVIEW.** (a) Within 180 days, but not less than 60 days, before the end of the participant's 60th month on assistance, the county agency or job counselor must review the participant's case to determine if the employment plan is still appropriate or if the participant is exempt under section 256J.56 from the

employment and training services component, and attempt to meet with the participant face-to-face.

(b) During the face-to-face meeting, a county agency or the job counselor must:

(1) inform the participant how many months of counted assistance the participant has accrued and when the participant is expected to reach the 60th month;

(2) explain the hardship extension criteria under section 256J.425 and what the participant should do if the participant thinks a hardship extension applies;

(3) identify other resources that may be available to the participant to meet the needs of the family; and

(4) inform the participant of the right to appeal the case closure under section 256J.40.

(c) If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5.

(d) Before a participant's case is closed under this section, the county must ensure that:

(1) the case has been reviewed by the job counselor's supervisor or the review team designated ~~in~~ by the ~~county's approved local service unit plan~~ county to determine if the criteria for a hardship extension, if requested, were applied appropriately; and

(2) the county agency or the job counselor attempted to meet with the participant face-to-face.

Sec. 54. Minnesota Statutes 2002, section 256J.425, subdivision 1, is amended to read:

Subdivision 1. **ELIGIBILITY.** (a) To be eligible for a hardship extension, a participant in an assistance unit subject to the time limit under section 256J.42, subdivision 1, ~~in which any participant has received 60 counted months of assistance,~~ must be in compliance in the participant's 60th counted month ~~the participant is applying for the extension~~. For purposes of determining eligibility for a hardship extension, a participant is in compliance in any month that the participant has not been sanctioned.

(b) If one participant in a two-parent assistance unit is determined to be ineligible for a hardship extension, the county shall give the assistance unit the option of disqualifying the ineligible participant from MFIP. In that case, the assistance unit shall be treated as a one-parent assistance unit and the assistance unit's MFIP grant shall be calculated using the shared household standard under section 256J.08, subdivision 82a.

Sec. 55. Minnesota Statutes 2002, section 256J.425, subdivision 1a, is amended to read:

Subd. 1a. **REVIEW.** If a county grants a hardship extension under this section, a county agency shall review the case every six or 12 months, whichever is appropriate based on the participant's circumstances and the extension category. More frequent reviews shall be required if eligibility for an extension is based on a condition that is subject to change in less than six months.

Sec. 56. Minnesota Statutes 2002, section 256J.425, subdivision 2, is amended to read:

Subd. 2. **ILL OR INCAPACITATED.** (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, ~~in which any participant has received 60 counted months of assistance,~~ is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) participants who are suffering from ~~a professionally certified~~ an illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and ~~which~~ prevents the person from obtaining or retaining employment ~~and who are following~~. These participants must follow the treatment recommendations of the ~~health care provider~~ qualified professional certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required as a caregiver because of ~~a professionally certified~~ the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household ~~and~~ when the illness or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph ~~(c)~~ (f), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or retaining employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3).

Sec. 57. Minnesota Statutes 2002, section 256J.425, subdivision 3, is amended to read:

Subd. 3. **HARD-TO-EMPLOY PARTICIPANTS.** An assistance unit subject to the time limit in section 256J.42, subdivision 1, ~~in which any participant has received 60 counted months of assistance,~~ is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) a person who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as mentally retarded or mentally ill, and that condition prevents the person from obtaining or retaining unsubsidized employment;

(2) a person who:

(i) has been assessed by a vocational specialist or the county agency to be unemployable for purposes of this subdivision; or

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but not at a level that makes the participant eligible for an extension under subdivision 4 ~~or~~,. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person ~~for whom it is not possible to provide a determination due to language barriers or absence of culturally appropriate assessment tools, is determined by a qualified professional to have an IQ below 80. A person is considered employable if positions of employment in the local labor market exist, regardless of the current availability of openings for those positions, that the person is capable of performing~~: (A) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

(3) a person who is determined by ~~the county agency~~ a qualified professional to be learning disabled ~~or~~, and the disability severely limits the person's ability to obtain, perform, or maintain suitable employment. For purposes of the initial approval of a learning disability extension, the determination must have been made or confirmed within the previous 12 months. In the case of a non-English-speaking person ~~for whom it is not possible to provide a medical diagnosis due to language barriers or absence of culturally appropriate assessment tools, is determined by a qualified professional to have a learning disability. If a rehabilitation plan for the person is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.52. For purposes of this section, "learning disabled" means the applicant or recipient has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. The disability must severely limit the applicant or recipient in obtaining, performing, or maintaining suitable employment. Learning disabled does not include 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~~: (i) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; and (ii) these reports must include a statement of confidence in the results. If a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the

requirement to develop and comply with an employment plan under section 256J.521; or

(4) a person who ~~is a victim of~~ has been granted a family violence ~~as defined in section 256J.49, subdivision 2~~ waiver, and who is ~~participating in~~ complying with an ~~alternative~~ employment plan under section ~~256J.49~~ 256J.521, subdivision ~~1a~~ 3.

Sec. 58. Minnesota Statutes 2002, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **EMPLOYED PARTICIPANTS.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, ~~in which any participant has received 60 months of assistance,~~ is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week every month are spent participating in employment;

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week every month are spent participating in employment; or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1), and the participant submits verification from a ~~health care provider~~ qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the ~~health care provider~~ qualified professional. The participant must be following the treatment recommendations of the ~~health care provider~~ qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the ~~health care provider~~ qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

(b) For purposes of this section, employment means:

(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);

(2) subsidized employment under section 256J.49, subdivision 13, clause (2);

(3) on-the-job training under section 256J.49, subdivision 13, clause ~~(4)~~ (2);

(4) an apprenticeship under section 256J.49, subdivision 13, clause ~~(19)~~ (1);

(5) supported work. ~~For purposes of this section, "supported work" means services supporting a participant on the job which include, but are not limited to,~~

~~supervision, job coaching, and subsidized wages~~ under section 256J.49, subdivision 13, clause (2);

(6) a combination of clauses (1) to (5); or

(7) child care under section 256J.49, subdivision 13, clause ~~(25)~~ (7), if it is in combination with paid employment.

(c) If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

(d) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

(e) To be eligible for a hardship extension for employed participants under this subdivision, a participant ~~in a one-parent assistance unit or both parents in a two-parent assistance unit~~ must be in compliance for at least ten out of the 12 months immediately preceding the participant's 61st month on assistance. ~~If only one parent in a two-parent assistance unit fails to be in compliance ten out of the 12 months immediately preceding the participant's 61st month, the county shall give the assistance unit the option of disqualifying the noncompliant parent. If the noncompliant participant is disqualified, the assistance unit must be treated as a one-parent assistance unit for the purposes of meeting the work requirements under this subdivision and the assistance unit's MFIP grant shall be calculated using the shared household standard under section 256J.08, subdivision 82a.~~

(f) The employment plan developed under section ~~256J.52~~ 256J.521, subdivision ~~5~~ 2, for participants under this subdivision must contain the number of hours specified in paragraph (a) related to employment and work activities. The job counselor and the participant must sign the employment plan to indicate agreement between the job counselor and the participant on the contents of the plan.

(g) Participants who fail to meet the requirements in paragraph (a), without good cause under section 256J.57, shall be sanctioned or permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which the good cause reason applies. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification.

(h) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification. This exemption is available to ~~one-parent assistance units~~ a participant two times in a 12-month period~~, and two-parent assistance units, two times per parent in a 12-month period~~.

~~(i) This subdivision expires on June 30, 2004.~~

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

Sec. 59. Minnesota Statutes 2002, section 256J.425, subdivision 6, is amended to read:

Subd. 6. **SANCTIONS FOR EXTENDED CASES.** (a) If one or both participants in an assistance unit receiving assistance under subdivision 3 or 4 are not in compliance with the employment and training service requirements in sections ~~256J.52~~ 256J.521 to ~~256J.55~~ 256J.57, the sanctions under this subdivision apply. For a first occurrence of noncompliance, an assistance unit must be sanctioned under section 256J.46, subdivision 1, paragraph ~~(d)~~ (c), clause (1). For a second or third occurrence of noncompliance, the assistance unit must be sanctioned under section 256J.46, subdivision 1, paragraph ~~(d)~~ (c), clause (2). For a fourth occurrence of noncompliance, the assistance unit is disqualified from MFIP. If a participant is determined to be out of compliance, the participant may claim a good cause exception under section 256J.57, however, the participant may not claim an exemption under section 256J.56.

(b) If both participants in a two-parent assistance unit are out of compliance at the same time, it is considered one occurrence of noncompliance.

Sec. 60. Minnesota Statutes 2002, section 256J.425, subdivision 7, is amended to read:

Subd. 7. **STATUS OF DISQUALIFIED PARTICIPANTS.** (a) An assistance unit that is disqualified under subdivision 6, paragraph (a), may be approved for MFIP if the participant complies with MFIP program requirements and demonstrates compliance for up to one month. No assistance shall be paid during this period.

(b) An assistance unit that is disqualified under subdivision 6, paragraph (a), and that reapplies under paragraph (a) is subject to sanction under section 256J.46, subdivision 1, paragraph ~~(d)~~ (c), clause (1), for a first occurrence of noncompliance. A subsequent occurrence of noncompliance results in a permanent disqualification.

(c) If one participant in a two-parent assistance unit receiving assistance under a hardship extension under subdivision 3 or 4 is determined to be out of compliance with the employment and training services requirements under sections ~~256J.52~~ 256J.521 to ~~256J.55~~ 256J.57, the county shall give the assistance unit the option of disqualifying the noncompliant participant from MFIP. In that case, the assistance unit shall be treated as a one-parent assistance unit for the purposes of meeting the work requirements under subdivision 4 and the assistance unit's MFIP grant shall be calculated using the shared household standard under section 256J.08, subdivision 82a. An applicant who is disqualified from receiving assistance under this paragraph may reapply under paragraph (a). If a participant is disqualified from MFIP under this subdivision a second time, the participant is permanently disqualified from MFIP.

(d) Prior to a disqualification under this subdivision, a county agency must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. If a face-to-face meeting is not conducted, the county agency must send the participant a notice of adverse action as provided in section 256J.31. During the face-to-face meeting, the county agency must:

(1) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause ~~(16), or services under a local intervention grant for self-sufficiency under section 256J.625~~ (9);

(2) determine whether the participant qualifies for a good cause exception under section 256J.57;

(3) inform the participant of the family violence waiver criteria and make appropriate referrals if the waiver is requested;

(4) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

~~(4)~~ (5) identify other resources that may be available to the participant to meet the needs of the family; and

~~(5)~~ (6) inform the participant of the right to appeal under section 256J.40.

Sec. 61. Minnesota Statutes 2002, section 256J.45, subdivision 2, is amended to read:

Subd. 2. **GENERAL INFORMATION.** The MFIP orientation must consist of a presentation that informs caregivers of:

(1) the necessity to obtain immediate employment;

(2) the work incentives under MFIP, including the availability of the federal earned income tax credit and the Minnesota working family tax credit;

(3) the requirement to comply with the employment plan and other requirements of the employment and training services component of MFIP, including a description of the range of work and training activities that are allowable under MFIP to meet the individual needs of participants;

(4) the consequences for failing to comply with the employment plan and other program requirements, and that the county agency may not impose a sanction when failure to comply is due to the unavailability of child care or other circumstances where the participant has good cause under subdivision 3;

(5) the rights, responsibilities, and obligations of participants;

(6) the types and locations of child care services available through the county agency;

(7) the availability and the benefits of the early childhood health and developmental screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

(8) the caregiver's eligibility for transition year child care assistance under section 119B.05;

(9) ~~the caregiver's eligibility for extended medical assistance when the caregiver loses eligibility for MFIP due to increased earnings or increased child or spousal support~~ the availability of all health care programs, including transitional medical assistance;

(10) the caregiver's option to choose an employment and training provider and information about each provider, including but not limited to, services offered, program components, job placement rates, job placement wages, and job retention rates;

(11) the caregiver's option to request approval of an education and training plan according to section ~~256J.52~~ 256J.53;

(12) the work study programs available under the higher education system; and

(13) ~~effective October 1, 2001,~~ information about the 60-month time limit ~~exemption and waivers of regular employment and training requirements for family violence victims~~ exemptions under the family violence waiver and referral information about shelters and programs for victims of family violence.

Sec. 62. Minnesota Statutes 2002, section 256J.46, subdivision 1, is amended to read:

Subdivision 1. **PARTICIPANTS NOT COMPLYING WITH PROGRAM REQUIREMENTS.** (a) A participant who fails without good cause under section 256J.57 to comply with the requirements of this chapter, and who is not subject to a sanction under subdivision 2, shall be subject to a sanction as provided in this subdivision. Prior to the imposition of a sanction, a county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

(b) ~~A participant who fails to comply with an alternative employment plan must have the plan reviewed by a person trained in domestic violence and a job counselor or the county agency to determine if components of the alternative employment plan are still appropriate. If the activities are no longer appropriate, the plan must be revised with a person trained in domestic violence and approved by a job counselor or the county agency. A participant who fails to comply with a plan that is determined not to need revision will lose their exemption and be required to comply with regular employment services activities.~~

~~(c)~~ A sanction under this subdivision becomes effective the month following the month in which a required notice is given. A sanction must not be imposed when a participant comes into compliance with the requirements for orientation under section 256J.45 ~~or third party liability for medical services under section 256J.30, subdivision 10,~~ prior to the effective date of the sanction. A sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services under sections ~~256J.49~~ 256J.515 to ~~256J.55~~ 256J.57 ten days prior to the effective date of the sanction. For purposes of this subdivision, each month that a participant fails to comply with a requirement of this chapter shall be considered a separate occurrence of noncompliance. ~~A participant who has had one or more~~

~~sanctions imposed must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.~~ If both participants in a two-parent assistance unit are out of compliance at the same time, it is considered one occurrence of noncompliance.

~~(d)~~ (c) Sanctions for noncompliance shall be imposed as follows:

(1) For the first occurrence of noncompliance by a participant in an assistance unit, the assistance unit's grant shall be reduced by ten percent of the MFIP standard of need for an assistance unit of the same size with the residual grant paid to the participant. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant returns to compliance.

(2) For a second ~~or subsequent~~, third, fourth, fifth, or sixth occurrence of noncompliance by a participant in an assistance unit, ~~or when each of the participants in a two-parent assistance unit have a first occurrence of noncompliance at the same time,~~ the assistance unit's shelter costs shall be vendor paid up to the amount of the cash portion of the MFIP grant for which the assistance unit is eligible. At county option, the assistance unit's utilities may also be vendor paid up to the amount of the cash portion of the MFIP grant remaining after vendor payment of the assistance unit's shelter costs. The residual amount of the grant after vendor payment, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size before the residual grant is paid to the assistance unit. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant in a one-parent assistance unit returns to compliance. In a two-parent assistance unit, the grant reduction must be in effect for a minimum of one month and shall be removed in the month following the month both participants return to compliance. The vendor payment of shelter costs and, if applicable, utilities shall be removed six months after the month in which the participant or participants return to compliance. If an assistance unit is sanctioned under this clause, the participant's case file must be reviewed ~~as required under paragraph (e)~~ to determine if the employment plan is still appropriate.

~~(e) When a sanction under paragraph (d), clause (2), is in effect~~ (d) For a seventh occurrence of noncompliance by a participant in an assistance unit, or when the participants in a two-parent assistance unit have a total of seven occurrences of noncompliance, the county agency shall close the MFIP assistance unit's financial assistance case, both the cash and food portions. The case must remain closed for a minimum of one full month. Closure under this paragraph does not make a participant automatically ineligible for food support, if otherwise eligible. Before the case is closed, the county agency must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. The participant may bring an advocate to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1).

(1) During the face-to-face meeting, the county agency must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause ~~(16),~~ ~~or~~ ~~services~~ ~~under~~ ~~a~~ ~~local~~ ~~intervention~~ ~~grant~~ ~~for~~ ~~self-sufficiency~~ ~~under~~ ~~section~~ ~~256J.625~~ (9);

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(iii) determine whether the participant qualifies for an exemption under section 256J.56 or the work activities in the employment plan are appropriate based on the criteria in section 256J.521, subdivision 2 or 3;

(iv) ~~determine~~ ~~whether~~ ~~the~~ ~~participant~~ ~~qualifies~~ ~~for~~ ~~an~~ ~~exemption~~ ~~from~~ ~~regular~~ ~~employment~~ ~~services~~ ~~requirements~~ ~~for~~ ~~victims~~ ~~of~~ ~~family~~ ~~violence~~ ~~under~~ ~~section~~ ~~256J.52,~~ ~~subdivision~~ 6 determine whether the participant qualifies for the family violence waiver;

(v) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

(vi) identify other resources that may be available to the participant to meet the needs of the family; and

(vii) inform the participant of the right to appeal under section 256J.40.

(2) If the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity, ~~and~~ ~~the~~ ~~county~~ ~~must~~ ~~restore~~ ~~the~~ ~~participant's~~ ~~grant~~ ~~amount~~ ~~to~~ ~~the~~ ~~full~~ ~~amount~~ ~~for~~ ~~which~~ ~~the~~ ~~assistance~~ ~~unit~~ ~~is~~ ~~eligible.~~ ~~The~~ ~~grant~~ ~~must~~ ~~be~~ ~~restored~~ ~~retroactively~~ ~~to~~ ~~the~~ ~~first~~ ~~day~~ ~~of~~ ~~the~~ ~~month~~ ~~in~~ ~~which~~ ~~the~~ participant ~~was~~ ~~found~~ ~~to~~ ~~lack~~ ~~preemployment~~ ~~activities~~ ~~or~~ ~~to~~ ~~qualify~~ ~~for~~ ~~an~~ ~~exemption~~ ~~under~~ ~~section~~ ~~256J.56,~~ ~~a~~ ~~good~~ ~~cause~~ ~~exception~~ ~~under~~ ~~section~~ ~~256J.57,~~ ~~or~~ ~~an~~ ~~exemption~~ ~~for~~ ~~victims~~ ~~of~~ ~~family~~ ~~violence~~ ~~under~~ ~~section~~ ~~256J.52,~~ ~~subdivision~~ 6.

(3) ~~If~~ ~~the~~ ~~participant~~ ~~is~~ ~~found~~ ~~to~~ ~~qualify~~ ~~for~~ ~~a~~ ~~good~~ ~~cause~~ ~~exception~~ ~~or~~ ~~an~~ ~~exemption,~~ ~~the~~ ~~county~~ ~~must~~ ~~restore~~ ~~the~~ ~~participant's~~ ~~grant~~ ~~to~~ ~~the~~ ~~full~~ ~~amount~~ ~~for~~ ~~which~~ ~~the~~ ~~assistance~~ ~~unit~~ ~~is~~ ~~eligible.~~ The grant must be restored to the full amount for which the assistance unit is eligible retroactively to the first day of the month in which the participant was found to lack preemployment activities or to qualify for an exemption under section 256J.56, a family violence waiver, or for a good cause exemption under section 256.741, subdivision 10, or 256J.57.

(e) For the purpose of applying sanctions under this section, only occurrences of noncompliance that occur after the effective date of this section shall be considered. If the participant is in 30 percent sanction in the month this section takes effect, that month counts as the first occurrence for purposes of applying the sanctions under this section, but the sanction shall remain at 30 percent for that month.

(f) An assistance unit whose case is closed under paragraph (d) or (g), or under an approved county option sanction plan under section 256J.462 in effect June 30, 2003, or a county pilot project under Laws 2000, chapter 488, article 10, section 29, in effect June 30, 2003, may reapply for MFIP and shall be eligible if the participant complies with MFIP program requirements and demonstrates compliance for up to one month. No assistance shall be paid during this period.

(g) An assistance unit whose case has been closed for noncompliance, that reapplies under paragraph (f) is subject to sanction under paragraph (c), clause (2), for a first occurrence of noncompliance. Any subsequent occurrence of noncompliance shall result in case closure under paragraph (d).

Sec. 63. Minnesota Statutes 2002, section 256J.46, subdivision 2, is amended to read:

Subd. 2. **SANCTIONS FOR REFUSAL TO COOPERATE WITH SUPPORT REQUIREMENTS.** The grant of an MFIP caregiver who refuses to cooperate, as determined by the child support enforcement agency, with support requirements under section 256.741, shall be subject to sanction as specified in this subdivision and subdivision 1. For a first occurrence of noncooperation, the assistance unit's grant must be reduced by ~~25~~ 30 percent of the applicable MFIP standard of need. Subsequent occurrences of noncooperation shall be subject to sanction under subdivision 1, paragraphs (c), clause (2), and (d). The residual amount of the grant, if any, must be paid to the caregiver. A sanction under this subdivision becomes effective the first month following the month in which a required notice is given. A sanction must not be imposed when a caregiver comes into compliance with the requirements under section 256.741 prior to the effective date of the sanction. The sanction shall be removed in the month following the month that the caregiver cooperates with the support requirements. Each month that an MFIP caregiver fails to comply with the requirements of section 256.741 must be considered a separate occurrence of noncompliance for the purpose of applying sanctions under subdivision 1, paragraphs (c), clause (2), and (d). ~~An MFIP caregiver who has had one or more sanctions imposed must remain in compliance with the requirements of section 256.741 for six months in order for a subsequent sanction to be considered a first occurrence.~~

Sec. 64. Minnesota Statutes 2002, section 256J.46, subdivision 2a, is amended to read:

Subd. 2a. **DUAL SANCTIONS.** (a) Notwithstanding the provisions of subdivisions 1 and 2, for a participant subject to a sanction for refusal to comply with child support requirements under subdivision 2 and subject to a concurrent sanction for refusal to cooperate with other program requirements under subdivision 1, sanctions shall be imposed in the manner prescribed in this subdivision.

~~A participant who has had one or more sanctions imposed under this subdivision must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.~~ Any

vendor payment of shelter costs or utilities under this subdivision must remain in effect for six months after the month in which the participant is no longer subject to sanction under subdivision 1.

(b) If the participant was subject to sanction for:

(i) noncompliance under subdivision 1 before being subject to sanction for noncooperation under subdivision 2; or

(ii) noncooperation under subdivision 2 before being subject to sanction for noncompliance under subdivision 1, the participant is considered to have a second occurrence of noncompliance and shall be sanctioned as provided in subdivision 1, paragraph ~~(d)~~ (c), clause (2). Each subsequent occurrence of noncompliance shall be considered one additional occurrence and shall be subject to the applicable level of sanction under subdivision 1~~, paragraph (d), or section 256J.462~~. The requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(e)~~ (d), remains in effect.

(c) A participant who first becomes subject to sanction under both subdivisions 1 and 2 in the same month is subject to sanction as follows:

(i) in the first month of noncompliance and noncooperation, the participant's grant must be reduced by ~~25~~ 30 percent of the applicable MFIP standard of need, with any residual amount paid to the participant;

(ii) in the second and subsequent months of noncompliance and noncooperation, the participant shall be subject to the applicable level of sanction under subdivision 1~~, paragraph (d), or section 256J.462~~.

The requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(e)~~ (d), remains in effect.

(d) A participant remains subject to sanction under subdivision 2 if the participant:

(i) returns to compliance and is no longer subject to sanction ~~under subdivision 1 or section 256J.462~~ for noncompliance with section 256J.45 or sections 256J.515 to 256J.57; or

(ii) has the sanction ~~under subdivision 1, paragraph (d), or section 256J.462~~ for noncompliance with section 256J.45 or sections 256J.515 to 256J.57 removed upon completion of the review under subdivision 1, paragraph (e).

A participant remains subject to the applicable level of sanction under subdivision 1~~, paragraph (d), or section 256J.462~~ if the participant cooperates and is no longer subject to sanction under subdivision 2.

Sec. 65. Minnesota Statutes 2002, section 256J.49, subdivision 4, is amended to read:

Subd. 4. **EMPLOYMENT AND TRAINING SERVICE PROVIDER.** "Employment and training service provider" means:

(1) a public, private, or nonprofit employment and training agency certified by the commissioner of economic security under sections 268.0122, subdivision 3, and 268.871, subdivision 1, or is approved under section 256J.51 and is included in the county ~~plan~~ service agreement submitted under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4;

(2) a public, private, or nonprofit agency that is not certified by the commissioner under clause (1), but with which a county has contracted to provide employment and training services and which is included in the county's ~~plan~~ service agreement submitted under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4; or

(3) a county agency, if the county has opted to provide employment and training services and the county has indicated that fact in the ~~plan~~ service agreement submitted under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4.

Notwithstanding section 268.871, an employment and training services provider meeting this definition may deliver employment and training services under this chapter.

Sec. 66. Minnesota Statutes 2002, section 256J.49, subdivision 5, is amended to read:

Subd. 5. **EMPLOYMENT PLAN.** "Employment plan" means a plan developed by the job counselor and the participant which identifies the participant's most direct path to unsubsidized employment, lists the specific steps that the caregiver will take on that path, and includes a timetable for the completion of each step. The plan should also identify any subsequent steps that support long-term economic stability. For participants who request and qualify for a family violence waiver, an employment plan must be developed by the job counselor and the participant, and in consultation with a person trained in domestic violence and follow the employment plan provisions in section 256J.521, subdivision 3.

Sec. 67. Minnesota Statutes 2002, section 256J.49, is amended by adding a subdivision to read:

Subd. 6a. **FUNCTIONAL WORK LITERACY.** "Functional work literacy" means an intensive English as a second language program that is work focused and offers at least 20 hours of class time per week.

Sec. 68. Minnesota Statutes 2002, section 256J.49, subdivision 9, is amended to read:

Subd. 9. **PARTICIPANT.** "Participant" means a recipient of MFIP assistance who participates or is required to participate in employment and training services under sections 256J.515 to 256J.57 and 256J.95.

Sec. 69. Minnesota Statutes 2002, section 256J.49, is amended by adding a subdivision to read:

Subd. 12a. **SUPPORTED WORK.** "Supported work" means a subsidized or unsubsidized work experience placement with a public or private sector employer,

which may include services such as individualized supervision and job coaching to support the participant on the job.

Sec. 70. Minnesota Statutes 2002, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **WORK ACTIVITY.** "Work activity" means any activity in a participant's approved employment plan that ~~is tied to the participant's~~ leads to employment ~~goal~~. For purposes of the MFIP program, ~~any activity that is included in a participant's approved employment plan meets~~ this includes activities that meet the definition of work activity as ~~counted~~ under the ~~federal~~ participation ~~standards~~ requirements of TANF. Work activity includes~~, but is not limited to~~:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, the self-employment investment demonstration program (SEID) as specified in section 256J.65, paid work experience, and supported work when a wage subsidy is provided;

(3) unpaid work experience, including ~~CWEP~~ community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and ~~including work associated with the refurbishing of publicly assisted housing if sufficient private sector employment is not available~~ supported work when a wage subsidy is not provided;

(4) ~~on-the-job training as specified in section 256J.66~~ job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

~~(5) job search, either supervised or unsupervised;~~

~~(6) job readiness assistance;~~

~~(7) job clubs, including job search workshops;~~

~~(8) job placement;~~

~~(9) job development;~~

~~(10) job-related counseling;~~

~~(11) job coaching;~~

~~(12) job retention services;~~

~~(13) job-specific training or education;~~

~~(14) job skills training directly related to employment;~~

~~(15) the self-employment investment demonstration (SEID), as specified in section 256J.65;~~

~~(16) preemployment activities, based on availability and resources, such as volunteer work, literacy programs and related activities, citizenship classes, English as a second language (ESL) classes as limited by the provisions of section 256J.52, subdivisions 3, paragraph (d), and 5, paragraph (c), or participation in dislocated worker services, chemical dependency treatment, mental health services, peer group networks, displaced homemaker programs, strength-based resiliency training, parenting education, or other programs designed to help families reach their employment goals and enhance their ability to care for their children;~~

~~(17) community service programs;~~

~~(18) vocational educational training or educational programs that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;~~

~~(19) apprenticeships;~~

~~(20) satisfactory attendance in general educational development diploma classes or an adult diploma program;~~

~~(21) satisfactory attendance at secondary school, if the participant has not received a high school diploma;~~

~~(22) adult basic education classes;~~

~~(23) internships;~~

~~(24) bilingual employment and training services;~~

~~(25) providing child care services to a participant who is working in a community service program; and~~

~~(26) activities included in an alternative employment plan that is developed under section 256J.52, subdivision 6.~~

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes as limited by the provisions of section 256J.531, subdivision 2, general educational development (GED) course work, high school completion, and adult basic education as limited by the provisions of section 256J.531, subdivision 1;

(6) job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

Sec. 71. Minnesota Statutes 2002, section 256J.50, subdivision 1, is amended to read:

Subdivision 1. **EMPLOYMENT AND TRAINING SERVICES COMPONENT OF MFIP.** (a) ~~By January 1, 1998,~~ Each county must develop and ~~implement~~ provide an employment and training services component ~~of MFIP~~ which is designed to put participants on the most direct path to unsubsidized employment. Participation in these services is mandatory for all MFIP caregivers, unless the caregiver is exempt under section 256J.56.

(b) A county must provide employment and training services under sections 256J.515 to 256J.74 within 30 days after the ~~caregiver's participation becomes mandatory under subdivision 5 or within 30 days of receipt of a request for services from a caregiver who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size. The request must be made within 12 months of the date the caregivers' MFIP case was closed~~ caregiver is determined eligible for MFIP, or within ten days when the caregiver participated in the diversionary work program under section 256J.95 within the past 12 months.

Sec. 72. Minnesota Statutes 2002, section 256J.50, subdivision 9, is amended to read:

Subd. 9. **EXCEPTION; FINANCIAL HARDSHIP.** Notwithstanding subdivision 8, a county that explains in the ~~plan~~ service agreement required under section 256J.626, subdivision ~~7~~ 4, that the provision of alternative employment and training service providers would result in financial hardship for the county is not required to make available more than one employment and training provider.

Sec. 73. Minnesota Statutes 2002, section 256J.50, subdivision 10, is amended to read:

Subd. 10. **REQUIRED NOTIFICATION TO VICTIMS OF FAMILY VIOLENCE.** (a) County agencies and their contractors must provide universal notification to all applicants and recipients of MFIP that:

(1) referrals to counseling and supportive services are available for victims of family violence;

(2) nonpermanent resident battered individuals married to United States citizens or permanent residents may be eligible to petition for permanent residency under the federal Violence Against Women Act, and that referrals to appropriate legal services are available;

(3) victims of family violence are exempt from the 60-month limit on assistance ~~while the individual is~~ if they are complying with an ~~approved safety plan or, after~~

~~October 1, 2001, an alternative~~ employment plan~~, as defined in~~ under section ~~256J.49~~ 256J.521, subdivision ~~1a~~ 3; and

(4) victims of family violence may choose to have regular work requirements waived while the individual is complying with an ~~alternative~~ employment plan ~~as defined in~~ under section ~~256J.49~~ 256J.521, subdivision ~~1a~~ 3.

(b) If an ~~alternative~~ employment plan under section 256J.521, subdivision 3, is denied, the county or a job counselor must provide reasons why the plan is not approved and document how the denial of the plan does not interfere with the safety of the participant or children.

Notification must be in writing and orally at the time of application and recertification, when the individual is referred to the title IV-D child support agency, and at the beginning of any job training or work placement assistance program.

Sec. 74. Minnesota Statutes 2002, section 256J.51, subdivision 1, is amended to read:

Subdivision 1. **PROVIDER APPLICATION.** An employment and training service provider that is not included in a county's ~~plan~~ service agreement under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4, because the county has demonstrated financial hardship under section 256J.50, subdivision 9 ~~of that section~~, may appeal its exclusion to the commissioner of economic security under this section.

Sec. 75. Minnesota Statutes 2002, section 256J.51, subdivision 2, is amended to read:

Subd. 2. **APPEAL; ALTERNATE APPROVAL.** (a) An employment and training service provider that is not included by a county agency in the ~~plan~~ service agreement under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4, and that meets the criteria in paragraph (b), may appeal its exclusion to the commissioner of economic security, and may request alternative approval by the commissioner of economic security to provide services in the county.

(b) An employment and training services provider that is requesting alternative approval must demonstrate to the commissioner that the provider meets the standards specified in section 268.871, subdivision 1, paragraph (b), except that the provider's past experience may be in services and programs similar to those specified in section 268.871, subdivision 1, paragraph (b).

Sec. 76. Minnesota Statutes 2002, section 256J.51, subdivision 3, is amended to read:

Subd. 3. **COMMISSIONER'S REVIEW.** (a) The commissioner must act on a request for alternative approval under this section within 30 days of the receipt of the request. If after reviewing the provider's request, and the county's ~~plan~~ service agreement submitted under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4, the commissioner determines that the provider meets the criteria under subdivision 2, paragraph (b), and that approval of the provider would not cause financial hardship to the county,

the county must submit a revised ~~plan~~ service agreement under subdivision 4 that includes the approved provider.

(b) If the commissioner determines that the approval of the provider would cause financial hardship to the county, the commissioner must notify the provider and the county of this determination. The alternate approval process under this section shall be closed to other requests for alternate approval to provide employment and training services in the county for up to 12 months from the date that the commissioner makes a determination under this paragraph.

Sec. 77. Minnesota Statutes 2002, section 256J.51, subdivision 4, is amended to read:

Subd. 4. **REVISED ~~PLAN~~ SERVICE AGREEMENT REQUIRED.** The commissioner of economic security must notify the county agency when the commissioner grants an alternative approval to an employment and training service provider under subdivision 2. Upon receipt of the notice, the county agency must submit a revised ~~plan~~ service agreement under section ~~256J.50~~ 256J.626, subdivision ~~7~~ 4, that includes the approved provider. The county has 90 days from the receipt of the commissioner's notice to submit the revised ~~plan~~ service agreement.

Sec. 78. **[256J.521] ASSESSMENT; EMPLOYMENT PLANS.**

Subdivision 1. **ASSESSMENTS.** (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be

modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d). Failure to complete the screens will result in sanction under section 256J.46; and

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Subd. 2. **EMPLOYMENT PLAN; CONTENTS.** (a) Based on the assessment under subdivision 1, the job counselor and the participant must develop an employment plan that includes participation in activities and hours that meet the requirements of section 256J.55, subdivision 1. The purpose of the employment plan is to identify for each participant the most direct path to unsubsidized employment and any subsequent steps that support long-term economic stability. The employment plan should be developed using the highest level of activity appropriate for the participant. Activities must be chosen from clauses (1) to (6), which are listed in order of preference. The employment plan must also list the specific steps the participant will take to obtain employment, including steps necessary for the participant to progress from one level of activity to another, and a timetable for completion of each step. Levels of activity include:

(1) unsubsidized employment;

(2) job search;

(3) subsidized employment or unpaid work experience;

(4) unsubsidized employment and job readiness education or job skills training;

(5) unsubsidized employment or unpaid work experience, and activities related to a family violence waiver or preemployment needs; and

(6) activities related to a family violence waiver or preemployment needs.

(b) Participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment must job search at least 30 hours per week for up to six weeks, and accept any offer of suitable employment. The remaining hours necessary to meet the requirements of section 256J.55, subdivision 1, may be met through participation in other work activities under section 256J.49, subdivision 13. The participant's employment plan must specify, at a minimum: (1) whether the job search is supervised or unsupervised; (2) support services that will be provided; and (3) how frequently the participant must report to the job counselor. Participants who are unable to find suitable employment after six weeks must meet with the job counselor to determine whether other activities in paragraph (a) should be incorporated into the employment plan. Job search activities which are continued after six weeks must be structured and supervised.

(c) Beginning July 1, 2004, activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d), must meet with the job counselor within ten days of the determination to revise the employment plan.

(d) Participants who are determined to have barriers to obtaining or retaining employment that will not be overcome during six weeks of job search under paragraph (b) must work with the job counselor to develop an employment plan that addresses those barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6). The employment plan must include enough hours to meet the participation requirements in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours is noted in the participant's file.

(e) The job counselor and the participant must sign the employment plan to indicate agreement on the contents. Failure to develop or comply with activities in the plan, or voluntarily quitting suitable employment without good cause, will result in the imposition of a sanction under section 256J.46.

(f) Employment plans must be reviewed at least every three months to determine whether activities and hourly requirements should be revised.

Subd. 3. **EMPLOYMENT PLAN; FAMILY VIOLENCE WAIVER.** (a) A participant who requests and qualifies for a family violence waiver shall develop or revise the employment plan as specified in this subdivision with a job counselor or county, and a person trained in domestic violence. The revised or new employment plan must be approved by the county or the job counselor. The plan may address safety, legal, or emotional issues, and other demands on the family as a result of the family

violence. Information in section 256J.515, clauses (1) to (8), must be included as part of the development of the plan.

(b) The primary goal of an employment plan developed under this subdivision is to ensure the safety of the caregiver and children. To the extent it is consistent with ensuring safety, the plan shall also include activities that are designed to lead to economic stability. An activity is inconsistent with ensuring safety if, in the opinion of a person trained in domestic violence, the activity would endanger the safety of the participant or children. A plan under this subdivision may not automatically include a provision that requires a participant to obtain an order for protection or to attend counseling.

(c) If at any time there is a disagreement over whether the activities in the plan are appropriate or the participant is not complying with activities in the plan under this subdivision, the participant must receive the assistance of a person trained in domestic violence to help resolve the disagreement or noncompliance with the county or job counselor. If the person trained in domestic violence recommends that the activities are still appropriate, the county or a job counselor must approve the activities in the plan or provide written reasons why activities in the plan are not approved and document how denial of the activities do not endanger the safety of the participant or children.

Subd. 4. **SELF-EMPLOYMENT.** (a) Self-employment activities may be included in an employment plan contingent on the development of a business plan which establishes a timetable and earning goals that will result in the participant exiting MFIP assistance. Business plans must be developed with assistance from an individual or organization with expertise in small business as approved by the job counselor.

(b) Participants with an approved plan that includes self-employment must meet the participation requirements in section 256J.55, subdivision 1. Only hours where the participant earns at least minimum wage shall be counted toward the requirement. Additional activities and hours necessary to meet the participation requirements in section 256J.55, subdivision 1, must be included in the employment plan.

(c) Employment plans which include self-employment activities must be reviewed every three months. Participants who fail, without good cause, to make satisfactory progress as established in the business plan must revise the employment plan to replace the self-employment with other approved work activities.

(d) The requirements of this subdivision may be waived for participants who are enrolled in the self-employment investment demonstration program (SEID) under section 256J.65, and who make satisfactory progress as determined by the job counselor and the SEID provider.

Subd. 5. **TRANSITION FROM THE DIVERSIONARY WORK PROGRAM.** Participants who become eligible for MFIP assistance after completing the diversionary work program under section 256J.95 must comply with all requirements of subdivisions 1 and 2. Participants who become eligible for MFIP assistance after being determined unable to benefit from the diversionary work program must comply with

the requirements of subdivisions 1 and 2, with the exception of subdivision 2, paragraph (b).

Subd. 6. **LOSS OF EMPLOYMENT.** Participants who are laid off, quit with good cause, or are terminated from employment through no fault of their own must meet with the job counselor within ten working days to ascertain the reason for the job loss and to revise the employment plan as necessary to address the problem.

Sec. 79. Minnesota Statutes 2002, section 256J.53, subdivision 1, is amended to read:

Subdivision 1. **LENGTH OF PROGRAM.** In order for a post-secondary education or training program to be an approved work activity as defined in section 256J.49, subdivision 13, clause ~~(18)~~ (6), it must be a program lasting 24 months or less, and the participant must meet the requirements of subdivisions 2 ~~and~~, 3, and 5.

Sec. 80. Minnesota Statutes 2002, section 256J.53, subdivision 2, is amended to read:

Subd. 2. ~~**DOCUMENTATION SUPPORTING PROGRAM**~~ **APPROVAL OF POSTSECONDARY EDUCATION OR TRAINING.** (a) In order for a post-secondary education or training program to be an approved activity in ~~a participant's~~ an employment plan, the participant ~~or the employment and training service provider~~ must ~~provide documentation that:~~ be working in unsubsidized employment at least 20 hours per week.

(b) Participants seeking approval of a postsecondary education or training plan must provide documentation that:

(1) the ~~participant's~~ employment ~~plan identifies specific goals that~~ goal can only be met with the additional education or training;

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

(c) The hourly unsubsidized employment requirement may be reduced for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

(d) Participants with an approved employment plan in place on July 1, 2003, which includes more than 12 months of postsecondary education or training shall be

allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph (b), and subdivisions 3 and 5 are met.

Sec. 81. Minnesota Statutes 2002, section 256J.53, subdivision 5, is amended to read:

Subd. 5. **~~JOB SEARCH AFTER COMPLETION OF WORK ACTIVITY~~ REQUIREMENTS AFTER POSTSECONDARY EDUCATION OR TRAINING.** ~~If a participant's employment plan includes a post-secondary educational or training program, the plan must include an anticipated completion date for those activities. At the time the education or training is completed, the participant must participate in job search. If, after three months of job search, the participant does not find a job that is consistent with the participant's employment goal, the participant must accept any offer of suitable employment.~~ Upon completion of an approved education or training program, a participant who does not meet the participation requirements in section 256J.55, subdivision 1, through unsubsidized employment must participate in job search. If, after six weeks of job search, the participant does not find a full-time job consistent with the employment goal, the participant must accept any offer of full-time suitable employment, or meet with the job counselor to revise the employment plan to include additional work activities necessary to meet hourly requirements.

Sec. 82. **[256J.531] BASIC EDUCATION; ENGLISH AS A SECOND LANGUAGE.**

Subdivision 1. **APPROVAL OF ADULT BASIC EDUCATION.** With the exception of classes related to obtaining a general educational development credential (GED), a participant must have reading or mathematics proficiency below a ninth grade level in order for adult basic education classes to be an approved work activity. The employment plan must also specify that the participant fulfill no more than one-half of the participation requirements in section 256J.55, subdivision 1, through attending adult basic education or general educational development classes.

Subd. 2. **APPROVAL OF ENGLISH AS A SECOND LANGUAGE.** In order for English as a second language (ESL) classes to be an approved work activity in an employment plan, a participant must be below a spoken language proficiency level of SPL6 or its equivalent, as measured by a nationally recognized test. In approving ESL as a work activity, the job counselor must give preference to enrollment in a functional work literacy program, if one is available, over a regular ESL program. A participant may not be 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. The employment plan must also specify that the participant fulfill no more than one-half of the participation requirements in section 256J.55, subdivision 1, through attending ESL classes. For participants enrolled in functional work literacy classes, no more than two-thirds of the participation requirements in section 256J.55, subdivision 1, may be met through attending functional work literacy classes.

Sec. 83. Minnesota Statutes 2002, section 256J.54, subdivision 1, is amended to read:

Subdivision 1. **ASSESSMENT OF EDUCATIONAL PROGRESS AND NEEDS.** (a) The county agency must document the educational level of each MFIP caregiver who is under the age of 20 and determine if the caregiver has obtained a high school diploma or its equivalent. If the caregiver has not obtained a high school diploma or its equivalent, ~~and is not exempt from the requirement to attend school under subdivision 5,~~ the county agency must complete an individual assessment for the caregiver unless the caregiver is exempt from the requirement to attend school under subdivision 5 or has chosen to have an employment plan under section 256J.521, subdivision 2, as allowed in paragraph (b). The assessment must be performed as soon as possible but within 30 days of determining MFIP eligibility for the caregiver. The assessment must provide an initial examination of the caregiver's educational progress and needs, literacy level, child care and supportive service needs, family circumstances, skills, and work experience. In the case of a caregiver under the age of 18, the assessment must also consider the results of either the caregiver's or the caregiver's minor child's child and teen checkup under Minnesota Rules, parts 9505.0275 and 9505.1693 to 9505.1748, if available, and the effect of a child's development and educational needs on the caregiver's ability to participate in the program. The county agency must advise the caregiver that the caregiver's first goal must be to complete an appropriate ~~educational~~ education option if one is identified for the caregiver through the assessment and, in consultation with educational agencies, must review the various school completion options with the caregiver and assist in selecting the most appropriate option.

(b) The county agency must 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 an education option under subdivision 3 or an employment plan under section 256J.521, subdivision 2.

Sec. 84. Minnesota Statutes 2002, section 256J.54, subdivision 2, is amended to read:

Subd. 2. **RESPONSIBILITY FOR ASSESSMENT AND EMPLOYMENT PLAN.** For caregivers who are under age 18 without a high school diploma or its equivalent, the assessment under subdivision 1 and the employment plan under subdivision 3 must be completed by the social services agency under section 257.33. For caregivers who are age 18 or 19 without a high school diploma or its equivalent who choose to have an employment plan with an education option under subdivision 3, the assessment under subdivision 1 and the employment plan under subdivision 3 must be completed by the job counselor or, at county option, by the social services agency under section 257.33. Upon reaching age 18 or 19 a caregiver who received social services under section 257.33 and is without a high school diploma or its equivalent has the option to choose whether to continue receiving services under the caregiver's plan from the social services agency or to utilize an MFIP employment and training service provider. The social services agency or the job counselor shall consult

with representatives of educational agencies that are required to assist in developing educational plans under section 124D.331.

Sec. 85. Minnesota Statutes 2002, section 256J.54, subdivision 3, is amended to read:

Subd. 3. **~~EDUCATIONAL~~ EDUCATION OPTION DEVELOPED.** If the job counselor or county social services agency identifies an appropriate ~~educational~~ education option for a minor caregiver ~~under the age of 20~~ without a high school diploma or its equivalent, or a caregiver age 18 or 19 without a high school diploma or its equivalent who chooses an employment plan with an education option, the job counselor or agency must develop an employment plan which reflects the identified option. The plan must specify that participation in an educational activity is required, what school or educational program is most appropriate, the services that will be provided, the activities the caregiver will take part in, including child care and supportive services, the consequences to the caregiver for failing to participate or comply with the specified requirements, and the right to appeal any adverse action. The employment plan must, to the extent possible, reflect the preferences of the caregiver.

Sec. 86. Minnesota Statutes 2002, section 256J.54, subdivision 5, is amended to read:

Subd. 5. **SCHOOL ATTENDANCE REQUIRED.** (a) Notwithstanding the provisions of section 256J.56, minor parents, or 18- or 19-year-old parents without a high school diploma or its equivalent who chooses an employment plan with an education option must attend school unless:

(1) transportation services needed to enable the caregiver to attend school are not available;

(2) appropriate child care services needed to enable the caregiver to attend school are not available;

(3) the caregiver is ill or incapacitated seriously enough to prevent attendance at school; or

(4) the caregiver is needed in the home because of the illness or incapacity of another member of the household. This includes a caregiver of a child who is younger than six weeks of age.

(b) The caregiver must be enrolled in a secondary school and meeting the school's attendance requirements. The county, social service agency, or job counselor must verify at least once per quarter that the caregiver is meeting the school's attendance requirements. An enrolled caregiver is considered to be meeting the attendance requirements when the school is not in regular session, including during holiday and summer breaks.

Sec. 87. **[256J.545] FAMILY VIOLENCE WAIVER CRITERIA.**

(a) In order to qualify for a family violence waiver, an individual must provide documentation of past or current family violence which may prevent the individual

from participating in certain employment activities. A claim of family violence must be documented by the applicant or participant providing a sworn statement which is supported by collateral documentation.

(b) Collateral documentation may consist of:

(1) police, government agency, or court records;

(2) a statement from a battered women's shelter staff with knowledge of the circumstances or credible evidence that supports the sworn statement;

(3) a statement from a sexual assault or domestic violence advocate with knowledge of the circumstances or credible evidence that supports the sworn statement;

(4) a statement from professionals from whom the applicant or recipient has sought assistance for the abuse; or

(5) a sworn statement from any other individual with knowledge of circumstances or credible evidence that supports the sworn statement.

Sec. 88. Minnesota Statutes 2002, section 256J.55, subdivision 1, is amended to read:

Subdivision 1. **~~COMPLIANCE WITH JOB SEARCH OR EMPLOYMENT PLAN; SUITABLE EMPLOYMENT~~ PARTICIPATION REQUIREMENTS.** ~~(a) Each MFIP participant must comply with the terms of the participant's job search support plan or employment plan. When the participant has completed the steps listed in the employment plan, the participant must comply with section 256J.53, subdivision 5, if applicable, and then the participant must not refuse any offer of suitable employment. The participant may choose to accept an offer of suitable employment before the participant has completed the steps of the employment plan.~~

~~(b) For a participant under the age of 20 who is without a high school diploma or general educational development diploma, the requirement to comply with the terms of the employment plan means the participant must meet the requirements of section 256J.54.~~

~~(c) Failure to develop or comply with a job search support plan or an employment plan, or quitting suitable employment without good cause, shall result in the imposition of a sanction as specified in sections 256J.46 and 256J.57.~~

(a) All caregivers must participate in employment services under sections 256J.515 to 256J.57 concurrent with receipt of MFIP assistance.

(b) Until July 1, 2004, participants who meet the requirements of section 256J.56 are exempt from participation requirements.

(c) Participants under paragraph (a) must develop and comply with an employment plan under section 256J.521, or section 256J.54 in the case of a participant under the age of 20 who has not obtained a high school diploma or its equivalent.

(d) With the exception of participants under the age of 20 who must meet the education requirements of section 256J.54, all participants must meet the hourly participation requirements of TANF or the hourly requirements listed in clauses (1) to (3), whichever is higher.

(1) In single-parent families with no children under six years of age, the job counselor and the caregiver must develop an employment plan that includes 30 to 35 hours per week of work activities.

(2) In single-parent families with a child under six years of age, the job counselor and the caregiver must develop an employment plan that includes 20 to 35 hours per week of work activities.

(3) In two-parent families, the job counselor and the caregivers must develop employment plans which result in a combined total of at least 55 hours per week of work activities.

(e) Failure to participate in employment services, including the requirement to develop and comply with an employment plan, including hourly requirements, without good cause under section 256J.57, shall result in the imposition of a sanction under section 256J.46.

Sec. 89. Minnesota Statutes 2002, section 256J.55, subdivision 2, is amended to read:

Subd. 2. **DUTY TO REPORT.** The participant must inform the job counselor within ~~three~~ ten working days regarding any changes related to the participant's employment status.

Sec. 90. Minnesota Statutes 2002, section 256J.56, is amended to read:

256J.56 **EMPLOYMENT AND TRAINING SERVICES COMPONENT; EXEMPTIONS.**

(a) An MFIP participant is exempt from the requirements of sections ~~256J.52~~ 256J.515 to ~~256J.55~~ 256J.57 if the participant belongs to any of the following groups:

(1) participants who are age 60 or older;

(2) participants who are suffering from a ~~professionally certified~~ permanent or temporary illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and ~~which~~ prevents the person from obtaining or retaining employment. Persons in this category with a temporary illness, injury, or incapacity must be reevaluated at least quarterly;

(3) participants whose presence in the home is required as a caregiver because of ~~a professionally certified~~ the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household ~~and~~ when the illness or incapacity and the need for a person to provide assistance in the home has

been certified by a qualified professional and is expected to continue for more than 30 days;

(4) women who are pregnant, if the pregnancy has resulted in a ~~professionally certified~~ an incapacity that prevents the woman from obtaining or retaining employment, and the incapacity has been certified by a qualified professional;

(5) caregivers of a child under the age of one year who personally provide full-time care for the child. This exemption may be used for only 12 months in a lifetime. In two-parent households, only one parent or other relative may qualify for this exemption;

(6) participants experiencing a personal or family crisis that makes them incapable of participating in the program, as determined by the county agency. If the participant does not agree with the county agency's determination, the participant may seek ~~professional~~ certification from a qualified professional, as defined in section 256J.08, that the participant is incapable of participating in the program.

Persons in this exemption category must be reevaluated every 60 days. A personal or family crisis related to family violence, as determined by the county or a job counselor with the assistance of a person trained in domestic violence, should not result in an exemption, but should be addressed through the development or revision of an ~~alternative~~ employment plan under section ~~256J.52~~ 256J.521, subdivision ~~6~~ 3; or

(7) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph ~~(c)~~ (f), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this exemption category are presumed to be prevented from obtaining or retaining employment.

A caregiver who is exempt under clause (5) must enroll in and attend an early childhood and family education class, a parenting class, or some similar activity, if available, during the period of time the caregiver is exempt under this section. Notwithstanding section 256J.46, failure to attend the required activity shall not result in the imposition of a sanction.

(b) The county agency must provide employment and training services to MFIP participants who are exempt under this section, but who volunteer to participate. Exempt volunteers may request approval for any work activity under section 256J.49, subdivision 13. The hourly participation requirements for nonexempt participants under section ~~256J.50~~ 256J.55, subdivision ~~5~~ 1, do not apply to exempt participants who volunteer to participate.

(c) This section expires on June 30, 2004.

Sec. 91. **[256J.561] UNIVERSAL PARTICIPATION REQUIRED.**

Subdivision 1. **IMPLEMENTATION OF UNIVERSAL PARTICIPATION REQUIREMENTS.** (a) All caregivers whose applications were received July 1, 2004, or after, are immediately subject to the requirements in subdivision 2.

(b) For all MFIP participants who were exempt from participating in employment services under section 256J.56 as of June 30, 2004, between July 1, 2004, and June 30, 2005, the county, as part of the participant's recertification under section 256J.32, subdivision 6, shall determine whether a new employment plan is required to meet the requirements in subdivision 2. Counties shall notify each participant who is in need of an employment plan that the participant must meet with a job counselor within ten days to develop an employment plan. Until a participant's employment plan is developed, the participant shall be considered in compliance with the participation requirements in this section if the participant continues to meet the criteria for an exemption under section 256J.56 as in effect on June 30, 2004, and is cooperating in the development of the new plan.

Subd. 2. **PARTICIPATION REQUIREMENTS.** (a) All MFIP caregivers, except caregivers who meet the criteria in subdivision 3, must participate in employment services. Except as specified in paragraphs (b) to (d), the employment plan must meet the requirements of section 256J.521, subdivision 2, contain allowable work activities, as defined in section 256J.49, subdivision 13, and, include at a minimum, the number of participation hours required under section 256J.55, subdivision 1.

(b) Minor caregivers and caregivers who are less than age 20 who have not completed high school or obtained a GED are required to comply with section 256J.54.

(c) A participant who has a family violence waiver shall develop and comply with an employment plan under section 256J.521, subdivision 3.

(d) As specified in section 256J.521, subdivision 2, paragraph (c), a participant who meets any one of the following criteria may work with the job counselor to develop an employment plan that contains less than the number of participation hours under section 256J.55, subdivision 1. Employment plans for participants covered under this paragraph must be tailored to recognize the special circumstances of caregivers and families including limitations due to illness or disability and caregiving needs:

(1) a participant who is age 60 or older;

(2) a participant who has been diagnosed by a qualified professional as suffering from an illness or incapacity that is expected to last for 30 days or more, including a pregnant participant who is determined to be unable to obtain or retain employment due to the pregnancy; or

(3) a participant who is determined by a qualified professional as being needed in the home to care for an ill or incapacitated family member, including caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (f), or a home and community-based waiver services program under chapter 256B, or meets the

criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c).

(e) For participants covered under paragraphs (c) and (d), the county shall review the participant's employment services status every three months to determine whether conditions have changed. When it is determined that the participant's status is no longer covered under paragraph (c) or (d), the county shall notify the participant that a new or revised employment plan is needed. The participant and job counselor shall meet within ten days of the determination to revise the employment plan.

Subd. 3. **CHILD UNDER 12 WEEKS OF AGE.** (a) A participant who has a natural born child who is less than 12 weeks of age who meets the criteria in clauses (1) and (2) is not required to participate in employment services until the child reaches 12 weeks of age. To be eligible for this provision, the following conditions must be met:

(1) the child must have been born within ten months of the caregiver's application for the diversionary work program or MFIP; and

(2) the assistance unit must not have already used this provision or the previously allowed child under age one exemption. However, an assistance unit that has an approved child under age one exemption at the time this provision becomes effective may continue to use that exemption until the child reaches one year of age.

(b) The provision in paragraph (a) ends the first full month after the child reaches 12 weeks of age. This provision is available only once in a caregiver's lifetime. In a two-parent household, only one parent shall be allowed to use this provision. The participant and job counselor must meet within ten days after the child reaches 12 weeks of age to revise the participant's employment plan.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 92. Minnesota Statutes 2002, section 256J.57, is amended to read:

256J.57 **GOOD CAUSE; FAILURE TO COMPLY; NOTICE; CONCILIATION CONFERENCE.**

Subdivision 1. **GOOD CAUSE FOR FAILURE TO COMPLY.** The county agency shall not impose the sanction under section 256J.46 if it determines that the participant has good cause for failing to comply with the requirements of sections ~~256J.52~~ 256J.515 to ~~256J.55~~ 256J.57. Good cause exists when:

(1) appropriate child care is not available;

(2) the job does not meet the definition of suitable employment;

(3) the participant is ill or injured;

(4) a member of the assistance unit, a relative in the household, or a foster child in the household is ill and needs care by the participant that prevents the participant

from complying with the ~~job search support plan or~~ employment plan;

(5) the parental caregiver is unable to secure necessary transportation;

(6) the parental caregiver is in an emergency situation that prevents compliance with the ~~job search support plan or~~ employment plan;

(7) the schedule of compliance with the ~~job search support plan or~~ employment plan conflicts with judicial proceedings;

(8) a mandatory MFIP meeting is scheduled during a time that conflicts with a judicial proceeding or a meeting related to a juvenile court matter, or a participant's work schedule;

(9) the parental caregiver is already participating in acceptable work activities;

(10) the employment plan requires an educational program for a caregiver under age 20, but the educational program is not available;

(11) activities identified in the ~~job search support plan or~~ employment plan are not available;

(12) the parental caregiver is willing to accept suitable employment, but suitable employment is not available; or

(13) the parental caregiver documents other verifiable impediments to compliance with the ~~job search support plan or~~ employment plan beyond the parental caregiver's control.

The job counselor shall work with the participant to reschedule mandatory meetings for individuals who fall under clauses (1), (3), (4), (5), (6), (7), and (8).

Subd. 2. **NOTICE OF INTENT TO SANCTION.** (a) When a participant fails without good cause to comply with the requirements of sections ~~256J.52~~ 256J.515 to ~~256J.55~~ 256J.57, the job counselor or the county agency must provide a notice of intent to sanction to the participant specifying the program requirements that were not complied with, informing the participant that the county agency will impose the sanctions specified in section 256J.46, and informing the participant of the opportunity to request a conciliation conference as specified in paragraph (b). The notice must also state that the participant's continuing noncompliance with the specified requirements will result in additional sanctions under section 256J.46, without the need for additional notices or conciliation conferences under this subdivision. The notice, written in English, must include the department of human services language block, and must be sent to every applicable participant. If the participant does not request a conciliation conference within ten calendar days of the mailing of the notice of intent to sanction, the job counselor must notify the county agency that the assistance payment should be reduced. The county must then send a notice of adverse action to the participant informing the participant of the sanction that will be imposed, the reasons for the sanction, the effective date of the sanction, and the participant's right to have a fair hearing under section 256J.40.

(b) The participant may request a conciliation conference by sending a written request, by making a telephone request, or by making an in-person request. The request must be received within ten calendar days of the date the county agency mailed the ten-day notice of intent to sanction. If a timely request for a conciliation is received, the county agency's service provider must conduct the conference within five days of the request. The job counselor's supervisor, or a designee of the supervisor, must review the outcome of the conciliation conference. If the conciliation conference resolves the noncompliance, the job counselor must promptly inform the county agency and request withdrawal of the sanction notice.

(c) Upon receiving a sanction notice, the participant may request a fair hearing under section 256J.40, without exercising the option of a conciliation conference. In such cases, the county agency shall not require the participant to engage in a conciliation conference prior to the fair hearing.

(d) If the participant requests a fair hearing or a conciliation conference, sanctions will not be imposed until there is a determination of noncompliance. Sanctions must be imposed as provided in section 256J.46.

Sec. 93. Minnesota Statutes 2002, section 256J.62, subdivision 9, is amended to read:

Subd. 9. **CONTINUATION OF CERTAIN SERVICES.** Only if services were approved as part of an employment plan prior to June 30, 2003, at the request of the participant, the county may continue to provide case management, counseling, or other support services to a participant:

~~(a)~~ (1) who has achieved the employment goal; or

~~(b)~~ (2) who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 115 percent of the federal poverty guidelines for a family of the same size.

These services may be provided for up to 12 months following termination of the participant's eligibility for MFIP.

Sec. 94. **[256J.626] MFIP CONSOLIDATED FUND.**

Subdivision 1. **CONSOLIDATED FUND.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Subd. 2. **ALLOWABLE EXPENDITURES.** (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities;

(3) direct and administrative costs of staff to deliver employment services for MFIP or the diversionary work program, to administer financial assistance, and to provide specialized services intended to assist hard-to-employ participants to transition to work;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP or diversionary work program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; and

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's reimbursement under this section. The commissioner shall define administrative costs for purposes of this subdivision.

Subd. 3. **ELIGIBILITY FOR SERVICES.** Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP or diversionary work program, and families at risk of receiving MFIP or diversionary work program.

Subd. 4. **COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.** (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

(b) The service agreements will be completed in a form prescribed by the commissioner. The agreement must include:

(1) a statement of the needs of the service population and strengths and resources in the community;

(2) numerical goals for participant outcomes measures to be accomplished during the biennial period. The commissioner may identify outcomes from section 256J.751, subdivision 2, as core outcomes for all counties and tribes;

(3) strategies the county or tribe will pursue to achieve the outcome targets. Strategies must include specification of how funds under this section will be used and may include community partnerships that will be established or strengthened; and

(4) other items prescribed by the commissioner in consultation with counties and tribes.

(c) The commissioner shall provide each county and tribe with information needed to complete an agreement, including: (1) information on MFIP cases in the county or tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome measures; and (4) promising program practices.

(d) The service agreement must be submitted to the commissioner by October 15, 2003, and October 15 of each second year thereafter. The county or tribe must allow a period of not less than 30 days prior to the submission of the agreement to solicit comments from the public on the contents of the agreement.

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

(f) The service agreement in this subdivision supersedes the plan requirements of section 268.88.

Subd. 5. **INNOVATION PROJECTS.** Beginning January 1, 2005, no more than $3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner for projects testing innovative approaches to improving outcomes for MFIP participants, and persons at risk of receiving MFIP as detailed in subdivision 3. Projects shall be targeted to geographic

areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes.

Subd. 6. **BASE ALLOCATION TO COUNTIES AND TRIBES.** (a) For purposes of this section, the following terms have the meanings given them:

(1) "2002 historic spending base" means the commissioner's determination of the sum of the reimbursement related to fiscal year 2002 of county or tribal agency expenditures for the base programs listed in clause (4), items (i) through (iv), and earnings related to calendar year 2002 in the base program listed in clause (4), item (v), and the amount of spending in fiscal year 2002 in the base program listed in clause (4), item (vi), issued to or on behalf of persons residing in the county or tribal service delivery area.

(2) "Initial allocation" means the amount potentially available to each county or tribe based on the formula in paragraphs (b) through (d).

(3) "Final allocation" means the amount available to each county or tribe based on the formula in paragraphs (b) through (d), after adjustment by subdivision 7.

(4) "Base programs" means the:

(i) MFIP employment and training services under section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June 30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under section 256J.48 in effect June 30, 2002.

(b)(1) Beginning July 1, 2003, the commissioner shall determine the initial allocation of funds available under this section according to clause (2).

(2) All of the funds available for the period beginning July 1, 2003, and ending December 31, 2004, shall be allocated to each county or tribe in proportion to the county's or tribe's share of the statewide 2002 historic spending base.

(c) For calendar year 2005, the commissioner shall determine the initial allocation of funds to be made available under this section in proportion to the county or tribe's initial allocation for the period of July 1, 2003 to December 31, 2004.

(d) The formula under this subdivision sunsets December 31, 2005.

(e) Before November 30, 2003, a county or tribe may ask for a review of the commissioner's determination of the historic base spending when the county or tribe believes the 2002 information was inaccurate or incomplete. By January 1, 2004, the commissioner must adjust that county's or tribe's base when the commissioner has determined that inaccurate or incomplete information was used to develop that base. The commissioner shall adjust each county's or tribe's initial allocation under paragraph (c) and final allocation under subdivision 7 to reflect the base change.

(f) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.

Subd. 7. **PERFORMANCE BASE FUNDS.** (a) Each county and tribe will be allocated 95 percent of their initial calendar year 2005 allocation. Counties and tribes will be allocated additional funds based on performance as follows:

(1) a county or tribe that achieves a 50 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) a county or tribe that performs above the top of its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year will receive an additional allocation equal to five percent of its initial allocation; or

(3) a county or tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement, will receive an additional allocation equal to 2.5 percent of its initial allocation.

(b) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

(c)(1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.

(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).

Subd. 8. **REPORTING REQUIREMENT AND REIMBURSEMENT.** (a) The commissioner shall specify requirements for reporting according to section 256.01,

subdivision 2, clause (17). Each county or tribe shall be reimbursed for eligible expenditures up to the limit of its allocation and subject to availability of funds.

(b) Reimbursements for county administrative-related expenditures determined through the income maintenance random moment time study shall be reimbursed at a rate of 50 percent of eligible expenditures.

(c) The commissioner of human services shall review county and tribal agency expenditures of the MFIP consolidated fund as appropriate and may reallocate unencumbered or unexpended money appropriated under this section to those county and tribal agencies that can demonstrate a need for additional money.

Subd. 9. **REPORT.** The commissioner shall, in consultation with counties and tribes:

(1) determine how performance-based allocations under subdivision 7, paragraph (a), clauses (2) and (3), will be allocated to groupings of counties and tribes when groupings are used to measure expected performance ranges for the self-support index under section 256J.751, subdivision 2, clause (7); and

(2) determine how performance-based allocations under subdivision 7, paragraph (a), clauses (2) and (3), will be allocated to tribes.

The commissioner shall report to the legislature on the formulas developed in clauses (1) and (2) by January 1, 2004.

Sec. 95. Minnesota Statutes 2002, section 256J.645, subdivision 3, is amended to read:

Subd. 3. **FUNDING.** If the commissioner and an Indian tribe are parties to an agreement under this subdivision, the agreement shall annually provide to the Indian tribe the funding allocated in section ~~256J.62, subdivisions 1 and 2a~~ 256J.626.

Sec. 96. Minnesota Statutes 2002, section 256J.66, subdivision 2, is amended to read:

Subd. 2. **TRAINING AND PLACEMENT.** (a) County agencies shall limit the length of training based on the complexity of the job and the caregiver's previous experience and training. Placement in an on-the-job training position with an employer is for the purpose of training and employment with the same employer who has agreed to retain the person upon satisfactory completion of training.

(b) Placement of any participant in an on-the-job training position must be compatible with the participant's assessment and employment plan under section ~~256J.52~~ 256J.521.

Sec. 97. Minnesota Statutes 2002, section 256J.69, subdivision 2, is amended to read:

Subd. 2. **TRAINING AND PLACEMENT.** (a) County agencies shall limit the length of training to nine months. Placement in a grant diversion training position with an employer is for the purpose of training and employment with the same employer

who has agreed to retain the person upon satisfactory completion of training.

(b) Placement of any participant in a grant diversion subsidized training position must be compatible with the assessment and employment plan or employability development plan established for the recipient under section ~~256J.52 or 256K.03, subdivision 8~~ 256J.521.

Sec. 98. Minnesota Statutes 2002, section 256J.75, subdivision 3, is amended to read:

Subd. 3. **RESPONSIBILITY FOR INCORRECT ASSISTANCE PAYMENTS.** A county of residence, when different from the county of financial responsibility, will be charged by the commissioner for the value of incorrect assistance payments ~~and medical assistance~~ paid to or on behalf of a person who was not eligible to receive that amount. Incorrect payments include payments to an ineligible person or family resulting from decisions, failures to act, miscalculations, or overdue recertification. However, financial responsibility does not accrue for a county when the recertification is overdue at the time the referral is received by the county of residence or when the county of financial responsibility does not act on the recommendation of the county of residence. ~~When federal or state law requires that medical assistance continue after assistance ends, this subdivision also governs financial responsibility for the extended medical assistance.~~

Sec. 99. Minnesota Statutes 2002, section 256J.751, subdivision 1, is amended to read:

Subdivision 1. **~~QUARTERLY~~ MONTHLY COUNTY CASELOAD REPORT.** The commissioner shall report ~~quarterly~~ monthly to each county ~~on~~ the ~~county's performance on the following measures~~ following caseload information:

~~(1) number of cases receiving only the food portion of assistance;~~

~~(2) number of child-only cases;~~

~~(3) number of minor caregivers;~~

~~(4) number of cases that are exempt from the 60-month time limit by the exemption category under section 256J.42;~~

~~(5) number of participants who are exempt from employment and training services requirements by the exemption category under section 256J.56;~~

~~(6) number of assistance units receiving assistance under a hardship extension under section 256J.425;~~

~~(7) number of participants and number of months spent in each level of sanction under section 256J.46, subdivision 1;~~

~~(8) number of MFIP cases that have left assistance;~~

~~(9) federal participation requirements as specified in title 1 of Public Law Number 104-193;~~

~~(10) median placement wage rate; and~~

~~(11) of each county's total MFIP caseload less the number of cases in clauses (1) to (6):~~

~~(i) number of one-parent cases;~~

~~(ii) number of two-parent cases;~~

~~(iii) percent of one-parent cases that are working more than 20 hours per week;~~

~~(iv) percent of two-parent cases that are working more than 20 hours per week; and~~

~~(v) percent of cases that have received more than 36 months of assistance.~~

(1) total number of cases receiving MFIP, and subtotals of cases with one eligible parent, two eligible parents, and an eligible caregiver who is not a parent;

(2) total number of child only assistance cases;

(3) total number of eligible adults and children receiving an MFIP grant, and subtotals for cases with one eligible parent, two eligible parents, an eligible caregiver who is not a parent, and child only cases;

(4) number of cases with an exemption from the 60-month time limit based on a family violence waiver;

(5) number of MFIP cases with work hours, and subtotals for cases with one eligible parent, two eligible parents, and an eligible caregiver who is not a parent;

(6) number of employed MFIP cases, and subtotals for cases with one eligible parent, two eligible parents, and an eligible caregiver who is not a parent;

(7) average monthly gross earnings, and averages for subgroups of cases with one eligible parent, two eligible parents, and an eligible caregiver who is not a parent;

(8) number of employed cases receiving only the food portion of assistance;

(9) number of parents or caregivers exempt from work activity requirements, with subtotals for each exemption type; and

(10) number of cases with a sanction, with subtotals by level of sanction for cases with one eligible parent, two eligible parents, and an eligible caregiver who is not a parent.

Sec. 100. Minnesota Statutes 2002, section 256J.751, subdivision 2, is amended to read:

Subd. 2. **QUARTERLY COMPARISON REPORT.** The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) federal participation requirements as specified in Title 1 of Public Law ~~Number~~ 104-193;

(5) median placement wage rate; ~~and~~

(6) caseload by months of TANF assistance;

(7) percent of MFIP cases off cash assistance or working 30 or more hours per week at one-year, two-year, and three-year follow-up points from a base line quarter. This measure is called the self-support index. Twice annually, the commissioner shall report an expected range of performance for each county, county grouping, and tribe on the self-support index. The expected range shall be derived by a statistical methodology developed by the commissioner in consultation with the counties and tribes. The statistical methodology shall control differences across counties in economic conditions and demographics of the MFIP case load; and

(8) the MFIP work participation rate, defined as the participation requirements specified in title 1 of Public Law 104-193 applied to all MFIP cases except child only cases and cases exempt under section 256J.56.

Sec. 101. Minnesota Statutes 2002, section 256J.751, subdivision 5, is amended to read:

Subd. 5. **FAILURE TO MEET FEDERAL PERFORMANCE STANDARDS.** (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law ~~Number~~ 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, the state shall pay 88 percent of the sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

(b) If a county fails to meet the performance standards specified in title 1 of Public Law ~~Number~~ 104-193 of the Personal Responsibility and Work Opportunity Act of 1996 for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the departments of economic security and children, families, and learning as necessary to achieve the purpose of this paragraph.

(c) For state performance measures, a low-performing county is one that:

(1) performs below the bottom of their expected range for the measure in subdivision 2, clause (7), in both measurements during the year; or

(2) performs below 40 percent for the measure in subdivision 2, clause (8), as averaged across the four quarterly measurements for the year, or the ten counties with the lowest rates if more than ten are below 40 percent.

(d) Low-performing counties under paragraph (c) must engage in corrective action planning as defined by the commissioner. The commissioner may coordinate technical assistance as specified in paragraph (b) for low-performing counties under paragraph (c).

Sec. 102. **[256J.95] DIVERSIONARY WORK PROGRAM.**

Subdivision 1. **ESTABLISHING A DIVERSIONARY WORK PROGRAM (DWP).** (a) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, establishes block grants to states for temporary assistance for needy families (TANF). TANF provisions allow states to use TANF dollars for nonrecurrent, short-term diversionary benefits. The diversionary work program established on July 1, 2003, is Minnesota's TANF program to provide short-term diversionary benefits to eligible recipients of the diversionary work program.

(b) The goal of the diversionary work program is to provide short-term, necessary services and supports to families which will lead to unsubsidized employment, increase economic stability, and reduce the risk of those families needing longer term assistance, under the Minnesota family investment program (MFIP).

(c) When a family unit meets the eligibility criteria in this section, the family must receive a diversionary work program grant and is not eligible for MFIP.

(d) A family unit is eligible for the diversionary work program for a maximum of four months only once in a 12-month period. The 12-month period begins at the date of application or the date eligibility is met, whichever is later. During the four-month period, family maintenance needs as defined in subdivision 2, shall be vendor paid, up to the cash portion of the MFIP standard of need for the same size household. To the extent there is a balance available between the amount paid for family maintenance needs and the cash portion of the transitional standard, a personal needs allowance of up to $70 per DWP recipient in the family unit shall be issued. The personal needs allowance payment plus the family maintenance needs shall not exceed the cash portion of the MFIP standard of need. Counties may provide supportive and other allowable services funded by the MFIP consolidated fund under section 256J.626 to eligible participants during the four-month diversionary period.

Subd. 2. **DEFINITIONS.** The terms used in this section have the following meanings.

(a) "Diversionary Work Program (DWP)" means the program established under this section.

(b) "Employment plan" means a plan developed by the job counselor and the participant which identifies the participant's most direct path to unsubsidized employment, lists the specific steps that the caregiver will take on that path, and includes a timetable for the completion of each step. For participants who request and qualify for a family violence waiver in section 256J.521, subdivision 3, an employment plan must be developed by the job counselor, the participant and a person trained in domestic violence and follow the employment plan provisions in section 256J.521, subdivision

3. Employment plans under this section shall be written for a period of time not to exceed four months.

(c) "Employment services" means programs, activities, and services in this section that are designed to assist participants in obtaining and retaining employment.

(d) "Family maintenance needs" means current housing costs including rent, manufactured home lot rental costs, or monthly principal, interest, insurance premiums, and property taxes due for mortgages or contracts for deed, association fees required for homeownership, utility costs for current month expenses of gas and electric, garbage, water and sewer, and a flat rate of $35 for telephone services.

(e) "Family unit" means a group of people applying for or receiving DWP benefits together. For the purposes of determining eligibility for this program, the unit includes the relationships in section 256J.24, subdivisions 2 and 4.

(f) "Minnesota family investment program (MFIP)" means the assistance program as defined in section 256J.08, subdivision 57.

(g) "Personal needs allowance" means an allowance of up to $70 per month per DWP unit member to pay for expenses such as household products and personal products.

(h) "Work activities" means allowable work activities as defined in section 256J.49, subdivision 13.

Subd. 3. **ELIGIBILITY FOR DIVERSIONARY WORK PROGRAM.** (a) Except for the categories of family units listed below, all family units who apply for cash benefits and who meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must participate in the diversionary work program. Family units that are not eligible for the diversionary work program include:

(1) child only cases;

(2) a single-parent family unit that includes a child under 12 weeks of age. A parent is eligible for this exception once in a parent's lifetime and is not eligible if the parent has already used the previously allowed child under age one exemption from MFIP employment services;

(3) a minor parent without a high school diploma or its equivalent;

(4) a caregiver 18 or 19 years of age without a high school diploma or its equivalent who chooses to have an employment plan with an education option;

(5) a caregiver age 60 or over;

(6) family units with a parent who received DWP benefits within a 12-month period as defined in subdivision 1, paragraph (d); and

(7) family units with a parent who received MFIP within the past 12 months.

(b) A two-parent family must participate in DWP unless both parents meet the criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit includes a parent who meets the criteria in paragraph (a), clause (6) or (7).

Subd. 4. **COOPERATION WITH PROGRAM REQUIREMENTS.** (a) To be eligible for DWP, an applicant must comply with the requirements of paragraphs (b) to (d).

(b) Applicants and participants must cooperate with the requirements of the child support enforcement program, but will not be charged a fee under section 518.551, subdivision 7.

(c) The applicant must provide each member of the family unit's social security number to the county agency. This requirement is satisfied when each member of the family unit cooperates with the procedures for verification of numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

(d) Before DWP benefits can be issued to a family unit, the caregiver must, in conjunction with a job counselor, develop and sign an employment plan. In two-parent family units, both parents must develop and sign employment plans before benefits can be issued. Food support and health care benefits are not contingent on the requirement for a signed employment plan.

Subd. 5. **SUBMITTING APPLICATION FORM.** The eligibility date for the diversionary work program begins with the date the signed combined application form (CAF) is received by the county agency or the date diversionary work program eligibility criteria are met, whichever is later. The county agency must inform the applicant that any delay in submitting the application will reduce the benefits paid for the month of application. The county agency must inform a person that an application may be submitted before the person has an interview appointment. Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The applicant may withdraw the application at any time prior to approval by giving written or oral notice to the county agency. The county agency must follow the notice requirements in section 256J.09, subdivision 3, when issuing a notice confirming the withdrawal.

Subd. 6. **INITIAL SCREENING OF APPLICATIONS.** Upon receipt of the application, the county agency must determine if the applicant may be eligible for other benefits as required in sections 256J.09, subdivision 3a, and 256J.28, subdivisions 1 and 5. The county must also follow the provisions in section 256J.09, subdivision 3b, clause (2).

Subd. 7. **PROGRAM AND PROCESSING STANDARDS.** (a) The interview to determine financial eligibility for the diversionary work program must be conducted within five working days of the receipt of the cash application form. During the intake interview the financial worker must discuss:

(1) the goals, requirements, and services of the diversionary work program;

(2) the availability of child care assistance. If child care is needed, the worker must obtain a completed application for child care from the applicant before the interview is terminated. The same day the application for child care is received, the application must be forwarded to the appropriate child care worker. For purposes of eligibility for child care assistance under chapter 119B, DWP participants shall be eligible for the same benefits as MFIP recipients; and

(3) if the applicant has not requested food support and health care assistance on the application, the county agency shall, during the interview process, talk with the applicant about the availability of these benefits.

(b) The county shall follow section 256J.74, subdivision 2, paragraph (b), clauses (1) and (2), when an applicant or a recipient of DWP has a person who is a member of more than one assistance unit in a given payment month.

(c) If within 30 days the county agency cannot determine eligibility for the diversionary work program, the county must deny the application and inform the applicant of the decision according to the notice provisions in section 256J.31. A family unit is eligible for a fair hearing under section 256J.40.

Subd. 8. **VERIFICATION REQUIREMENTS.** (a) A county agency must only require verification of information necessary to determine DWP eligibility and the amount of the payment. The applicant or participant must document the information required or authorize the county agency to verify the information. The applicant or participant has the burden of providing documentary evidence to verify eligibility. The county agency shall assist the applicant or participant in obtaining required documents when the applicant or participant is unable to do so.

(b) A county agency must not request information about an applicant or participant that is not a matter of public record from a source other than county agencies, the department of human services, or the United States Department of Health and Human Services without the person's prior written consent. An applicant's signature on an application form constitutes consent for contact with the sources specified on the application. A county agency may use a single consent form to contact a group of similar sources, but the sources to be contacted must be identified by the county agency prior to requesting an applicant's consent.

(c) Factors to be verified shall follow section 256J.32, subdivision 4. Except for personal needs, family maintenance needs must be verified before the expense can be allowed in the calculation of the DWP grant.

Subd. 9. **PROPERTY AND INCOME LIMITATIONS.** The asset limits and exclusions in section 256J.20, apply to applicants and recipients of DWP. All payments, unless excluded in section 256J.21, must be counted as income to determine eligibility for the diversionary work program. The county shall treat income as outlined in section 256J.37, except for subdivision 3a. The initial income test and the disregards in section 256J.21, subdivision 3, shall be followed for determining eligibility for the diversionary work program.

Subd. 10. **DIVERSIONARY WORK PROGRAM GRANT.** (a) The amount of cash benefits that a family unit is eligible for under the diversionary work program is based on the number of persons in the family unit, the family maintenance needs, personal needs allowance, and countable income. The county agency shall evaluate the income of the family unit that is requesting payments under the diversionary work program. Countable income means gross earned and unearned income not excluded or disregarded under MFIP. The same disregards for earned income that are allowed under MFIP are allowed for the diversionary work program.

(b) The DWP grant is based on the family maintenance needs for which the DWP family unit is responsible plus a personal needs allowance. Housing and utilities, except for telephone service, shall be vendor paid. Unless otherwise stated in this section, actual housing and utility expenses shall be used when determining the amount of the DWP grant.

(c) The maximum monthly benefit amount available under the diversionary work program is the difference between the family unit's needs under paragraph (b) and the family unit's countable income not to exceed the cash portion of the MFIP standard of need as defined in section 256J.08, subdivision 55a, for the family unit's size.

(d) Once the county has determined a grant amount, the DWP grant amount will not be decreased if the determination is based on the best information available at the time of approval and shall not be decreased because of any additional income to the family unit. The grant must be increased if a participant later verifies an increase in family maintenance needs or family unit size. The minimum cash benefit amount, if income and asset tests are met, is $10. Benefits of $10 shall not be vendor paid.

(e) When all criteria are met, including the development of an employment plan as described in subdivision 14 and eligibility exists for the month of application, the amount of benefits for the diversionary work program retroactive to the date of application is as specified in section 256J.35, paragraph (a).

(f) Any month during the four-month DWP period that a person receives a DWP benefit directly or through a vendor payment made on the person's behalf, that person is ineligible for MFIP or any other TANF cash assistance program except for benefits defined in section 256J.626, subdivision 2, clause (1).

If during the four-month period a family unit that receives DWP benefits moves to a county that has not established a diversionary work program, the family unit may be eligible for MFIP the month following the last month of the issuance of the DWP benefit.

Subd. 11. **UNIVERSAL PARTICIPATION REQUIRED.** (a) All DWP caregivers, except caregivers who meet the criteria in paragraph (d), are required to participate in DWP employment services. Except as specified in paragraphs (b) and (c), employment plans under DWP must, at a minimum, meet the requirements in section 256J.55, subdivision 1.

(b) A caregiver who is a member of a two-parent family that is required to participate in DWP who would otherwise be ineligible for DWP under subdivision 3

may be allowed to develop an employment plan under section 256J.521, subdivision 2, paragraph (c), that may contain alternate activities and reduced hours.

(c) A participant who has a family violence waiver shall be allowed to develop an employment plan under section 256J.521, subdivision 3.

(d) One parent in a two-parent family unit that has a natural born child under 12 weeks of age is not required to have an employment plan until the child reaches 12 weeks of age unless the family unit has already used the exclusion under section 256J.561, subdivision 2, or the previously allowed child under age one exemption under section 256J.56, paragraph (a), clause (5).

(e) The provision in paragraph (d) ends the first full month after the child reaches 12 weeks of age. This provision is allowable only once in a caregiver's lifetime. In a two-parent household, only one parent shall be allowed to use this category.

(f) The participant and job counselor must meet within ten working days after the child reaches 12 weeks of age to revise the participant's employment plan. The employment plan for a family unit that has a child under 12 weeks of age that has already used the exclusion in section 256J.561 or the previously allowed child under age one exemption under section 256J.56, paragraph (a), clause (5), must be tailored to recognize the caregiving needs of the parent.

Subd. 12. **CONVERSION OR REFERRAL TO MFIP.** (a) If at any time during the DWP application process or during the four-month DWP eligibility period, it is determined that a participant is unlikely to benefit from the diversionary work program, the county shall convert or refer the participant to MFIP as specified in paragraph (d). Participants who are determined to be unlikely to benefit from the diversionary work program must develop and sign an employment plan. Participants who meet any one of the criteria in paragraph (b) shall be considered to be unlikely to benefit from DWP, provided the necessary documentation is available to support the determination.

(b) A participant who:

(1) has been determined by a qualified professional as being unable to obtain or retain employment due to an illness, injury, or incapacity that is expected to last at least 60 days;

(2) is required in the home as a caregiver because of the illness, injury, or incapacity, of a family member, or a relative in the household, or a foster child, and the illness, injury, or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue more than 60 days;

(3) is determined by a qualified professional as being needed in the home to care for a child meeting the special medical criteria in section 256J.425, subdivision 2, clause (3);

(4) is pregnant and is determined by a qualified professional as being unable to obtain or retain employment due to the pregnancy; or

(5) has applied for SSI or RSDI.

(c) In a two-parent family unit, both parents must be determined to be unlikely to benefit from the diversionary work program before the family unit can be converted or referred to MFIP.

(d) A participant who is determined to be unlikely to benefit from the diversionary work program shall be converted to MFIP and, if the determination was made within 30 days of the initial application for benefits, no additional application form is required. A participant who is determined to be unlikely to benefit from the diversionary work program shall be referred to MFIP and, if the determination is made more than 30 days after the initial application, the participant must submit a program change request form. The county agency shall process the program change request form by the first of the following month to ensure that no gap in benefits is due to delayed action by the county agency. In processing the program change request form, the county must follow section 256J.32, subdivision 1, except that the county agency shall not require additional verification of the information in the case file from the DWP application unless the information in the case file is inaccurate, questionable, or no longer current.

(e) The county shall not request a combined application form for a participant who has exhausted the four months of the diversionary work program, has continued need for cash and food assistance, and has completed, signed, and submitted a program change request form within 30 days of the fourth month of the diversionary work program. The county must process the program change request according to section 256J.32, subdivision 1, except that the county agency shall not require additional verification of information in the case file unless the information is inaccurate, questionable, or no longer current. When a participant does not request MFIP within 30 days of the diversionary work program benefits being exhausted, a new combined application form must be completed for any subsequent request for MFIP.

Subd. 13. **IMMEDIATE REFERRAL TO EMPLOYMENT SERVICES.** Within one working day of determination that the applicant is eligible for the diversionary work program, but before benefits are issued to or on behalf of the family unit, the county shall refer all caregivers to employment services. The referral to the DWP employment services must be in writing and must contain the following information:

(1) notification that, as part of the application process, applicants are required to develop an employment plan or the DWP application will be denied;

(2) the employment services provider name and phone number;

(3) the date, time, and location of the scheduled employment services interview;

(4) the immediate availability of supportive services, including, but not limited to, child care, transportation, and other work-related aid; and

(5) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for good cause, the consequences of refusing or failing to participate fully with program requirements, and the appeal process.

Subd. 14. **EMPLOYMENT PLAN; DWP BENEFITS.** As soon as possible, but no later than ten working days of being notified that a participant is financially eligible for the diversionary work program, the employment services provider shall provide the participant with an opportunity to meet to develop an initial employment plan. Once the initial employment plan has been developed and signed by the participant and the job counselor, the employment services provider shall notify the county within one working day that the employment plan has been signed. The county shall issue DWP benefits within one working day after receiving notice that the employment plan has been signed.

Subd. 15. **LIMITATIONS ON CERTAIN WORK ACTIVITIES.** (a) Except as specified in paragraphs (b) to (d), employment activities listed in section 256J.49, subdivision 13, are allowable under the diversionary work program.

(b) Work activities under section 256J.49, subdivision 13, clause (5), shall be allowable only when in combination with approved work activities under section 256J.49, subdivision 13, clauses (1) to (4), and shall be limited to no more than one-half of the hours required in the employment plan.

(c) In order for an English as a second language (ESL) class to be an approved work activity, a participant must:

(1) be below a spoken language proficiency level of SPL6 or its equivalent, as measured by a nationally recognized test; and

(2) not have been enrolled in ESL for more than 24 months while previously participating in MFIP or DWP. A participant who has been enrolled in ESL for 20 or more months may be approved for ESL until the participant has received 24 total months.

(d) Work activities under section 256J.49, subdivision 13, clause (6), shall be allowable only when the training or education program will be completed within the four-month DWP period. Training or education programs that will not be completed within the four-month DWP period shall not be approved.

Subd. 16. **FAILURE TO COMPLY WITH REQUIREMENTS.** A family unit that includes a participant who fails to comply with DWP employment service or child support enforcement requirements, without good cause as defined in sections 256.741 and 256J.57, shall be disqualified from the diversionary work program. The county shall provide written notice as specified in section 256J.31 to the participant prior to disqualifying the family unit due to noncompliance with employment service or child support. The disqualification does not apply to food support or health care benefits.

Subd. 17. **GOOD CAUSE FOR NOT COMPLYING WITH REQUIREMENTS.** A participant who fails to comply with the requirements of the diversionary work program may claim good cause for reasons listed in sections 256.741 and

256J.57, subdivision 1, clauses (1) to (13). The county shall not impose a disqualification if good cause exists.

Subd. 18. **REINSTATEMENT FOLLOWING DISQUALIFICATION.** A participant who has been disqualified from the diversionary work program due to noncompliance with employment services may regain eligibility for the diversionary work program by complying with program requirements. A participant who has been disqualified from the diversionary work program due to noncooperation with child support enforcement requirements may regain eligibility by complying with child support requirements under section 256.741. Once a participant has been reinstated, the county shall issue prorated benefits for the remaining portion of the month. A family unit that has been disqualified from the diversionary work program due to noncompliance shall not be eligible for MFIP or any other TANF cash program during the period of time the participant remains noncompliant. In a two-parent family, both parents must be in compliance before the family unit can regain eligibility for benefits.

Subd. 19. **RECOVERY OF OVERPAYMENTS.** When an overpayment or an ATM error is determined, the overpayment shall be recouped or recovered as specified in section 256J.38.

Subd. 20. **IMPLEMENTATION OF DWP.** Counties may establish a diversionary work program according to this section any time on or after July 1, 2003. Prior to establishing a diversionary work program, the county must notify the commissioner. All counties must implement the provisions of this section no later than July 1, 2004.

Sec. 103. Minnesota Statutes 2002, section 261.063, is amended to read:

261.063 **TAX LEVY FOR SOCIAL SERVICES; BOARD DUTY; PENALTY.**

(a) The board of county commissioners of each county shall annually levy taxes and fix a rate sufficient to produce the full amount required for poor relief, general assistance, Minnesota family investment program, diversionary work program, county share of county and state supplemental aid to supplemental security income applicants or recipients, and any other social security measures wherein there is now or may hereafter be county participation, sufficient to produce the full amount necessary for each such item, including administrative expenses, for the ensuing year, within the time fixed by law in addition to all other tax levies and tax rates, however fixed or determined, and any commissioner who shall fail to comply herewith shall be guilty of a gross misdemeanor and shall be immediately removed from office by the governor. For the purposes of this paragraph, "poor relief" means county services provided under sections 261.035~~, 261.04,~~ and 261.21 to 261.231.

(b) Nothing within the provisions of this section shall be construed as requiring a county agency to provide income support or cash assistance to needy persons when they are no longer eligible for assistance under general assistance, ~~the Minnesota family investment program~~ chapter 256J, or Minnesota supplemental aid.

Sec. 104. Minnesota Statutes 2002, section 393.07, subdivision 10, is amended to read:

Subd. 10. **FEDERAL FOOD STAMP PROGRAM AND THE MATERNAL AND CHILD NUTRITION ACT.** (a) The local social services agency shall establish and administer the food stamp or support program according to rules of the commissioner of human services, the supervision of the commissioner as specified in section 256.01, and all federal laws and regulations. The commissioner of human services shall monitor food stamp or support program delivery on an ongoing basis to ensure that each county complies with federal laws and regulations. Program requirements to be monitored include, but are not limited to, number of applications, number of approvals, number of cases pending, length of time required to process each application and deliver benefits, number of applicants eligible for expedited issuance, length of time required to process and deliver expedited issuance, number of terminations and reasons for terminations, client profiles by age, household composition and income level and sources, and the use of phone certification and home visits. The commissioner shall determine the county-by-county and statewide participation rate.

(b) On July 1 of each year, the commissioner of human services shall determine a statewide and county-by-county food stamp program participation rate. The commissioner may designate a different agency to administer the food stamp program in a county if the agency administering the program fails to increase the food stamp program participation rate among families or eligible individuals, or comply with all federal laws and regulations governing the food stamp program. The commissioner shall review agency performance annually to determine compliance with this paragraph.

(c) A person who commits any of the following acts has violated section 256.98 or 609.821, or both, and is subject to both the criminal and civil penalties provided under those sections:

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willful statement or misrepresentation, or intentional concealment of a material fact, food stamps or vouchers issued according to sections 145.891 to 145.897 to which the person is not entitled or in an amount greater than that to which that person is entitled or which specify nutritional supplements to which that person is not entitled; or

(2) presents or causes to be presented, coupons or vouchers issued according to sections 145.891 to 145.897 for payment or redemption knowing them to have been received, transferred or used in a manner contrary to existing state or federal law; or

(3) willfully uses, possesses, or transfers food stamp coupons, authorization to purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner contrary to existing state or federal law, rules, or regulations; or

(4) buys or sells food stamp coupons, authorization to purchase cards, other assistance transaction devices, vouchers issued according to sections 145.891 to 145.897, or any food obtained through the redemption of vouchers issued according to

sections 145.891 to 145.897 for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps, authorization to purchase cards, or other assistance transaction devices found in the possession of any person who is neither a recipient of the food stamp program nor otherwise authorized to possess and use such materials. Confiscated property shall be disposed of as the commissioner may direct and consistent with state and federal food stamp law. The confiscated property must be retained for a period of not less than 30 days to allow any affected person to appeal the confiscation under section 256.045.

(e) Food stamp overpayment claims which are due in whole or in part to client error shall be established by the county agency for a period of six years from the date of any resultant overpayment.

(f) With regard to the federal tax revenue offset program only, recovery incentives authorized by the federal food and consumer service shall be retained at the rate of 50 percent by the state agency and 50 percent by the certifying county agency.

(g) A peace officer, welfare fraud investigator, federal law enforcement official, or the commissioner of health may confiscate vouchers found in the possession of any person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise authorized to possess and use such vouchers. Confiscated property shall be disposed of as the commissioner of health may direct and consistent with state and federal law. The confiscated property must be retained for a period of not less than 30 days.

(h) The commissioner of human services may seek a waiver from the United States Department of Agriculture 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. The commissioner shall consult with the members of the house of representatives and senate policy committees having jurisdiction over food support issues in developing the waiver. The commissioner, in consultation with the commissioners of health and education, shall develop a broad public health policy related to improved nutrition and health status. The commissioner must seek legislative approval prior to implementing the waiver.

Sec. 105. Laws 1997, chapter 203, article 9, section 21, as amended by Laws 1998, chapter 407, article 6, section 111, Laws 2000, chapter 488, article 10, section 28, and Laws 2001, First Special Session chapter 9, article 10, section 62, is amended to read:

Sec. 21. **INELIGIBILITY FOR STATE FUNDED PROGRAMS.**

~~(a) Effective on the date specified, the following persons~~ Beginning July 1, 2007, legal noncitizens ineligible for federally funded cash or food benefits due to 1996 changes in federal law and subsequent relevant enactments, who are eligible for state-funded MFIP cash or food assistance, will be ineligible for ~~general assistance and general assistance medical care under Minnesota Statutes, chapter 256D, group residential housing under Minnesota Statutes, chapter 256I, and~~ state-funded MFIP

~~assistance~~ under Minnesota Statutes, chapter 256J~~, funded with state money~~:.

~~(1) Beginning July 1, 2002, persons who are terminated from or denied Supplemental Security Income due to the 1996 changes in the federal law making persons whose alcohol or drug addiction is a material factor contributing to the person's disability ineligible for Supplemental Security Income, and are eligible for general assistance under Minnesota Statutes, section 256D.05, subdivision 1, paragraph (a), clause (15), general assistance medical care under Minnesota Statutes, chapter 256D, or group residential housing under Minnesota Statutes, chapter 256I; and~~

~~(2) Beginning July 1, 2002, legal noncitizens who are ineligible for Supplemental Security Income due to the 1996 changes in federal law making certain noncitizens ineligible for these programs due to their noncitizen status; and~~

~~(3) beginning July 1, 2003, legal noncitizens who are eligible for MFIP assistance, either the cash assistance portion or the food assistance portion, funded entirely with state money.~~

~~(b) State money that remains unspent due to changes in federal law enacted after May 12, 1997, that reduce state spending for legal noncitizens or for persons whose alcohol or drug addiction is a material factor contributing to the person's disability, or enacted after February 1, 1998, that reduce state spending for food benefits for legal noncitizens shall not cancel and shall be deposited in the TANF reserve account.~~

Sec. 106. **REVISOR'S INSTRUCTION.**

(a) In the next publication of Minnesota Statutes, the revisor of statutes shall codify section 108 of this act.

(b) Wherever "food stamp" or "food stamps" appears in Minnesota Statutes and Rules, the revisor of statutes shall insert "food support" or "or food support" except for instances where federal code or federal law is referenced.

(c) For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 107. **REPEALER.**

(a) Minnesota Statutes 2002, sections 256J.02, subdivision 3; 256J.08, subdivisions 28 and 70; 256J.24, subdivision 8; 256J.30, subdivision 10; 256J.462; 256J.47; 256J.48; 256J.49, subdivisions 1a, 2, 6, and 7; 256J.50, subdivisions 2, 3, 3a, 5, and 7; 256J.52; 256J.55, subdivision 5; 256J.62, subdivisions 1, 2a, 4, 6, 7, and 8; 256J.625; 256J.655; 256J.74, subdivision 3; 256J.751, subdivisions 3 and 4; 256J.76; and 256K.30, are repealed.

(b) Laws 2000, chapter 488, article 10, section 29, is repealed.

## ARTICLE 2

## LONG-TERM CARE

Section 1. Minnesota Statutes 2002, section 61A.072, subdivision 6, is amended to read:

Subd. 6. **ACCELERATED BENEFITS.** (a) "Accelerated benefits" covered under this section are benefits payable under the life insurance contract:

(1) to a policyholder or certificate holder, during the lifetime of the insured, ~~in anticipation of death~~ upon the occurrence of a specified life-threatening or catastrophic condition as defined by the policy or rider;

(2) that reduce the death benefit otherwise payable under the life insurance contract; and

(3) that are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

(b) "Qualifying event" means one or more of the following:

(1) a medical condition that would result in a drastically limited life span as specified in the contract;

(2) a medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support without which the insured would die; ~~or~~

(3) a condition that requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of the insured's life;

(4) a long-term care illness or physical condition that results in cognitive impairment or the inability to perform the activities of daily life or the substantial and material duties of any occupation; or

(5) other qualifying events that the commissioner approves for a particular filing.

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to policies issued on or after that date.

Sec. 2. Minnesota Statutes 2002, section 62A.315, is amended to read:

62A.315 **EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

(1) coverage for all of the Medicare part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, and the Medicare part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country, and prescription drug expenses, not covered by Medicare;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;

(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) for purposes of this benefit, the following definitions shall apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of ~~$40~~ $100 per visit;

(III) ~~$1,600~~ $4,000 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by ~~family members,~~ unpaid volunteers~~,~~ or providers who are not care providers.

**EFFECTIVE DATE.** This section is effective January 1, 2004, and applies to policies issued on or after that date.

Sec. 3. Minnesota Statutes 2002, section 62A.48, is amended by adding a subdivision to read:

Subd. 12. **REGULATORY FLEXIBILITY.** The commissioner may upon written request issue an order to modify or suspend a specific provision or provisions of sections 62A.46 to 62A.56 with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) the modification or suspension is in the best interest of the insureds;

(2) the purpose to be achieved could not be effectively or efficiently achieved without the modifications or suspension; and

(3)(i) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(ii) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(iii) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

**EFFECTIVE DATE.** This section is effective January 1, 2004, and applies to policies issued on or after that date.

Sec. 4. Minnesota Statutes 2002, section 62A.49, is amended by adding a subdivision to read:

Subd. 3. **PROHIBITED LIMITATIONS.** A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;

(2) requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;

(3) limiting eligible services to services provided by a registered nurse or licensed practical nurse;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;

(5) excluding coverage for personal care services provided by a home health aide;

(6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) requiring that the insured have an acute condition before home health care services are covered;

(8) limiting benefits to services provided by Medicare-certified agencies or providers;

(9) excluding coverage for adult day care services; or

(10) excluding coverage based upon location or type of residence in which the home health care services would be provided.

**EFFECTIVE DATE.** This section is effective January 1, 2004, and applies to policies issued on or after that date.

Sec. 5. Minnesota Statutes 2002, section 62S.22, subdivision 1, is amended to read:

Subdivision 1. **PROHIBITED LIMITATIONS.** A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

(1) requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;

(2) requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;

(3) limiting eligible services to services provided by a registered nurse or licensed practical nurse;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;

(5) excluding coverage for personal care services provided by a home health aide;

(6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) requiring that the insured have an acute condition before home health care services are covered;

(8) limiting benefits to services provided by Medicare-certified agencies or providers; ~~or~~

(9) excluding coverage for adult day care services; or

(10) excluding coverage based upon location or type of residence in which the home health care services would be provided.

**EFFECTIVE DATE.** This section is effective January 1, 2004, and applies to policies issued on or after that date.

Sec. 6. **[62S.34] REGULATORY FLEXIBILITY.**

The commissioner may upon written request issue an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) the modification or suspension is in the best interest of the insureds;

(2) the purpose to be achieved could not be effectively or efficiently achieved without the modifications or suspension; and

(3)(i) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(ii) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(iii) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

**EFFECTIVE DATE.** This section is effective January 1, 2004, and applies to policies issued on or after that date.

Sec. 7. Minnesota Statutes 2002, section 144A.04, subdivision 3, is amended to read:

Subd. 3. **STANDARDS.** (a) The facility must meet the minimum health, sanitation, safety and comfort standards prescribed by the rules of the commissioner of health with respect to the construction, equipment, maintenance and operation of a nursing home. The commissioner of health may temporarily waive compliance with one or more of the standards if the commissioner determines that:

~~(a)~~ (1) temporary noncompliance with the standard will not create an imminent risk of harm to a nursing home resident; and

~~(b)~~ (2) a controlling person on behalf of all other controlling persons:

~~(1)~~ (i) has entered into a contract to obtain the materials or labor necessary to meet the standard set by the commissioner of health, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to meet the standard is due solely to that failure; or

~~(2)~~ (ii) is otherwise making a diligent good faith effort to meet the standard.

The commissioner shall make available to other nursing homes information on facility-specific waivers related to technology or physical plant that are granted. The commissioner shall, upon the request of a facility, extend a waiver granted to a specific facility related to technology or physical plant to the facility making the request, if the commissioner determines that the facility also satisfies clauses (1) and (2) and any other terms and conditions of the waiver.

The commissioner of health shall allow, by rule, a nursing home to provide fewer hours of nursing care to intermediate care residents of a nursing home than required by the present rules of the commissioner if the commissioner determines that the needs of the residents of the home will be adequately met by a lesser amount of nursing care.

(b) A facility is not required to seek a waiver for room furniture or equipment under paragraph (a) when responding to resident-specific requests, if the facility has discussed health and safety concerns with the resident and the resident request and discussion of health and safety concerns are documented in the resident's patient record.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2002, section 144A.04, is amended by adding a subdivision to read:

Subd. 11. **INCONTINENT RESIDENTS.** Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 9. Minnesota Statutes 2002, section 144A.071, subdivision 4c, as added by Laws 2003, chapter 16, section 1, is amended to read:

Subd. 4c. **EXCEPTIONS FOR REPLACEMENT BEDS AFTER JUNE 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet county to be constructed on the site of a new city-owned hospital to replace an existing 85-bed

facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility; and

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis county, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis county that had 235 beds on April 1, 2003. The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Sec. 10. Minnesota Statutes 2002, section 144A.10, is amended by adding a subdivision to read:

Subd. 16. **INDEPENDENT INFORMAL DISPUTE RESOLUTION.** (a) Notwithstanding subdivision 15, a facility certified under the federal Medicare or Medicaid programs may request from the commissioner, in writing, an independent informal dispute resolution process regarding any deficiency citation issued to the facility. The facility must specify in its written request each deficiency citation that it disputes. The commissioner shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility, the parties must submit the issues raised to arbitration by an administrative law judge.

(b) Upon receipt of a written request for an arbitration proceeding, the commissioner shall file with the office of administrative hearings a request for the appointment of an arbitrator and simultaneously serve the facility with notice of the request. The arbitrator for the dispute shall be an administrative law judge appointed by the office of administrative hearings. The disclosure provisions of section 572.10 and the notice provisions of section 572.12 apply. The facility and the commissioner have the right to be represented by an attorney.

(c) The commissioner and the facility may present written evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral statements and arguments may be made by telephone.

(d) Within ten working days of the close of the arbitration proceeding, the administrative law judge shall issue findings regarding each of the deficiencies in dispute. The findings shall be one or more of the following:

(1) Supported in full. The citation is supported in full, with no deletion of findings and no change in the scope or severity assigned to the deficiency citation.

(2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency.

(3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation.

(4) Scope not supported. The citation is amended through a change in the scope assigned to the citation.

(5) Severity not supported. The citation is amended through a change in the severity assigned to the citation.

(6) No deficient practice. The citation is deleted because the findings did not support the citation or the negative resident outcome was unavoidable. The findings of the arbitrator are not binding on the commissioner.

(e) The commissioner shall reimburse the office of administrative hearings for the costs incurred by that office for the arbitration proceeding. The facility shall reimburse the commissioner for the proportion of the costs that represent the sum of deficiency citations supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause (2), divided by the total number of deficiencies disputed. A deficiency citation for which the administrative law judge's sole finding is that the deficient practice was cited under the wrong requirements of participation shall not be counted in the numerator or denominator in the calculation of the proportion of costs.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 11. **[144A.351] BALANCING LONG-TERM CARE: REPORT REQUIRED.**

The commissioners of health and human services, with the cooperation of counties and regional entities, shall prepare a report to the legislature by January 15, 2004, and biennially thereafter, regarding the status of the full range of long-term care services for the elderly in Minnesota. The report shall address:

(1) demographics and need for long-term care in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems regarding long-term care; and

(iii) comparative measures of long-term care availability and progress over time; and

(4) recommendations regarding goals for the future of long-term care services, policy changes, and resource needs.

Sec. 12. Minnesota Statutes 2002, section 144A.4605, subdivision 4, is amended to read:

Subd. 4. **LICENSE REQUIRED.** (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain an assisted living home care license according to this section or a class A or class E license according to rule. A housing with services establishment that obtains a class E license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision ~~5~~ 5f, paragraph ~~(h)~~ (b), and 256B.0915, subdivision ~~3, paragraph (g)~~ 3d.

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.47, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

(c) An adult foster care provider licensed by the department of human services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.

(d) An assisted living home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

Sec. 13. Minnesota Statutes 2002, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **NURSING HOME LICENSE SURCHARGE.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

(f) Between April 1, 2002, and August 15, ~~2003~~ 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431, subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

**EFFECTIVE DATE.** This section is effective June 30, 2003.

Sec. 14. Minnesota Statutes 2002, section 256.9657, is amended by adding a subdivision to read:

Subd. 3a. **ICF/MR LICENSE SURCHARGE.** Effective July 1, 2003, each nonstate-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 15. Minnesota Statutes 2002, section 256.9657, subdivision 4, is amended to read:

Subd. 4. **PAYMENTS INTO THE ACCOUNT.** (a) Payments to the commissioner under subdivisions 1 to 3 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the

annual surcharge divided by 12. Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.

(b) Effective October 1, 1995, and each October 1 thereafter, the payments in subdivisions 2 and 3 must be based on revenues earned in the previous calendar year.

(c) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital and health maintenance organization surcharges, the commissioner of human services may estimate base year revenue and use that estimate for the purposes of this section until actual data is provided by the commissioner of health.

(d) Payments to the commissioner under subdivision 3a must be paid in monthly installments due on the 15th of the month beginning July 15, 2003. The monthly payment must be equal to the annual surcharge divided by 12.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2002, section 256B.056, subdivision 6, is amended to read:

Subd. 6. **ASSIGNMENT OF BENEFITS.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's ~~spouse~~ legal representative from any third ~~person~~ party liable for the costs of medical care ~~for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments.~~ By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by Title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By ~~signing an application for~~ accepting medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. ~~Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to notification of the assignment by the person or organization providing the benefits.~~ For the purposes of this section, "the department of human services or the state" includes prepaid health plans under contract with the commissioner according to sections 256B.031, 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12;

children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Sec. 17. Minnesota Statutes 2002, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **IMPOSITION OF MONETARY RECOVERY AND SANCTIONS.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in ~~paragraph~~ paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except for a nursing home or convalescent care facility, the commissioner may withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner receives reliable evidence of fraud or willful misrepresentation by the vendor.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(3) identify the types of claims to which the withholding applies; and

(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud or willful misrepresentation by the vendor, or after legal proceedings relating to the alleged fraud or willful misrepresentation are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner may suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the

suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination;

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program; and

(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

Sec. 18. Minnesota Statutes 2002, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY FOR SERVICES.** Alternative care services are available to Minnesotans age 65 or older ~~who are not eligible for medical assistance without a spenddown or waiver obligation but~~ who would be eligible for medical assistance within 180 days of admission to a nursing facility and subject to subdivisions 4 to 13.

Sec. 19. Minnesota Statutes 2002, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing

facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs services that are not funded through other state or federal funding; ~~and~~

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the ~~statewide weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities~~ monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph.~~;~~ and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the county to ensure prompt fee payments.

The county shall extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, ~~upon federal approval,~~ alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance ~~or which~~; (ii) is used by a recipient to meet a ~~medical assistance income spenddown or~~ waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process ~~to~~ for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1, in the year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 20. Minnesota Statutes 2002, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **SERVICES COVERED UNDER ALTERNATIVE CARE.** ~~(a)~~ Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) nursing services;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) telehome care ~~devices~~ to ~~monitor recipients~~ provide services in their own homes ~~as an alternative to hospital care, nursing home care, or home~~ in conjunction with in-home visits;

(19) ~~other services which includes~~ discretionary ~~funds and direct cash payments to clients,~~ services, for which counties may make payment from their alternative care program allocation or services not otherwise defined in this section or section 256B.0625, following approval by the commissioner~~, subject to the provisions of paragraph (j). Total annual payments for "other services" for all clients within a county may not exceed 25 percent of that county's annual alternative care program base allocation~~; and

(20) environmental modifications~~.~~; and

(21) direct cash payments for which counties may make payment from their alternative care program allocation to clients for the purpose of purchasing services, following approval by the commissioner, and subject to the provisions of subdivision 5h, until approval and implementation of consumer-directed services through the federally approved elderly waiver plan. Upon implementation, consumer-directed services under the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available.

Total annual payments for discretionary services and direct cash payments, until the federally approved consumer-directed service option is implemented statewide, for

all clients within a county may not exceed 25 percent of that county's annual alternative care program base allocation. Thereafter, discretionary services are limited to 25 percent of the county's annual alternative care program base allocation.

Subd. 5a. **SERVICES; SERVICE DEFINITIONS; SERVICE STANDARDS.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except for transitional support services.

(b) The county agency must ensure that the funds are not used to supplant services available through other public assistance or services programs.

~~(c) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or~~ For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the county when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

~~(d)~~ Subd. 5b. **ADULT FOSTER CARE RATE.** The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care rate shall be negotiated between the county agency and the foster care provider. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

~~(e) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services~~

~~if the county agency ensures supervision of this service by a qualified professional as defined in section 256B.0625, subdivision 19c.~~

~~(f)~~ Subd. 5c. **RESIDENTIAL CARE SERVICES; SUPPORTIVE SERVICES; HEALTH-RELATED SERVICES.** For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments under section 157.16, and are registered with the department of health as providing special services under section 157.17 ~~and are not subject to registration~~ except settings that are currently registered under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means ~~the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate~~ services as defined in section 157.17, subdivision 1, paragraph (a). "Health-related services" ~~are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested~~ means services covered in section 157.17, subdivision 1, paragraph (b). Individuals receiving residential care services cannot receive homemaking services funded under this section.

~~(g)~~ Subd. 5d. **ASSISTED LIVING SERVICES.** For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, ~~and~~ oversight, and supportive services as defined in ~~clause (1)~~ section 157.17, subdivision 1, paragraph (a), individualized home care aide tasks as defined in ~~clause (2)~~ Minnesota Rules, part 4668.0110, and individualized home management tasks as defined in ~~clause (3)~~ Minnesota Rules, part 4668.0120 provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

~~(1) Supportive services include:~~

~~(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;~~

~~(ii) assisting clients in setting up meetings and appointments; and~~

~~(iii) providing transportation, when provided by the residential center only.~~

~~(2) Home care aide tasks means:~~

~~(i) preparing modified diets, such as diabetic or low sodium diets;~~

~~(ii) reminding residents to take regularly scheduled medications or to perform exercises;~~

~~(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;~~

~~(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and~~

~~(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.~~

~~(3) Home management tasks means:~~

~~(i) housekeeping;~~

~~(ii) laundry;~~

~~(iii) preparation of regular snacks and meals; and~~

~~(iv) shopping.~~

Subd. 5e. **FURTHER ASSISTED LIVING REQUIREMENTS.** (a) Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

~~(h)~~ (b) For establishments registered under chapter 144D, assisted living services under this section means either the services described in ~~paragraph (g)~~ subdivision 5d and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

~~(i)~~ Subd. 5f. **PAYMENT RATES FOR ASSISTED LIVING SERVICES AND RESIDENTIAL CARE.** (a) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

~~(1)~~ (b) The individualized monthly negotiated payment for assisted living services as described in ~~paragraph (g)~~ subdivision 5d or ~~(h)~~ 5e, paragraph (b), and residential

care services as described in ~~paragraph (f)~~ subdivision 5c, shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic ~~groups' weighted average monthly nursing facility payment rate of the case mix resident class to which the alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities~~ groups according to subdivision 4, paragraph (a), clause (6).

~~(2)~~ (c) The individualized monthly negotiated payment for assisted living services described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

~~(j)~~ Subd. 5g. **PROVISIONS GOVERNING DIRECT CASH PAYMENTS.** A county agency may make payment from their alternative care program allocation for ~~"other services" which include use of "discretionary funds" for services that are not otherwise defined in this section and~~ direct cash payments to the client for the purpose of purchasing the services. The following provisions apply to payments under this ~~paragraph~~ subdivision:

(1) a cash payment to a client under this provision cannot exceed the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (6); and

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services~~;~~.

~~(3)~~ Subd. 5h. **CASH PAYMENTS TO PERSONS.** (a) Cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

~~(i)~~ (1) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

~~(ii)~~ (2) they must be directly attributable to the person's functional limitations;

~~(iii)~~ (3) they must have the potential to be effective at meeting the goals of the program; and

~~(iv)~~ (4) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant~~; and~~.

~~(v)~~ (b) The person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed~~;~~.

(c) Persons receiving grants under this section shall have the following responsibilities:

(1) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(2) notify the local agency of any necessary changes in the grant expenditures;

(3) arrange and pay for supports; and

(4) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

(d) The county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

~~(4)~~ Subd. 5i. **IMMUNITY.** The state of Minnesota, county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA)~~;~~.

~~(5) persons receiving grants under this section shall have the following responsibilities:~~

~~(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;~~

~~(ii) notify the local agency of any necessary changes in the grant expenditures;~~

~~(iii) arrange and pay for supports; and~~

~~(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and~~

~~(6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.~~

Sec. 21. Minnesota Statutes 2002, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. **ALTERNATIVE CARE PROGRAM ADMINISTRATION.** (a) The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

(b) Alternative care pilot projects operate according to this section and the provisions of Laws 1993, First Special Session chapter 1, article 5, section 133, under agreement with the commissioner. Each pilot project agreement period shall begin no later than the first payment cycle of the state fiscal year and continue through the last payment cycle of the state fiscal year.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 22. Minnesota Statutes 2002, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. **CASE MANAGEMENT.** ~~Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b.~~ The case manager must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). ~~The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the~~

~~individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.~~

Sec. 23. Minnesota Statutes 2002, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **REQUIREMENTS FOR INDIVIDUAL CARE PLAN.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by the lead agency when the lead agency maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

**EFFECTIVE DATE.** This section is effective July 1, 2005.

Sec. 24. Minnesota Statutes 2002, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **ALLOCATION FORMULA.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients. By July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the county's adjusted base allocation, the allocation for the next

fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in paragraphs (c) and (d).

(f) On agreement between the commissioner and the lead agency, the commissioner may have discretion to reallocate alternative care base allocations distributed to lead agencies in which the base amount exceeds program expenditures.

Sec. 25. Minnesota Statutes 2002, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **CLIENT ~~PREMIUMS~~ FEES.** (a) A ~~premium~~ fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the ~~premium~~ fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is ~~greater than the recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but~~ less than ~~150~~ 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the ~~premium~~ fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the ~~premium~~ fee is being computed, and total assets are less than $10,000, the fee is ~~25~~ five percent of the cost of alternative care services ~~or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and~~

(3) when the alternative care client's ~~total assets are greater~~ income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is ~~25~~ 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty

guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services ~~except case management~~ shall be included in the estimated costs for the purpose of determining ~~25 percent of~~ the ~~costs~~ fee.

~~Premiums~~ Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the ~~premium~~ fee, in which case the fee is the lesser amount.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) ~~a person is applying for medical assistance;~~

~~(3)~~ a married couple is requesting an asset assessment under the spousal impoverishment provisions;

~~(4)~~ (3) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

~~(5) a person's fee under paragraph (a) is less than $25~~

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The county agency must record in the state's receivable system the client's assessed ~~premium~~ fee amount or the reason the ~~premium~~ fee has been waived. The commissioner will bill and collect the ~~premium~~ fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the ~~premium~~ fee from the client. The commissioner shall collect unpaid ~~premiums~~ fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a ~~premium~~ fee is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a

county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total ~~premiums~~ fees billed to clients;

(2) total collections of ~~premiums~~ fees billed; and

(3) balance of ~~premiums~~ fees owed by clients.

If a county does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the county involved to operate under the procedures set forth in this paragraph.

Sec. 26. Minnesota Statutes 2002, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. **LIMITS OF CASES, ~~RATES, PAYMENTS, AND FORECASTING.~~** ~~(a)~~ The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

~~(b)~~ Subd. 3a. **ELDERLY WAIVER COST LIMITS.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

~~(c)~~ (b) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph ~~(b)~~ (a), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph ~~(b)~~ (a).

~~(d)~~ Subd. 3b. **COST LIMITS FOR ELDERLY WAIVER APPLICANTS WHO RESIDE IN A NURSING FACILITY.** (a) For a person who is a nursing

facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate may be adjusted by the greater of any subsequent legislatively adopted home and community-based services cost-of-living percentage increase or any subsequent legislatively adopted statewide percentage rate increase for nursing facilities. The limit under this ~~clause~~ subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

~~(e)~~ Subd. 3c. **SERVICE APPROVAL AND CONTRACTING PROVISIONS.** (a) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

~~(f)~~ (b) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

~~(g)~~ Subd. 3d. **ADULT FOSTER CARE RATE.** The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph ~~(b)~~ (a).

~~(h)~~ Subd. 3e. **ASSISTED LIVING SERVICE RATE.** (a) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

~~(1)~~ (b) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, ~~subdivision 5, paragraph (g) or (h)~~ subdivisions 5d to 5f, and residential care services as described in section 256B.0913, subdivision ~~5, paragraph (f)~~ 5c, shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

~~(2)~~ (c) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in ~~paragraph (b)~~ subdivision 3a.

~~(i)~~ Subd. 3f. **INDIVIDUAL SERVICE RATES; EXPENDITURE FORECASTS.** (a) The county shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the county's current approved rate. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

~~(j)~~ (b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

~~(k)~~ Subd. 3g. **SERVICE RATE LIMITS; STATE ASSUMPTION OF COSTS.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall

establish statewide maximum service rate limits and eliminate county-specific service rate limits.

~~(1)~~ (b) Effective July 1, 2001, for service rate limits, except those described or defined in ~~paragraphs (g) and (h)~~ subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

~~(2)~~ (c) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 27. Minnesota Statutes 2002, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D~~, but does not include the alternative care program for nonmedical assistance recipients under section 256B.0913, subdivision~~ 4 and alternative care for nonmedical assistance recipients under section 256B.0913.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for decedents dying on or after that date.

Sec. 28. Minnesota Statutes 2002, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **ESTATES SUBJECT TO CLAIMS.** If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over 55 years of age, and received services under this chapter~~, excluding alternative care~~;

(b) the person resided in a medical institution for six months or longer, received services under this chapter ~~excluding alternative care~~, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

(c) the person received general assistance medical care services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

**EFFECTIVE DATE.** The amendments in this section relating to the alternative care program are effective July 1, 2003, and apply to the estates of decedents who die on or after that date. The remaining amendments in this section are effective August 1, 2003, and apply to the estates of decedents who die on and after that date.

Sec. 29. Minnesota Statutes 2002, section 256B.15, subdivision 2, is amended to read:

Subd. 2. **LIMITATIONS ON CLAIMS.** The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for decedents dying on or after that date.

Sec. 30. Minnesota Statutes 2002, section 256B.431, subdivision 2r, is amended to read:

Subd. 2r. **PAYMENT RESTRICTIONS ON LEAVE DAYS.** Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident. For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the commissioner shall limit payment for leave days in a nursing facility to 60 percent of that nursing facility's total payment rate for the involved resident.

Sec. 31. Minnesota Statutes 2002, section 256B.431, is amended by adding a subdivision to read:

Subd. 2t. **PAYMENT LIMITATION.** For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the Medicaid RUG-III case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III case-mix payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Sec. 32. Minnesota Statutes 2002, section 256B.431, subdivision 32, is amended to read:

Subd. 32. **PAYMENT DURING FIRST 90 DAYS.** (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 paid days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class; ~~and~~

(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class.~~,~~;

~~(b)~~ (3) beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section.~~,~~; and

~~(c)~~ (4) payments under this ~~subdivision applies~~ paragraph apply to admissions occurring on or after July 1, 2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.

(b) For rate years beginning on or after July 1, 2003, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section shall be:

(1) for the first 30 calendar days after admission, the rate shall be 120 percent of the facility's medical assistance rate for each RUG class;

(2) beginning with the 31st calendar day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(3) payments under this paragraph apply to admissions occurring on or after July 1, 2003.

(c) Effective January 1, 2004, the enhanced rates under this subdivision shall not be allowed if a resident has resided during the previous 30 calendar days in:

(1) the same nursing facility;

(2) a nursing facility owned or operated by a related party; or

(3) a nursing facility or part of a facility that closed.

Sec. 33. Minnesota Statutes 2002, section 256B.431, subdivision 36, is amended to read:

Subd. 36. **EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A facility receiving a rate adjustment under this subdivision may submit to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner a calculation of the scholarship per diem, including: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the per diem amount of these costs based on actual resident days.

(c) On July 1, 2003, the commissioner shall remove the 25 cent scholarship per diem from the total operating payment rate of each facility.

(d) For rate years beginning after June 30, 2003, the commissioner shall provide to each facility the scholarship per diem determined in paragraph (b). In calculating the per diem under paragraph (b), the commissioner shall allow only costs related to tuition and direct educational expenses.

Sec. 34. Minnesota Statutes 2002, section 256B.431, is amended by adding a subdivision to read:

Subd. 38. **NURSING HOME RATE INCREASES EFFECTIVE IN FISCAL YEAR 2003.** Effective June 1, 2003, the commissioner shall provide to each nursing home reimbursed under this section or section 256B.434, an increase in each case mix payment rate equal to the increase in the per-bed surcharge paid under section 256.9657, subdivision 1, paragraph (d), divided by 365 and further divided by .90. The increase shall not be subject to any annual percentage increase. The 30-day advance notice requirement in section 256B.47, subdivision 2, shall not apply to rate increases

resulting from this section. The commissioner shall not adjust the rate increase under this subdivision unless the adjustment is greater than 1.5 percent of the monthly surcharge payment amount under section 256.9657, subdivision 4.

**EFFECTIVE DATE.** This section is effective May 31, 2003.

Sec. 35. Minnesota Statutes 2002, section 256B.431, is amended by adding a subdivision to read:

Subd. 39. **FACILITY RATES BEGINNING ON OR AFTER JULY 1, 2003.** For rate years beginning on or after July 1, 2003, nursing facilities reimbursed under this section shall have their July 1 operating payment rate be equal to their operating payment rate in effect on the prior June 30th.

Sec. 36. Minnesota Statutes 2002, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **ALTERNATE RATES FOR NURSING FACILITIES.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in health department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by ~~Data Resources, Inc.~~ the commissioner of finance's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, ~~and~~ July 1, 2002, July 1, 2003, and July 1, 2004, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in health department licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels

of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 37. Minnesota Statutes 2002, section 256B.434, subdivision 10, is amended to read:

Subd. 10. **EXEMPTIONS.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an

exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

(e) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

(f) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 38. Minnesota Statutes 2002, section 256B.5012, is amended by adding a subdivision to read:

Subd. 5. **RATE INCREASE EFFECTIVE JUNE 1, 2003.** For rate periods beginning on or after June 1, 2003, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $3 per day. The increase shall not be subject to any annual percentage increase.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 39. Minnesota Statutes 2002, section 256B.76, is amended to read:

256B.76 **PHYSICIAN AND DENTAL REIMBURSEMENT.**

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk,

shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may, within the limits of available appropriation, increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) ~~Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates:~~

~~(1)~~ a Medicare-certified ~~comprehensive outpatient rehabilitation facility;~~ and

~~(2)~~ a facility ~~that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.~~

~~(e)~~ An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 40. Minnesota Statutes 2002, section 256B.761, is amended to read:

256B.761 **REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

Sec. 41. Minnesota Statutes 2002, section 256D.03, subdivision 3a, is amended to read:

Subd. 3a. **CLAIMS; ASSIGNMENT OF BENEFITS.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By ~~signing an application for~~ accepting general assistance, a person assigns to the department of human services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect. ~~The assignment shall not affect benefits paid or provided under automobile accident coverage and private health care coverage until the person or organization providing the benefits has received notice of the assignment.~~

Sec. 42. Minnesota Statutes 2002, section 256I.02, is amended to read:

256I.02 **PURPOSE.**

The Group Residential Housing Act establishes a comprehensive system of rates and payments for persons who reside in ~~a group residence~~ the community and who meet the eligibility criteria under section 256I.04, subdivision 1.

Sec. 43. Minnesota Statutes 2002, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **MORATORIUM ON THE DEVELOPMENT OF GROUP RESIDENTIAL HOUSING BEDS.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except: (1) ~~for group residential housing establishments meeting the requirements of subdivision 2a, clause (2) with department approval;~~ (2) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with mental retardation or related conditions at regional treatment centers; ~~(3)~~ (2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with mental retardation or related conditions or mental illness; ~~(4)~~ (3) up to 80 beds in a single, specialized facility located in Hennepin county that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the housing finance agency under section 462A.05, subdivision 20a, paragraph (b); ~~(5)~~ (4) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey county for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this

section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a; or (6) for group residential housing beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving home and community-based waiver services under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six months immediately prior to the month of entry into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus $426.37 for any case.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

Sec. 44. Minnesota Statutes 2002, section 256I.05, subdivision 1, is amended to read:

Subdivision 1. **MAXIMUM RATES.** ~~(a)~~ Monthly room and board rates negotiated by a county agency for a recipient living in group residential housing must not exceed the MSA equivalent rate specified under section 256I.03, subdivision 5~~,~~. ~~with the exception that a county agency may negotiate a supplementary room and board rate that exceeds the MSA equivalent rate for recipients of waiver services under title XIX of the Social Security Act. This exception is subject to the following conditions:~~

~~(1) the setting is licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265;~~

~~(2) the setting is not the primary residence of the license holder and in which the license holder is not the primary caregiver; and~~

~~(3) the average supplementary room and board rate in a county for a calendar year may not exceed the average supplementary room and board rate for that county in effect on January 1, 2000. For calendar years beginning on or after January 1, 2002, within the limits of appropriations specifically for this purpose, the commissioner shall increase each county's supplemental room and board rate average on an annual basis by a factor consisting of the percentage change in the Consumer Price Index-All items, United States city average (CPI-U) for that calendar year compared to the preceding calendar year as forecasted by Data Resources, Inc., in the third quarter of the preceding calendar year. If a county has not negotiated supplementary room and board rates for any facilities located in the county as of January 1, 2000, or has an average supplemental room and board rate under $100 per person as of January 1, 2000, it may submit a supplementary room and board rate request with budget information for a facility to the commissioner for approval.~~

~~The county agency may at any time negotiate a higher or lower room and board rate than the average supplementary room and board rate.~~

~~(b) Notwithstanding paragraph (a), clause (3), county agencies may negotiate a supplementary room and board rate that exceeds the MSA equivalent rate by up to $426.37 for up to five facilities, serving not more than 20 individuals in total, that were established to replace an intermediate care facility for persons with mental retardation and related conditions located in the city of Roseau that became uninhabitable due to flood damage in June 2002.~~

**EFFECTIVE DATE.** This section is effective July 1, 2004, or upon receipt of federal approval of waiver amendment, whichever is later.

Sec. 45. Minnesota Statutes 2002, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **SUPPLEMENTARY SERVICE RATES.** (a) Subject to the provisions of section 256I.04, subdivision 3, ~~in addition to the room and board rate specified in subdivision 1,~~ the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the department of health, or licensed by

the department of human services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0627, subdivision 4, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0627, subdivision 4, then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate ~~plus the supplementary room and board rate~~ exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the GRH fund to county human service agencies for beds permanently removed from the GRH census under a plan submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) The provisions of paragraph (b) do not apply to a facility that has its reimbursement rate established under section 256B.431, subdivision 4, paragraph (c).

Sec. 46. Minnesota Statutes 2002, section 256I.05, subdivision 7c, is amended to read:

Subd. 7c. **DEMONSTRATION PROJECT.** The commissioner is authorized to pursue a demonstration project under federal food stamp regulation for the purpose of gaining federal reimbursement of food and nutritional costs currently paid by the state group residential housing program. The commissioner shall seek approval no later than January 1, 2004. Any reimbursement received is nondedicated revenue to the general fund.

Sec. 47. **[514.991] ALTERNATIVE CARE LIENS; DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** The definitions in this section apply to sections 514.991 to 514.995.

Subd. 2. **ALTERNATIVE CARE AGENCY, AGENCY, OR DEPARTMENT.** "Alternative care agency," "agency," or "department" means the department of human services when it pays for or provides alternative care benefits for a nonmedical assistance recipient directly or through a county social services agency under chapter 256B according to section 256B.0913.

Subd. 3. **ALTERNATIVE CARE BENEFIT OR BENEFITS.** "Alternative care benefit" or "benefits" means a benefit provided to a nonmedical assistance recipient under chapter 256B according to section 256B.0913.

Subd. 4. **ALTERNATIVE CARE RECIPIENT OR RECIPIENT.** "Alternative care recipient" or "recipient" means a person who receives alternative care grant benefits.

Subd. 5. **ALTERNATIVE CARE LIEN OR LIEN.** "Alternative care lien" or "lien" means a lien filed under sections 514.992 to 514.995.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for services 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 in the alternative care program prior to July 1, 2003.

Sec. 48. **[514.992] ALTERNATIVE CARE LIEN.**

Subdivision 1. **PROPERTY SUBJECT TO LIEN; LIEN AMOUNT.** (a) Subject to sections 514.991 to 514.995, payments made by an alternative care agency to provide benefits to a recipient or to the recipient's spouse who owns property in this state constitute a lien in favor of the agency on all real property the recipient owns at and after the time the benefits are first paid.

(b) The amount of the lien is limited to benefits paid for services provided to recipients over 55 years of age and provided on and after July 1, 2003.

Subd. 2. **ATTACHMENT.** (a) A lien attaches to and becomes enforceable against specific real property as of the date when all of the following conditions are met:

(1) the agency has paid benefits for a recipient;

(2) the recipient has been given notice and an opportunity for a hearing under paragraph (b);

(3) the lien has been filed as provided for in section 514.993 or memorialized on the certificate of title for the property it describes; and

(4) all restrictions against enforcement have ceased to apply.

(b) An agency may not file a lien until it has sent the recipient, their authorized representative, or their legal representative written notice of its lien rights by certified mail, return receipt requested, or registered mail and there has been an opportunity for a hearing under section 256.045. No person other than the recipient shall have a right to a hearing under section 256.045 prior to the time the lien is filed. The hearing shall

be limited to whether the agency has met all of the prerequisites for filing the lien and whether any of the exceptions in this section apply.

(c) An agency may not file a lien against the recipient's homestead when any of the following exceptions apply:

(1) while the recipient's spouse is also physically present and lawfully and continuously residing in the homestead;

(2) a child of the recipient who is under age 21 or who is blind or totally and permanently disabled according to supplemental security income criteria is also physically present on the property and lawfully and continuously residing on the property from and after the date the recipient first receives benefits;

(3) a child of the recipient who has also lawfully and continuously resided on the property for a period beginning at least two years before the first day of the month in which the recipient began receiving alternative care, and who provided uncompensated care to the recipient which enabled the recipient to live without alternative care services for the two-year period;

(4) a sibling of the recipient who has an ownership interest in the property of record in the office of the county recorder or registrar of titles for the county in which the real property is located and who has also continuously occupied the homestead for a period of at least one year immediately prior to the first day of the first month in which the recipient received benefits and continuously since that date.

(d) A lien only applies to the real property it describes.

Subd. 3. **CONTINUATION OF LIEN.** A lien remains effective from the time it is filed until it is paid, satisfied, discharged, or becomes unenforceable under sections 514.991 to 514.995.

Subd. 4. **PRIORITY OF LIEN.** (a) A lien which attaches to the real property it describes is subject to the rights of anyone else whose interest in the real property is perfected of record before the lien has been recorded or filed under section 514.993, including:

(1) an owner, other than the recipient or the recipient's spouse;

(2) a good faith purchaser for value without notice of the lien;

(3) a holder of a mortgage or security interest; or

(4) a judgment lien creditor whose judgment lien has attached to the recipient's interest in the real property.

(b) The rights of the other person have the same protections against an alternative care lien as are afforded against a judgment lien that arises out of an unsecured obligation and arises as of the time of the filing of an alternative care grant lien under section 514.993. The lien shall be inferior to a lien for property taxes and special

assessments and shall be superior to all other matters first appearing of record after the time and date the lien is filed or recorded.

Subd. 5. **SETTLEMENT, SUBORDINATION, AND RELEASE.** (a) An agency may, with absolute discretion, settle or subordinate the lien to any other lien or encumbrance of record upon the terms and conditions it deems appropriate.

(b) The agency filing the lien shall release and discharge the lien:

(1) if it has been paid, discharged, or satisfied;

(2) if it has received reimbursement for the amounts secured by the lien, has entered into a binding and legally enforceable agreement under which it is reimbursed for the amount of the lien, or receives other collateral sufficient to secure payment of the lien;

(3) against some, but not all, of the property it describes upon the terms, conditions, and circumstances the agency deems appropriate;

(4) to the extent it cannot be lawfully enforced against the property it describes because of an error, omission, or other material defect in the legal description contained in the lien or a necessary prerequisite to enforcement of the lien; and

(5) if, in its discretion, it determines the filing or enforcement of the lien is contrary to the public interest.

(c) The agency executing the lien shall execute and file the release as provided for in section 514.993, subdivision 2.

Subd. 6. **LENGTH OF LIEN.** (a) A lien shall be a lien on the real property it describes for a period of ten years from the date it attaches according to subdivision 2, paragraph (a), except as otherwise provided for in sections 514.992 to 514.995. The agency filing the lien may renew the lien for one additional ten-year period from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate of renewal shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The recorder or registrar of titles shall record, file, index, and return the certificate of renewal in the same manner provided for liens in section 514.993, subdivision 2.

(b) An alternative care lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the lien in whole or in part because of the homestead exemption under section 256B.15, subdivision 4, the rights of a surviving spouse or a minor child under section 524.2-403, paragraphs (a) and (b), or claims with a priority under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult children to exempt property under section 524.2-403, paragraph

(b), shall not be considered costs of administration under section 524.3-805, paragraph (a), clause (1).

**EFFECTIVE DATE.** This section is effective July 1, 2003, for services 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 in the alternative care program prior to July 1, 2003.

Sec. 49. **[514.993] LIEN; CONTENTS AND FILING.**

Subdivision 1. **CONTENTS.** A lien shall be dated and must contain:

(1) the recipient's full name, last known address, and social security number;

(2) a statement that benefits have been paid to or for the recipient's benefit;

(3) a statement that all of the recipient's interests in the real property described in the lien may be subject to or affected by the agency's right to reimbursement for benefits;

(4) a legal description of the real property subject to the lien and whether it is registered or abstract property; and

(5) such other contents, if any, as the agency deems appropriate.

Subd. 2. **FILING.** Any lien, release, or other document required or permitted to be filed under sections 514.991 to 514.995 must be recorded or filed in the office of the county recorder or registrar of titles, as appropriate, in the county where the real property is located. Notwithstanding section 386.77, the agency shall pay the applicable filing fee for any documents filed under sections 514.991 to 514.995. An attestation, certification, or acknowledgment is not required as a condition of filing. If the property described in the lien is registered property, the registrar of titles shall record it on the certificate of title for each parcel of property described in the lien. If the property described in the lien is abstract property, the recorder shall file the lien in the county's grantor-grantee indexes and any tract indexes the county maintains for each parcel of property described in the lien. The recorder or registrar shall return the recorded or filed lien to the agency at no cost. If the agency provides a duplicate copy of the lien, the recorder or registrar of titles shall show the recording or filing data on the copy and return it to the agency at no cost. The agency is responsible for filing any lien, release, or other documents under sections 514.991 to 514.995.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for services 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 in the alternative care program prior to July 1, 2003.

Sec. 50. **[514.994] ENFORCEMENT; OTHER REMEDIES.**

Subdivision 1. **FORECLOSURE OR ENFORCEMENT OF LIEN.** The agency may enforce or foreclose a lien filed under sections 514.991 to 514.995 in the manner provided for by law for enforcement of judgment liens against real estate or by

a foreclosure by action under chapter 581. The lien shall remain enforceable as provided for in sections 514.991 to 514.995 notwithstanding any laws limiting the enforceability of judgments.

Subd. 2. **HOMESTEAD EXEMPTION.** The lien may not be enforced against the homestead property of the recipient or the spouse while they physically occupy it as their lawful residence.

Subd. 3. **AGENCY CLAIM OR REMEDY.** Sections 514.992 to 514.995 do not limit the agency's right to file a claim against the recipient's estate or the estate of the recipient's spouse, do not limit any other claims for reimbursement the agency may have, and do not limit the availability of any other remedy to the agency.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for services 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 in the alternative care program prior to July 1, 2003.

Sec. 51. **[514.995] AMOUNTS RECEIVED TO SATISFY LIEN.**

Amounts the agency receives to satisfy the lien must be deposited in the state treasury and credited to the fund from which the benefits were paid.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for services 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 in the alternative care program prior to July 1, 2003.

Sec. 52. Minnesota Statutes 2002, section 524.3-805, is amended to read:

524.3-805 **CLASSIFICATION OF CLAIMS.**

(a) If the applicable assets of the estate are insufficient to pay all claims in full, the personal representative shall make payment in the following order:

(1) costs and expenses of administration;

(2) reasonable funeral expenses;

(3) debts and taxes with preference under federal law;

(4) reasonable and necessary medical, hospital, or nursing home expenses of the last illness of the decedent, including compensation of persons attending the decedent, a claim filed under section 256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913, and including a claim filed pursuant to section 256B.15;

(5) reasonable and necessary medical, hospital, and nursing home expenses for the care of the decedent during the year immediately preceding death;

(6) debts with preference under other laws of this state, and state taxes;

(7) all other claims.

(b) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due and payable shall not be entitled to a preference over claims not due, except that if claims for expenses of the last illness involve only claims filed under section 256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913, section 246.53 for costs of state hospital care and claims filed under section 256B.15, claims filed to recover expenditures for alternative care for nonmedical assistance recipients under section 256B.0913 shall have preference over claims filed under both sections 246.53 and other claims filed under section 256B.15, and claims filed under section 246.53 have preference over claims filed under section 256B.15 for recovery of amounts other than those for expenditures for alternative care for nonmedical assistance recipients under section 256B.0913.

**EFFECTIVE DATE.** This section is effective July 1, 2003, for decedents dying on or after that date.

Sec. 53. **IMPOSITION OF FEDERAL CERTIFICATION REMEDIES.**

The commissioner of health shall seek changes in the federal policy that mandates the imposition of federal sanctions without providing an opportunity for a nursing facility to correct deficiencies, solely as the result of previous deficiencies issued to the nursing facility.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 54. **REPORT ON LONG-TERM CARE.**

The report on long-term care services required under Minnesota Statutes, section 144A.351, that is presented to the legislature by January 15, 2004, must also address the feasibility of offering government or private sector loans or lines of credit to individuals age 65 and over, for the purchase of long-term care services.

Sec. 55. **REPORTS; POTENTIAL SAVINGS TO STATE FROM CERTAIN LONG-TERM CARE INSURANCE PURCHASE INCENTIVES.**

The commissioner of human services shall report to the legislature by January 15, 2005, on long-term care financing reform. The report must include a new mix of public and private approaches to the financing of long-term care. The report shall examine strategies and financing options that will increase the availability and use of nongovernment resources to pay for long-term care, including new ways of using limited government funds for long-term care. The report shall examine the feasibility of:

(1) initiating a long-term care insurance partnership program, similar to those adopted in other states, under which the state would encourage the purchase of private long-term care insurance by permitting the insured to retain assets in excess of those otherwise permitted for medical assistance eligibility, if the insured later exhausts the private long-term care insurance benefits. The report must include the feasibility of obtaining any necessary federal waiver;

(2) using state medical assistance funds to subsidize the purchase of private long-term care insurance by individuals who would be unlikely to purchase it without a subsidy, in order to generate long-term medical assistance savings; and

(3) adding a nursing facility benefit to Medicare-related coverage, as defined in Minnesota Statutes, section 62Q.01, subdivision 6. The report must quantify the costs or savings resulting from adding a nursing facility benefit.

The report must comply with Minnesota Statutes, sections 3.195 and 3.197.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 56. **REVISOR'S INSTRUCTION.**

For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 57. **REPEALER.**

(a) Minnesota Statutes 2002, sections 256.973; 256.9772; and 256B.437, subdivision 2, are repealed effective July 1, 2003.

(b) Minnesota Statutes 2002, sections 62J.66; 62J.68; 144A.071, subdivision 5; and 144A.35, are repealed.

(c) Laws 1998, chapter 407, article 4, section 63, is repealed.

(d) Minnesota Rules, parts 9505.3045; 9505.3050; 9505.3055; 9505.3060; 9505.3068; 9505.3070; 9505.3075; 9505.3080; 9505.3090; 9505.3095; 9505.3100; 9505.3105; 9505.3107; 9505.3110; 9505.3115; 9505.3120; 9505.3125; 9505.3130; 9505.3138; 9505.3139; 9505.3140; 9505.3680; 9505.3690; and 9505.3700, are repealed effective July 1, 2003.

(e) Laws 2003, chapter 55, sections 1 and 4, are repealed effective the day following final enactment.

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## ARTICLE 3

## CONTINUING CARE FOR PERSONS WITH DISABILITIES

Section 1. Minnesota Statutes 2002, section 174.30, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY.** (a) The operating standards for special transportation service adopted under this section do not apply to special transportation provided by:

(1) a common carrier operating on fixed routes and schedules;

(2) a volunteer driver using a private automobile;

(3) a school bus as defined in section 169.01, subdivision 6; or

(4) an emergency ambulance regulated under chapter 144.

(b) The operating standards adopted under this section only apply to providers of special transportation service who receive grants or other financial assistance from either the state or the federal government, or both, to provide or assist in providing that service; except that the operating standards adopted under this section do not apply to any nursing home licensed under section 144A.02, to any board and care facility licensed under section 144.50, or to any day training and habilitation services, day care, or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or program provides transportation to nonresidents on a regular basis and the facility receives reimbursement, other than per diem payments, for that service under rules promulgated by the commissioner of human services.

(c) Notwithstanding paragraph (b), the operating standards adopted under this section do not apply to any vendor of services licensed under chapter 245B that provides transportation services to consumers or residents of other vendors licensed under chapter 245B and transports 15 or fewer persons, including consumers or residents and the driver.

Sec. 2. Minnesota Statutes 2002, section 245B.06, subdivision 8, is amended to read:

Subd. 8. **LEAVING THE RESIDENCE.** ~~As specified in each consumer's individual service plan,~~ Each consumer requiring a 24-hour plan of care ~~must leave the residence to participate in regular education, employment, or community activities~~ shall receive services during the day outside the residence unless otherwise specified in the individual's service plan. License holders, providing services to consumers living in a licensed site, shall ensure that they are prepared to care for consumers whenever they are at the residence during the day because of illness, work schedules, or other reasons.

Sec. 3. Minnesota Statutes 2002, section 245B.07, subdivision 11, is amended to read:

Subd. 11. **TRAVEL TIME TO AND FROM A DAY TRAINING AND HABILITATION SITE.** Except in unusual circumstances, the license holder must not transport a consumer receiving services for longer than ~~one hour~~ 90 minutes per one-way trip. Nothing in this subdivision relieves the provider of the obligation to provide the number of program hours as identified in the individualized service plan.

Sec. 4. Minnesota Statutes 2002, section 246.54, is amended to read:

246.54 **LIABILITY OF COUNTY; REIMBURSEMENT.**

Subdivision 1. **COUNTY PORTION FOR COST OF CARE.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal ~~ten~~ 20 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility. If payments received by the state under sections 246.50 to 246.53 exceed ~~90~~ 80 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. No such payments shall be made for any client who was last committed prior to July 1, 1947.

Subd. 2. **EXCEPTIONS.** Subdivision 1 does not apply to services provided at the Minnesota security hospital, the Minnesota sex offender program, or the Minnesota extended treatment options program. For services at these facilities, a county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal ten percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. If payments received by the state under sections 246.50 to 246.53 exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 5. Minnesota Statutes 2002, section 252.32, subdivision 1, is amended to read:

Subdivision 1. **PROGRAM ESTABLISHED.** In accordance with state policy established in section 256F.01 that all children are entitled to live in families that offer safe, nurturing, permanent relationships, and that public services be directed toward preventing the unnecessary separation of children from their families, and because many families who have children with ~~mental retardation or related conditions~~ disabilities have special needs and expenses that other families do not have, the commissioner of human services shall establish a program to assist families who have ~~dependents~~ dependent children with ~~mental retardation or related conditions~~ disabilities living in their home. The program shall make support grants available to the families.

Sec. 6. Minnesota Statutes 2002, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **SUPPORT GRANTS.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of ~~22 and who~~

~~have mental retardation or who have a related condition~~ 21 and who have been ~~determined by a screening team established~~ certified disabled under section ~~256B.092 to be at risk of institutionalization~~ 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving home and community-based waivered services for persons with mental retardation or related conditions are not eligible for support grants.

~~Families receiving grants who will be receiving home and community-based waiver services for persons with mental retardation or a related condition for their family member within the grant year, and who have ongoing payments for environmental or vehicle modifications which have been approved by the county as a grant expense and would have qualified for payment under this waiver may receive a onetime grant payment from the commissioner to reduce or eliminate the principal of the remaining debt for the modifications, not to exceed the maximum amount allowable for the remaining years of eligibility for a family support grant. The commissioner is authorized to use up to $20,000 annually from the grant appropriation for this purpose. Any amount unexpended at the end of the grant year shall be allocated by the commissioner in accordance with subdivision 3a, paragraph (b), clause (2).~~ Families whose annual adjusted gross income is $60,000 or more are not eligible for support grants except in cases where extreme hardship is demonstrated. Beginning in state fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics consumer price index (all urban) for that year.

(b) Support grants may be made available as monthly subsidy grants and lump sum grants.

(c) Support grants may be issued in the form of cash, voucher, and direct county payment to a vendor.

(d) Applications for the support grant shall be made by the legal guardian to the county social service agency. The application shall specify the needs of the families, the form of the grant requested by the families, and ~~that~~ the ~~families have agreed to use the support grant for~~ items and services ~~within the designated reimbursable expense categories and recommendations of the county~~ to be reimbursed.

~~(e) Families who were receiving subsidies on the date of implementation of the $60,000 income limit in paragraph (a) continue to be eligible for a family support grant until December 31, 1991, if all other eligibility criteria are met. After December 31, 1991, these families are eligible for a grant in the amount of one-half the grant they would otherwise receive, for as long as they remain eligible under other eligibility criteria.~~

Sec. 7. Minnesota Statutes 2002, section 252.32, subdivision 3, is amended to read:

Subd. 3. **AMOUNT OF SUPPORT GRANT; USE.** Support grant amounts shall be determined by the county social service agency. ~~Each service~~ Services and ~~item~~

items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

The design and delivery of services and items purchased under this section must suit the dependent's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of the disabled child;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

The maximum monthly grant amount shall be $250 per eligible dependent, or $3,000 per eligible dependent per state fiscal year, within the limits of available funds. The county social service agency may consider the dependent's supplemental security income in determining the amount of the support grant. ~~The county social service agency may exceed $3,000 per state fiscal year per eligible dependent for emergency circumstances in cases where exceptional resources of the family are required to meet the health, welfare-safety needs of the child.~~

~~County social service agencies shall continue to provide funds to families receiving state grants on June 30, 1997, if eligibility criteria continue to be met.~~ Any adjustments to their monthly grant amount must be based on the needs of the family and funding availability.

Sec. 8. Minnesota Statutes 2002, section 252.32, subdivision 3c, is amended to read:

Subd. 3c. **COUNTY BOARD RESPONSIBILITIES.** County boards receiving funds under this section shall:

(1) ~~determine the needs of families for services in accordance with section 256B.092 or 256E.08 and any rules adopted under those sections;~~ submit a plan to the department for the management of the family support grant program. The plan must

include the projected number of families the county will serve and policies and procedures for:

(i) identifying potential families for the program;

(ii) grant distribution;

(iii) waiting list procedures; and

(iv) prioritization of families to receive grants;

(2) determine the eligibility of all persons proposed for program participation;

(3) approve a plan for items and services to be reimbursed and inform families of the county's approval decision;

(4) issue support grants directly to, or on behalf of, eligible families;

(5) inform recipients of their right to appeal under subdivision 3e;

(6) submit quarterly financial reports under subdivision 3b and indicate ~~on the screening documents~~ the annual grant level for each family, the families denied grants, and the families eligible but waiting for funding; and

(7) coordinate services with other programs offered by the county.

Sec. 9. Minnesota Statutes 2002, section 252.41, subdivision 3, is amended to read:

Subd. 3. **DAY TRAINING AND HABILITATION SERVICES FOR ADULTS WITH MENTAL RETARDATION, RELATED CONDITIONS.** "Day training and habilitation services for adults with mental retardation and related conditions" means services that:

(1) include supervision, training, assistance, and supported employment, work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; and

(2) are provided under contract with the county where the services are delivered by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services; ~~and~~

~~(3) are regularly provided to one or more adults with mental retardation or related conditions in a place other than the adult's own home or residence unless medically contraindicated.~~

Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Handicapped Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

Sec. 10. Minnesota Statutes 2002, section 252.46, subdivision 1, is amended to read:

Subdivision 1. **RATES.** (a) Payment rates to vendors, except regional centers, for county-funded day training and habilitation services and transportation provided to persons receiving day training and habilitation services established by a county board are governed by subdivisions 2 to 19. The commissioner shall approve the following three payment rates for services provided by a vendor:

(1) a full-day service rate for persons who receive at least six service hours a day, including the time it takes to transport the person to and from the service site;

(2) a partial-day service rate that must not exceed 75 percent of the full-day service rate for persons who receive less than a full day of service; and

(3) a transportation rate for providing, or arranging and paying for, transportation of a person to and from the person's residence to the service site.

~~(b) The commissioner may also approve an hourly job coach, follow-along rate for services provided by one employee at or en route to or from community locations to supervise, support, and assist one person receiving the vendor's services to learn job-related skills necessary to obtain or retain employment when and where no other persons receiving services are present and when all the following criteria are met:~~

~~(1) the vendor requests and the county recommends the optional rate;~~

~~(2) the service is prior authorized by the county on the Medicaid Management Information System for no more than 414 hours in a 12-month period and the daily per person charge to medical assistance does not exceed the vendor's approved full day plus transportation rates;~~

~~(3) separate full day, partial day, and transportation rates are not billed for the same person on the same day;~~

~~(4) the approved hourly rate does not exceed the sum of the vendor's current average hourly direct service wage, including fringe benefits and taxes, plus a component equal to the vendor's average hourly nondirect service wage expenses; and~~

~~(5) the actual revenue received for provision of hourly job coach, follow-along services is subtracted from the vendor's total expenses for the same time period and those adjusted expenses are used for determining recommended full day and transportation payment rates under subdivision 5 in accordance with the limitations in subdivision 3.~~

(b) Notwithstanding any law or rule to the contrary, the commissioner may authorize county participation in a voluntary individualized payment rate structure for day training and habilitation services to allow a county the flexibility to change, after consulting with providers, from a site-based payment rate structure to an individual payment rate structure for the providers of day training and habilitation services in the

county. The commissioner shall seek input from providers and consumers in establishing procedures for determining the structure of voluntary individualized payment rates to ensure that there is no additional cost to the state or counties and that the rate structure is cost-neutral to providers of day training and habilitation services, on July 1, 2004, or on day one of the individual rate structure, whichever is later.

(c) Medical assistance rates for home and community-based service provided under section 256B.501, subdivision 4, by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under sections 252.40 to 252.46. For very dependent persons with special needs the commissioner may approve an exception to the approved payment rate under section 256B.501, subdivision 4 or 8.

Sec. 11. Minnesota Statutes 2002, section 256.476, subdivision 1, is amended to read:

Subdivision 1. **PURPOSE AND GOALS.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

(1) make support grants ~~or exception grants described in subdivision 11~~ available to individuals or families as an effective alternative to ~~existing programs and services, such as~~ the developmental disability family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

**EFFECTIVE DATE.** This section is effective January 1, 2004.

Sec. 12. Minnesota Statutes 2002, section 256.476, subdivision 3, is amended to read:

Subd. 3. **ELIGIBILITY TO APPLY FOR GRANTS.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the department of health or human services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving ~~home and community-based services under United States Code, title 42, section 1396h(c);~~ personal care attendant and home health aide services, or private duty nursing under section 256B.0625; a developmental disability family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) ~~The commissioner may limit the participation of recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.~~ Individuals receiving home and community-based waivers under United States Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 13. Minnesota Statutes 2002, section 256.476, subdivision 4, is amended to read:

Subd. 4. **SUPPORT GRANTS; CRITERIA AND LIMITATIONS.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the

health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person or a person's family will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person or the person's family to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service ~~plan~~ agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person or the person's family. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person or the person's family shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, if any, or the person's family. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or

other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 14. Minnesota Statutes 2002, section 256.476, subdivision 5, is amended to read:

Subd. 5. **REIMBURSEMENT, ALLOCATIONS, AND REPORTING.** (a) For the purpose of transferring persons to the consumer support grant program from ~~specific programs or services, such as~~ the developmental disability family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the developmental disability family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each individual or individual's family cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 15. Minnesota Statutes 2002, section 256.476, subdivision 11, is amended to read:

Subd. 11. **CONSUMER SUPPORT GRANT PROGRAM AFTER JULY 1, 2001.** (a) Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under section 256B.0627, the maximum allowable monthly grant levels are calculated by:

(i) determining the nonfederal share of the average service authorization for each home care rating;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to the average service authorization level of each home care rating;

(iv) adjusting the result for any authorized rate increases provided by the legislature; and

(v) adjusting the result for the average monthly utilization per recipient~~; and~~.

(2) ~~for persons with programs of origination other than the program described in clause (1), the maximum grant level for an individual shall not exceed the total of the nonfederal dollars expended on the individual by the program of origination~~ The commissioner may review and evaluate the methodology to reflect changes in the home care programs overall ratio of actual payments to service authorizations.

(b) Effective January 1, 2004, persons previously receiving ~~consumer support~~ exception grants ~~prior to July 1, 2001, may continue to receive the grant amount established prior to July 1, 2001~~ will have their grants calculated using the

methodology in paragraph (a), clause (1). If a person currently receiving an exception grant wishes to have their home care rating reevaluated, they may request an assessment as defined in section 256B.0627, subdivision 1, paragraph (b).

~~(c) The commissioner may provide up to 200 exception grants, including grants in use under paragraph (b). Eligible persons shall be provided an exception grant in priority order based upon the date of the commissioner's receipt of the county request. The maximum allowable grant level for an exception grant shall be based upon the nonfederal share of the average service authorization from the most recent fiscal year for each home care rating category. The amount of each exception grant shall be based upon the commissioner's determination of the nonfederal dollars that would have been expended if services had been available for an individual who is unable to obtain the support needed from the program of origination due to the unavailability of qualified service providers at the time or the location where the supports are needed.~~

Sec. 16. Minnesota Statutes 2002, section 256.482, subdivision 8, is amended to read:

Subd. 8. **SUNSET.** Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, ~~2003~~ 2007.

**EFFECTIVE DATE.** This section is effective May 30, 2003.

Sec. 17. Minnesota Statutes 2002, section 256B.0621, subdivision 4, is amended to read:

Subd. 4. **RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.** ~~The following qualifications and certification standards must be met by providers of relocation targeted case management:~~

~~(a) The commissioner must certify each provider of relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6.~~

~~(b)~~ (a) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

(b) A provider of targeted case management under section 256B.0625, subdivision 20, may be deemed a certified provider of relocation targeted case management.

(c) A relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management provider also provides, or will provide, the recipient's services and supports. Contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

Sec. 18. Minnesota Statutes 2002, section 256B.0621, subdivision 7, is amended to read:

Subd. 7. **TIME LINES.** The following time lines must be met for assigning a case manager:

~~(1)~~ (a) For relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G.

(1) If a county agency, its contractor, or federally recognized tribe does not provide case management services as required, the recipient may~~, after written notice to the county agency,~~ obtain targeted relocation case management services from a ~~home care targeted case management provider, as defined in subdivision 5; and~~ an alternative provider of targeted case management services enrolled by the commissioner.

(2) The commissioner may waive the provider requirements in subdivision 4, paragraph (a), clauses (1) and (4), to ensure recipient access to the assistance necessary to move from an institution to the community. The recipient or the recipient's legal guardian shall provide written notice to the county or tribe of the decision to obtain services from an alternative provider.

(3) Providers of relocation targeted case management enrolled under this subdivision shall:

(i) meet the provider requirements under subdivision 4 that are not waived by the commissioner;

(ii) be qualified to provide the services specified in subdivision 6;

(iii) coordinate efforts with local social service agencies and tribes; and

(iv) comply with the conflict of interest provisions established under subdivision 4, paragraph (c).

(4) Local social service agencies and federally recognized tribes shall cooperate with providers certified by the commissioner under this subdivision to facilitate the recipient's successful relocation from an institution to the community.

(b) For home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 5.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 19. **[256B.0622] INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.**

Subdivision 1. **SCOPE.** Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential and residential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Subd. 2. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, and mental health rehabilitation workers.

Subd. 3. **ELIGIBILITY.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of two or more inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 4. **PROVIDER CERTIFICATION AND CONTRACT REQUIREMENTS.** (a) The intensive nonresidential rehabilitative mental health services provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential rehabilitative mental health services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Subd. 5. **STANDARDS APPLICABLE TO BOTH NONRESIDENTIAL AND RESIDENTIAL PROVIDERS.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according

to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause (3)(iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least monthly with the recipient.

Subd. 6. **ADDITIONAL STANDARDS APPLICABLE ONLY TO INTENSIVE RESIDENTIAL REHABILITATIVE MENTAL HEALTH SERVICES.** (a) The provider of intensive residential services must have sufficient staff to provide 24 hour per day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of recipients given the recipient's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education when appropriate.

(b) At a minimum:

(1) staff must be available and provide direction and supervision whenever recipients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine recipients for each day and evening shift. If more than nine recipients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to recipients who need the services of a medical professional, the provider shall assure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must assure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the

effectiveness and safety of medication administration in the facility and assessing patients for medication side effects and drug interactions.

Subd. 7. **ADDITIONAL STANDARDS FOR NONRESIDENTIAL SERVICES.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Subd. 8. **MEDICAL ASSISTANCE PAYMENT FOR INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.** (a) Payment for residential and nonresidential services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section and crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The host county shall recommend to the commissioner one rate for each entity that will bill medical assistance for residential services under this section and two rates for each nonresidential provider. The first nonresidential rate is for recipients who are not receiving residential services. The second nonresidential rate is for recipients who are temporarily receiving residential services and need continued contact with the nonresidential team to assure timely discharge from residential services. In developing these rates, the host county shall consider and document:

(1) the cost for similar services in the local trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each recipient;

(4) the degree to which recipients will receive services other than services under this section;

(5) the costs of other services, such as case management, that will be separately reimbursed; and

(6) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as case management, partial hospitalization, home care, and inpatient services. Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.

(e) When services under this section are provided by an assertive community team, case management functions must be an integral part of the team. The county must allocate costs which are reimbursable under this section versus costs which are reimbursable through case management or other reimbursement, so that payment is not duplicated.

(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c).

Subd. 9. **PROVIDER ENROLLMENT; RATE SETTING FOR COUNTY-OPERATED ENTITIES.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

Subd. 10. **PROVIDER ENROLLMENT; RATE SETTING FOR SPECIALIZED PROGRAM.** A provider proposing to serve a subpopulation of eligible recipients may bypass the county approval procedures in this section and receive approval for provider enrollment and rate setting directly from the commissioner under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

Sec. 20. Minnesota Statutes 2002, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician's assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 21. Minnesota Statutes 2002, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **PROVIDER ENTITY STANDARDS.** (a) The provider entity must be:

~~(1) a county operated entity certified by the state; or~~

~~(2) a noncounty entity certified by the entity's host county~~ certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) ~~If an entity seeks to provide services outside its host county, it~~ A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) Recertification must occur at least every ~~two~~ three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure adequate preservice and inservice and ongoing training for staff;

(4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;

(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;

(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized

American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(10) develop and maintain recipient files, individual treatment plans, and contact charting;

(11) develop and maintain staff training and personnel files;

(12) submit information as required by the state;

(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

~~(g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.~~

Sec. 22. Minnesota Statutes 2002, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **QUALIFICATIONS OF PROVIDER STAFF.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (6), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in subitem (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) is fluent in the non-English language or competent in the culture of the ethnic group to which at least ~~50~~ 20 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Sec. 23. Minnesota Statutes 2002, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **REQUIRED TRAINING AND SUPERVISION.** (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least ~~twice a month~~ monthly with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner; and

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates~~; and~~

~~(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.~~

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by ~~the~~

a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Sec. 24. Minnesota Statutes 2002, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **DIAGNOSTIC ASSESSMENT.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that

reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. For initial implementation of adult rehabilitative mental health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission is acceptable.

Sec. 25. Minnesota Statutes 2002, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **PERSONAL CARE.** Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 26. Minnesota Statutes 2002, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at

least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in section 245A.04.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual ~~residing with a recipient of personal care assistant services~~ who is capable of providing the ~~supportive care~~ support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not a the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties ~~who are parents of minors or guardians of minors or incapacitated persons~~ may delegate the responsibility to another adult ~~during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition~~

~~of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party~~ who is not the personal care assistant. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 27. Minnesota Statutes 2002, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. **PERSONAL CARE ASSISTANT SERVICES.** (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on

assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) ~~services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:~~

~~(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;~~

~~(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;~~

~~(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;~~

~~(iv) the relative incurs substantial expenses by providing personal care for the recipient; or~~

~~(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;~~

~~(11)~~ homemaker services that are not an integral part of a personal care assistant services;

~~(12)~~ (11) home maintenance, or chore services;

~~(13)~~ (12) services not specified under paragraph (a); and

~~(14)~~ (13) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

Sec. 28. Minnesota Statutes 2002, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. **FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.** (a) ~~The commissioner may allow for the flexible use of personal care assistant hours.~~ "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) ~~The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and ensures that the:~~

~~(1) health and safety needs of the recipient will be met;~~

~~(2) total annual authorization will not exceed before the end date; and~~

~~(3) how actual use of hours will be monitored.~~

~~(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.~~

~~(d)~~ The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. ~~The provider must ensure that the month-to-month plan is incorporated into the care plan.~~ Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

~~(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.~~

~~(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.~~

Sec. 29. Minnesota Statutes 2002, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **PREADMISSION SCREENING OF INDIVIDUALS UNDER 65 YEARS OF AGE.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within ~~20 working~~ 40 calendar days of admission.

(d) Individuals under 65 years of age who are admitted to a nursing facility without preadmission screening according to the exemption described in subdivision 4b, paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive a face-to-face assessment within 40 days of admission.

(e) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(f) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(g) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within ~~20 working days~~ 40 calendar days of admission.

(h) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(i) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(j) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

Sec. 30. Minnesota Statutes 2002, section 256B.0915, is amended by adding a subdivision to read:

Subd. 9. **TRIBAL MANAGEMENT OF ELDERLY WAIVER.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner and White Earth reservation may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and White Earth reservation. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by counties but shall not include tribal financial eligibility determination for medical assistance.

Sec. 31. Minnesota Statutes 2002, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **CASE MANAGEMENT ADMINISTRATION AND SERVICES.** (a) The administrative functions of case management provided to or arranged for a person include:

(1) ~~intake~~ review of eligibility for services;

(2) ~~diagnosis~~ screening;

(3) ~~screening~~ intake;

(4) ~~service authorization~~ diagnosis;

(5) ~~review of eligibility for services~~ the review and authorization of services based upon an individualized service plan; and

(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the individual service plan~~;~~

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

~~(3)~~ (4) assisting the person in the identification of potential providers;

~~(4)~~ (5) assisting the person to access services;

~~(5)~~ (6) coordination of services, if coordination is not provided by another service provider;

~~(6)~~ (7) evaluation and monitoring of the services identified in the plan; and

~~(7)~~ (8) annual reviews of service plans and services provided.

(c) Case management administration and service activities that are provided to the person with mental retardation or a related condition shall be provided directly by county agencies or under contract.

(d) Case managers are responsible for the administrative duties and service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the individualized service and habilitation plans.

(e) The department of human services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

Sec. 32. Minnesota Statutes 2002, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **FEDERAL WAIVERS.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial

participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

(b) The commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The individual service plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, ~~and~~ protection, and habilitation needs will be met ~~by~~, including how frequent and regular contact with persons other than the residential service provider will occur. The individualized service plan must address the provision of services during the day outside the residence on weekdays.

(c) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 33. Minnesota Statutes 2002, section 256B.095, is amended to read:

256B.095 **QUALITY ASSURANCE ~~PROJECT~~ SYSTEM ESTABLISHED.**

(a) Effective July 1, 1998, ~~an alternative~~ a quality assurance ~~licensing~~ system ~~project~~ for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs ~~for persons with developmental disabilities~~, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system ~~project~~ or may continue regulation of these programs under the licensing system operated by the commissioner. The project expires on June 30, ~~2005~~ 2007.

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The

commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 34. Minnesota Statutes 2002, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. **MEMBERSHIP.** The ~~region 10~~ quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. ~~Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution.~~ The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, ~~2005~~ 2007.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 35. Minnesota Statutes 2002, section 256B.0951, subdivision 2, is amended to read:

Subd. 2. **AUTHORITY TO HIRE STAFF; CHARGE FEES; PROVIDE TECHNICAL ASSISTANCE.** (a) The commission may hire staff to perform the duties assigned in this section.

(b) The commission may charge fees for its services.

(c) The commission may provide technical assistance to other counties, families, providers, and advocates interested in participating in a quality assurance system under section 256B.095, paragraph (b) or (c).

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 36. Minnesota Statutes 2002, section 256B.0951, subdivision 3, is amended to read:

Subd. 3. **COMMISSION DUTIES.** (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; and (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined.

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

(c) The commission and the commissioner shall establish an ongoing review process for the alternative quality assurance licensing system. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients~~, as compared to the current licensing system~~.

(d) ~~The commission shall contract with an independent entity to conduct a financial review of the alternative quality assurance project. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system. The review shall include an evaluation of possible budgetary savings within the department of human services as a result of implementation of the alternative quality assurance project. If a federal waiver is approved under subdivision 7, the financial review shall also evaluate possible savings within the department of health. This review must be completed by December 15, 2000.~~

~~(e)~~ The commission shall ~~submit a report to the legislature by January 15, 2001, on the results of the review process for the alternative quality assurance project, a summary of the results of the independent financial review, and a recommendation on whether the project should be extended beyond June 30, 2001.~~

~~(f)~~ The ~~commissioner~~ commission, in consultation with the ~~commission~~ commissioner, shall ~~examine the feasibility of expanding~~ work cooperatively with other

populations to expand the ~~project~~ system to ~~other~~ those populations ~~or geographic areas~~ and identify barriers to expansion. The commissioner shall report findings and recommendations to the legislature by December 15, 2004.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 37. Minnesota Statutes 2002, section 256B.0951, subdivision 5, is amended to read:

Subd. 5. **VARIANCE OF CERTAIN STANDARDS PROHIBITED.** The safety standards, rights, or procedural protections under sections 245.825; 245.91 to 245.97; 245A.04, subdivisions 3, 3a, 3b, and 3c; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative ~~licensing~~ quality assurance licensing system ~~project~~. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules and procedures referenced in this subdivision.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 38. Minnesota Statutes 2002, section 256B.0951, subdivision 7, is amended to read:

Subd. 7. **WAIVER OF RULES.** If a federal waiver is approved under subdivision 8, the commissioner of health may exempt residents of intermediate care facilities for persons with mental retardation (ICFs/MR) who participate in the alternative quality assurance ~~project~~ system established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 39. Minnesota Statutes 2002, section 256B.0951, subdivision 9, is amended to read:

Subd. 9. **EVALUATION.** The commission, in consultation with the commissioner of human services, shall conduct an evaluation of the ~~alternative~~ quality assurance system, and present a report to the commissioner by June 30, 2004.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 40. Minnesota Statutes 2002, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. **NOTIFICATION.** ~~For each year of the project, region 10~~ Counties shall give notice to the commission and commissioners of human services and health ~~by March 15~~ of intent to join the ~~quality assurance~~ alternative quality assurance licensing system~~, effective July 1 of that year~~. A county choosing to participate in the alternative quality assurance licensing system commits to participate ~~until June 30, 2005. Counties participating in the quality assurance alternative licensing system as of January 1, 2001, shall notify the commission and the~~

~~commissioners of human services and health by March 15, 2001, of intent to continue participation. Counties that elect to continue participation must participate in the alternative licensing system until June 30, 2005~~ for three years.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 41. Minnesota Statutes 2002, section 256B.0953, subdivision 2, is amended to read:

Subd. 2. **LICENSURE PERIODS.** (a) In order to be licensed under the alternative quality assurance ~~process~~ licensing system, a facility, program, or service must satisfy the health and safety outcomes approved for the ~~pilot project~~ alternative quality assurance licensing system.

(b) Licensure shall be approved for periods of one to three years for a facility, program, or service that satisfies the requirements of paragraph (a) and achieves the outcome measurements in the categories of consumer evaluation, education and training, providers, and systems.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 42. Minnesota Statutes 2002, section 256B.0955, is amended to read:

256B.0955 **DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.**

(a) Effective July 1, 1998, the commissioner of human services shall delegate authority to perform licensing functions and activities, in accordance with section 245A.16, to counties participating in the alternative quality assurance licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with developmental disabilities in a county that participates in the alternative quality assurance licensing system if the commissioner has received from the appropriate county notification that the facility, program, or service has been reviewed by a quality assurance team and has failed to qualify for licensure.

(b) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951 at facilities, programs, and services governed by the alternative quality assurance licensing system. The role of such random inspections shall be to verify that the alternative quality assurance licensing system protects the safety and well-being of consumers and maintains the availability of high-quality services for persons with developmental disabilities.

~~(c) The commissioner shall provide technical assistance and support or training to the alternative licensing system pilot project.~~

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 43. Minnesota Statutes 2002, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. **DIVISION OF COST.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers; ~~and~~

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance~~.~~;

(3) beginning July 1, 2004, 80 percent state funds and 20 percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with mental retardation or a related condition that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; and

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Sec. 44. Minnesota Statutes 2002, section 256B.47, subdivision 2, is amended to read:

Subd. 2. **NOTICE TO RESIDENTS.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a ~~necessary~~ change in the ~~level of care provided to~~ a case-mix classification of the resident. If the state fails to set rates as required by section 256B.431, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256B.431, subdivision 1, nursing facilities shall meet the requirement for advance notice by

informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date. If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Sec. 45. Minnesota Statutes 2002, section 256B.47, subdivision 2, is amended to read:

Subd. 2. **NOTICE TO RESIDENTS.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a ~~necessary~~ change in the ~~level of care provided to a~~ case-mix classification of the resident. If the state fails to set rates as required by section 256B.431, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256B.431, subdivision 1, nursing facilities shall meet the requirement for advance notice by informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date. If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Sec. 46. Minnesota Statutes 2002, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **INDIVIDUALIZED SERVICE PLAN.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 47. Minnesota Statutes 2002, section 256B.501, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For the purposes of this section, the following terms have the meaning given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Facility" means a facility licensed as a mental retardation residential facility under section 252.28, licensed as a supervised living facility under chapter 144, and certified as an intermediate care facility for persons with mental retardation or related conditions. The term does not include a state regional treatment center.

(c) "Habilitation services" means health and social services directed toward increasing and maintaining the physical, intellectual, emotional, and social functioning of persons with mental retardation or related conditions. Habilitation services include therapeutic activities, assistance, training, supervision, and monitoring in the areas of self-care, sensory and motor development, interpersonal skills, communication, socialization, reduction or elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management, and household chores.

(d) "Services during the day" means services or supports provided to a person that enables the person to be fully integrated into the community. Services during the day must include habilitation services, and may include a variety of supports to enable the person to exercise choices for community integration and inclusion activities. Services during the day may include, but are not limited to: supported work, support during community activities, community volunteer opportunities, adult day care, recreational activities, and other individualized integrated supports.

(e) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1987, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

Sec. 48. Minnesota Statutes 2002, section 256B.501, is amended by adding a subdivision to read:

Subd. 3m. **SERVICES DURING THE DAY.** When establishing a rate for services during the day, the commissioner shall ensure that these services comply with active treatment requirements for persons residing in an ICF/MR as defined under federal regulations and shall ensure that services during the day for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of services during the day by the residential service provider, consistent with the individual service plan. The individual service plan for individuals who choose to have their residential service provider provide their services during the day must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The individualized service plan must address the provision of services during the day outside the residence.

Sec. 49. Minnesota Statutes 2002, section 256B.5013, is amended by adding a subdivision to read:

Subd. 7. **RATE ADJUSTMENTS FOR SHORT-TERM ADMISSIONS FOR CRISIS OR SPECIALIZED MEDICAL CARE.** Beginning July 1, 2003, the commissioner may designate up to 25 beds in ICF/MR facilities statewide for short-term admissions due to crisis care needs or care for medically fragile individuals. The commissioner shall adjust the monthly facility rate to provide payment for vacancies in designated short-term beds by an amount equal to the rate for each recipient residing in a designated bed for up to 15 days per bed per month. The commissioner may designate short-term beds in ICF/MR facilities based on the short-term care needs of a region or county as provided in section 252.28. Nothing in this section shall be construed as limiting payments for short-term admissions of eligible recipients to an ICF/MR that is not designated for short-term admissions for crisis or specialized medical care under this subdivision and does not receive a temporary rate adjustment.

Sec. 50. Minnesota Statutes 2002, section 256B.5015, is amended to read:

256B.5015 **PASS-THROUGH OF ~~TRAINING AND HABILITATION~~ OTHER SERVICES COSTS.**

Subdivision 1. **DAY TRAINING AND HABILITATION SERVICES.** Day training and habilitation services costs shall be paid as a pass-through payment at the lowest rate paid for the comparable services at that site under sections 252.40 to 252.46. The pass-through payments for training and habilitation services shall be paid separately by the commissioner and shall not be included in the computation of the ICF/MR facility total payment rate.

Subd. 2. **SERVICES DURING THE DAY.** Services during the day, as defined in section 256B.501, but excluding day training and habilitation services, shall be paid

as a pass-through payment no later than January 1, 2004. The commissioner shall establish rates for these services, other than day training and habilitation services, at levels that do not exceed 75 percent of a recipient's day training and habilitation service costs prior to the service change.

When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the individualized service plan and the person's need for active treatment as defined under federal regulations. The pass-through payments for services during the day shall be paid separately by the commissioner and shall not be included in the computation of the ICF/MR facility total payment rate.

Sec. 51. Minnesota Statutes 2002, section 256B.82, is amended to read:

256B.82 **PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.**

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623, intensive rehabilitative services under section 256B.0622, and adult mental health crisis response services under section 256B.0624, beginning January 1, ~~2004~~ 2005.

By January 15, ~~2003~~ 2004, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

Sec. 52. **[256I.08] COUNTY SHARE FOR CERTAIN NURSING FACILITY STAYS.**

Beginning July 1, 2004, if group residential housing is used to pay for a nursing facility placement due to the facility's status as an Institution for Mental Diseases, the county is liable for 20 percent of the nonfederal share of costs for persons under the age of 65 that have exceeded 90 days.

Sec. 53. **CASE MANAGEMENT ACCESS FOR PERSONS SEEKING COMMUNITY-BASED SERVICES.**

When a person requests services authorized under Minnesota Statutes, section 256B.0621, 256B.092, or 256B.49, subdivision 13, the county must determine whether the person qualifies, begin the screening process, begin individualized service plan development, and provide mandated case management services or relocation service coordination to those eligible within a reasonable time. If a county is unable to provide case management services within the required time period under Minnesota Statutes, sections 256B.0621, subdivision 7; 256B.49, subdivision 13; and Minnesota Rules,

parts 9525.0004 to 9525.0036, the county shall contract for case management services to meet the obligation.

Sec. 54. **CASE MANAGEMENT SERVICES REDESIGN.**

The commissioner shall report to the legislature on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, and service providers. The report shall include draft legislation for case management changes that will (1) streamline administration, (2) improve consumer access to case management services, (3) address the use of a comprehensive universal assessment protocol for persons seeking community supports, (4) establish case management performance measures, (5) provide for consumer choice of the case management service vendor, and (6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5). The proposed legislation shall be provided to the legislative committees with jurisdiction over health and human services issues by January 15, 2005.

Sec. 55. **VACANCY LISTINGS.**

The commissioner of human services shall work with interested stakeholders on how provider and industry specific Web sites can provide useful information to consumers on bed vacancies for group residential housing providers and intermediate care facilities for persons with mental retardation and related conditions. Providers and industry trade organizations are responsible for all costs related to maintaining Web sites listing bed vacancies.

Sec. 56. **HOMELESS SERVICES; STATE CONTRACTS.**

The commissioner of human services may contract directly with nonprofit organizations providing homeless services in two or more counties.

Sec. 57. **GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITY, OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION, AND COUNCIL ON DISABILITIES.**

The governor's council on developmental disability under Minnesota Statutes, section 16B.053, the ombudsman for mental health and mental retardation under Minnesota Statutes, section 245.92, the centers for independent living, and the council on disability under Minnesota Statutes, section 256.482, must study the feasibility of reducing costs and increasing effectiveness through (1) space coordination, (2) shared use of technology, (3) coordination of resource priorities, and (4) consolidation and make recommendations to the house and senate committees with jurisdiction over these entities by January 15, 2004.

Sec. 58. **LICENSING CHANGE.**

Notwithstanding Minnesota Statutes, sections 245A.11 and 252.291, the commissioner of human services shall allow an existing intermediate care facility for persons with mental retardation or related conditions located in Goodhue county serving 39

children to be converted to four separately licensed or certified cottages serving up to six children each.

Sec. 59. **REVISOR'S INSTRUCTION.**

For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 60. **REPEALER.**

(a) Minnesota Statutes 2002, sections 252.32, subdivision 2; and 256B.5013, subdivision 4, are repealed July 1, 2003.

(b) Laws 2001, First Special Session chapter 9, article 13, section 24, is repealed July 1, 2003.

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## ARTICLE 4

## CHILDREN'S SERVICES

Section 1. Minnesota Statutes 2002, section 124D.23, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT.** (a) In order to qualify as a family services collaborative, a minimum of one school district, one county, one public health entity, one community action agency as defined in section 119A.375, and one Head Start grantee if the community action agency is not the designated federal grantee for the Head Start program must agree in writing to provide coordinated family services and commit resources to an integrated fund. Collaboratives are expected to have broad community representation, which may include other local providers, including additional school districts, counties, and public health entities, other municipalities, public libraries, existing culturally specific community organizations, tribal entities, local health organizations, private and nonprofit service providers, child care providers, local foundations, community-based service groups, businesses, local transit authorities or other transportation providers, community action agencies under section 119A.375, senior citizen volunteer organizations, parent organizations, parents, and sectarian organizations that provide nonsectarian services.

(b) Members of the governing bodies of political subdivisions involved in the establishment of a family services collaborative shall select representatives of the nongovernmental entities listed in paragraph (a) to serve on the governing board of a collaborative. The governing body members of the political subdivisions shall select

one or more representatives of the nongovernmental entities within the family service collaborative.

(c) Two or more family services collaboratives or children's mental health collaboratives may consolidate decision-making, pool resources, and collectively act on behalf of the individual collaboratives, based on a written agreement among the participating collaboratives.

Sec. 2. Minnesota Statutes 2002, section 245.4874, is amended to read:

245.4874 **DUTIES OF COUNTY BOARD.**

The county board in each county shall use its share of mental health and Community Social Services Act funds allocated by the commissioner according to a biennial children's mental health component of the community social services plan required under section 245.4888, and approved by the commissioner. The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4888;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) develop a biennial children's mental health component of the community social services plan required under section 256E.09 which considers the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4888;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4888 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4888;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age; ~~and~~

(13) assure that culturally informed mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(14) arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results

shall be considered private data and the commissioner shall not collect individual screening results.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 3. Minnesota Statutes 2002, section 245.493, subdivision 1a, is amended to read:

Subd. 1a. **DUTIES OF CERTAIN COORDINATING BODIES.** (a) By mutual agreement of the collaborative and a coordinating body listed in this subdivision, a children's mental health collaborative or a collaborative established by the merger of a children's mental health collaborative and a family services collaborative under section 124D.23, may assume the duties of a community transition interagency committee established under section 125A.22; an interagency early intervention committee established under section 125A.30; a local advisory council established under section 245.4875, subdivision 5; or a local coordinating council established under section 245.4875, subdivision 6.

(b) Two or more family services collaboratives or children's mental health collaboratives may consolidate decision-making, pool resources, and collectively act on behalf of the individual collaboratives, based on a written agreement among the participating collaboratives.

Sec. 4. Minnesota Statutes 2002, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **DAY TREATMENT SERVICES.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day treatment for adults according to section 256B.0625, subdivision 25. Effective July 1, 2004, medical assistance covers day treatment services for children as specified under section 256B.0943.

Sec. 5. Minnesota Statutes 2002, section 256B.0625, is amended by adding a subdivision to read:

Subd. 35a. **CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 6. Minnesota Statutes 2002, section 256B.0625, is amended by adding a subdivision to read:

Subd. 35b. **CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 7. Minnesota Statutes 2002, section 256B.0625, is amended by adding a subdivision to read:

Subd. 45. **SUBACUTE PSYCHIATRIC CARE FOR PERSONS UNDER 21 YEARS OF AGE.** Medical assistance covers subacute psychiatric care for person under 21 years of age when:

(1) the services meet the requirements of Code of Federal Regulations, title 42, section 440.160;

(2) the facility is accredited as a psychiatric treatment facility by the joint commission on accreditation of healthcare organizations, the commission on accreditation of rehabilitation facilities, or the council on accreditation; and

(3) the facility is licensed by the commissioner of health under section 144.50.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 8. **[256B.0943] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive

therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

(n) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

(o) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.

Subd. 2. **COVERED SERVICE COMPONENTS OF CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; and

(5) direction of a mental health behavioral aide.

(c) Service components may be combined to constitute therapeutic programs, including day treatment programs and preschool programs. Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).

Subd. 3. **DETERMINATION OF CLIENT ELIGIBILITY.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental health professional that is performed within 180 days of the initial start of service. The diagnostic assessment must:

(1) include current diagnoses on all five axes of the client's current mental health status;

(2) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(3) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals;

(4) be used in the development of the individualized treatment plan; and

(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental health status and service needs.

Subd. 4. **PROVIDER ENTITY CERTIFICATION.** (a) Effective July 1, 2003, the commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity that no longer meets the requirements in this section. The county, tribe, and the commissioner shall be mutually responsible and accountable for the county's, tribe's, and state's part of the certification, recertification, and decertification processes.

(b) For purposes of this section, a provider entity must be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-368 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity recommended for certification by the provider's host county and certified by the state.

Subd. 5. **PROVIDER ENTITY ADMINISTRATIVE INFRASTRUCTURE REQUIREMENTS.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and performance measurement. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that a mental health professional, mental health

practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) if a client is receiving services from a case manager or other provider entity, a service coordination process that ensures services are provided in the most appropriate manner to achieve maximum benefit to the client. The provider entity must ensure coordination and nonduplication of services consistent with county board coordination procedures established under section 245.4881, subdivision 5;

(4) a performance measurement system, including monitoring to determine cultural appropriateness of services identified in the individual treatment plan, as determined by the client's culture, beliefs, values, and language, and family-driven services; and

(5) a process to establish and maintain individual client records. The client's records must include: (i) the client's personal information; (ii) forms applicable to data privacy; (iii) the client's diagnostic assessment, updates, tests, individual treatment plan, and individual behavior plan, if necessary; (iv) documentation of service delivery as specified under subdivision 6; (v) telephone contacts; (vi) discharge plan; and (vii) if applicable, insurance information.

Subd. 6. **PROVIDER ENTITY CLINICAL INFRASTRUCTURE REQUIREMENTS.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is: (i) based on the information in the client's diagnostic assessment; (ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy; (iii) developed through a child-centered, family-driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster

family; (iv) reviewed at least once every 90 days and revised, if necessary; and (v) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include: (i) detailed instructions on the service to be provided; (ii) time allocated to each service; (iii) methods of documenting the child's behavior; (iv) methods of monitoring the child's progress in reaching objectives; and (v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must: (i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes; (ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly; (iii) demonstrate family-friendly behaviors that support healthy

collaboration among the child, the child's family, and providers as treatment is planned and implemented; (iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and (v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Subd. 7. **QUALIFICATIONS OF INDIVIDUAL AND TEAM PROVIDERS.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider and multidisciplinary team include:

(1) a mental health professional as defined in subdivision 1, paragraph (m);

(2) a mental health practitioner as defined in section 245.4871, subdivision 26. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) a mental health behavioral aide working under the direction of a mental health professional to implement the rehabilitative mental health services identified in the client's individual treatment plan. A level I mental health behavioral aide must: (i) be at least 18 years old; (ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and (iii) meet preservices and continuing education requirements under subdivision 8. A level II mental health behavioral aide must: (i) be at least 18 years old; (ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents; and (iii) meet preservice and continuing education requirements in subdivision 8;

(4) a preschool program multidisciplinary team that includes at least one mental health professional and one or more of the following individuals under the clinical supervision of a mental health professional: (i) a mental health practitioner; or (ii) a program person, including a teacher, assistant teacher, or aide, who meets the

qualifications and training standards of a level I mental health behavioral aide; or

(5) a day treatment multidisciplinary team that includes at least one mental health professional and one mental health practitioner.

Subd. 8. **REQUIRED PRESERVICE AND CONTINUING EDUCATION.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills, and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include topics specified in Minnesota Rules, part 9535.4068, subparts 1 and 2, and parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family. The topics covered in orientation and training must conform to Minnesota Rules, part 9535.4068.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 9. **SERVICE DELIVERY CRITERIA.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a minimum three-hour time block. The three-hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three-hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two-hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

(b) A provider entity must delivery the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, parts 9505.0523;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be an intense, time-limited, and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) medically necessary services that are provided by a mental health behavioral aide must be designed to improve the functioning of the child and support the family in activities of daily and community living. A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement goals in the treatment plan for the child's emotional disturbance that allow the child to acquire developmentally and therapeutically appropriate daily living skills, social skills, and leisure and recreational skills through targeted activities. These activities may include:

(i) assisting a child as needed with skills development in dressing, eating, and toileting;

(ii) assisting, monitoring, and guiding the child to complete tasks, including facilitating the child's participation in medical appointments;

(iii) observing the child and intervening to redirect the child's inappropriate behavior;

(iv) assisting the child in using age-appropriate self-management skills as related to the child's emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills;

(v) implementing deescalation techniques as recommended by the mental health professional;

(vi) implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties; or

(vii) assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child's individual treatment plan or individual behavioral plan. Parenting skills must be directed exclusively to the child's treatment; and

(5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on-site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Subd. 10. **SERVICE AUTHORIZATION.** The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate the list are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision on whether prior authorization is required for a health service is not subject to administrative appeal.

Subd. 11. **DOCUMENTATION AND BILLING.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner.

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Subd. 12. **EXCLUDED SERVICES.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(4) services that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure;

(5) up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital, a group home as defined in Minnesota Rules, part 9560.0520, subpart 4, a residential treatment facility licensed under Minnesota Rules, parts 9545.0900 to 9545.1090, a regional treatment center, or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) consultation with other providers or service agency staff about the care or progress of a client;

(iv) prevention or education programs provided to the community; and

(v) treatment for clients with primary diagnoses of alcohol or other drug abuse.

**EFFECTIVE DATE.** Unless otherwise specified, this section is effective July 1, 2004.

Sec. 9. **[256B.0944] COVERED SERVICES; CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests

the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on-site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **MEDICAL ASSISTANCE COVERAGE.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **ELIGIBILITY.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **PROVIDER ENTITY STANDARDS.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4888; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 5. **MOBILE CRISIS INTERVENTION STAFF QUALIFICATIONS.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (m); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including as the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **INITIAL SCREENING, CRISIS ASSESSMENT, AND MOBILE INTERVENTION TREATMENT PLANNING.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health

problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **CRISIS STABILIZATION SERVICES.** (a) Crisis stabilization services must be provided by a mental health professional or a mental health practitioner who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity, and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. **TREATMENT PLAN.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **SUPERVISION.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **CLIENT RECORD.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **EXCLUDED SERVICES.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 10. Minnesota Statutes 2002, section 256B.0945, subdivision 2, is amended to read:

Subd. 2. **COVERED SERVICES.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

~~(a) For facilities that are institutions for mental diseases according to statute and regulation or are not institutions for mental diseases but are approved by the commissioner to provide services under this paragraph, medical assistance covers the full contract rate, including room and board if the services meet the requirements of Code of Federal Regulations, title 42, section 440.160.~~

~~(b)~~ For facilities that are not institutions for mental diseases according to federal statute and regulation ~~and are not providing services under paragraph (a)~~, medical assistance covers mental health related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board.

Sec. 11. Minnesota Statutes 2002, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **PAYMENT RATES.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. ~~Payment to counties for services provided according to subdivision 2, paragraph (a), shall be the federal share of the contract rate.~~ Payment to counties for services provided according to ~~subdivision 2, paragraph (b),~~ this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

Sec. 12. Minnesota Statutes 2002, section 257.05, is amended to read:

257.05 **IMPORTATION.**

Subdivision 1. **NOTIFICATION AND DUTIES OF COMMISSIONER.** No person, except as provided by ~~subdivision~~ subdivisions 2 and 3, shall bring or send into the state any child for the purpose of placing the child out or procuring the child's adoption without first obtaining the consent of the commissioner of human services, and such person shall conform to all rules of the commissioner of human services and laws of the state of Minnesota relating to protection of children in foster care. Before any child shall be brought or sent into the state for the purpose of being placed in foster care, the person bringing or sending the child into the state shall first notify the commissioner of human services of the person's intention, and shall obtain from the commissioner of human services a certificate stating that the home in which the child is to be placed is, in the opinion of the commissioner of human services, a suitable adoptive home for the child if legal adoption is contemplated or that the home meets

the commissioner's requirements for licensing of foster homes if legal adoption is not contemplated. The commissioner is responsible for protecting the child's interests so long as the child remains within the state and until the child reaches the age of 18 or is legally adopted. Notice to the commissioner shall state the name, age, and personal description of the child, and the name and address of the person with whom the child is to be placed, and such other information about the child and the foster home as may be required by the commissioner.

Subd. 2. **EXEMPT RELATIVES.** A parent, stepparent, grandparent, brother, sister and aunt or uncle in the first degree of the minor child who bring a child into the state for placement within their own home shall be exempt from the provisions of subdivision 1. This relationship may be by blood or marriage.

Subd. 3. **INTERNATIONAL ADOPTIONS.** Subject to state and federal laws and rules, adoption agencies licensed under chapter 245A and Minnesota Rules, parts 9545.0755 to 9545.0845, and county social services agencies are authorized to certify that the prospective adoptive home of a child brought into the state from another country for the purpose of adoption is a suitable home, or that the home meets the commissioner's requirements for licensing of foster homes if legal adoption is not contemplated.

Sec. 13. Minnesota Statutes 2002, section 259.67, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY CONDITIONS.** (a) The placing agency shall use the AFDC requirements as specified in federal law as of July 16, 1996, when determining the child's eligibility for adoption assistance under title IV-E of the Social Security Act. If the child does not qualify, the placing agency shall certify a child as eligible for state funded adoption assistance only if the following criteria are met:

(1) Due to the child's characteristics or circumstances it would be difficult to provide the child an adoptive home without adoption assistance.

(2)(i) A placement agency has made reasonable efforts to place the child for adoption without adoption assistance, but has been unsuccessful; or

(ii) the child's licensed foster parents desire to adopt the child and it is determined by the placing agency that the adoption is in the best interest of the child.

(3) The child has been a ward of the commissioner ~~or~~, a Minnesota-licensed child-placing agency, or a tribal social service agency of Minnesota recognized by the Secretary of the Interior.

(b) For purposes of this subdivision, the characteristics or circumstances that may be considered in determining whether a child is a child with special needs under United States Code, title 42, chapter 7, subchapter IV, part E, or meets the requirements of paragraph (a), clause (1), are the following:

(1) The child is a member of a sibling group to be placed as one unit in which at least one sibling is older than 15 months of age or is described in clause (2) or (3).

(2) The child has documented physical, mental, emotional, or behavioral disabilities.

(3) The child has a high risk of developing physical, mental, emotional, or behavioral disabilities.

(4) The child is adopted according to tribal law without a termination of parental rights or relinquishment, provided that the tribe has documented the valid reason why the child cannot or should not be returned to the home of the child's parent.

(c) When a child's eligibility for adoption assistance is based upon the high risk of developing physical, mental, emotional, or behavioral disabilities, payments shall not be made under the adoption assistance agreement unless and until the potential disability manifests itself as documented by an appropriate health care professional.

Sec. 14. Minnesota Statutes 2002, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **INVESTIGATION.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall have a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications and the assessment criteria shall comply with Minnesota Rules, parts 9530.6600 to 9530.6655. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment and placement must comply with all provisions of Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of $100.

The court shall have a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its

jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 15. Minnesota Statutes 2002, section 260B.176, subdivision 2, is amended to read:

Subd. 2. **REASONS FOR DETENTION.** (a) If the child is not released as provided in subdivision 1, the person taking the child into custody shall notify the court as soon as possible of the detention of the child and the reasons for detention.

(b) No child may be detained in a juvenile secure detention facility or shelter care facility longer than 36 hours, excluding Saturdays, Sundays, and holidays, after being taken into custody for a delinquent act as defined in section 260B.007, subdivision 6, unless a petition has been filed and the judge or referee determines pursuant to section 260B.178 that the child shall remain in detention.

(c) No child may be detained in an adult jail or municipal lockup longer than 24 hours, excluding Saturdays, Sundays, and holidays, or longer than six hours in an adult jail or municipal lockup in a standard metropolitan statistical area, after being taken into custody for a delinquent act as defined in section 260B.007, subdivision 6, unless:

(1) a petition has been filed under section 260B.141; and

(2) a judge or referee has determined under section 260B.178 that the child shall remain in detention.

After August 1, 1991, no child described in this paragraph may be detained in an adult jail or municipal lockup longer than 24 hours, excluding Saturdays, Sundays, and holidays, or longer than six hours in an adult jail or municipal lockup in a standard metropolitan statistical area, unless the requirements of this paragraph have been met and, in addition, a motion to refer the child for adult prosecution has been made under section 260B.125. Notwithstanding this paragraph, continued detention of a child in an adult detention facility outside of a standard metropolitan statistical area county is permissible if:

(i) the facility in which the child is detained is located where conditions of distance to be traveled or other ground transportation do not allow for court appearances within 24 hours. A delay not to exceed 48 hours may be made under this clause; or

(ii) the facility is located where conditions of safety exist. Time for an appearance may be delayed until 24 hours after the time that conditions allow for reasonably safe

travel. "Conditions of safety" include adverse life-threatening weather conditions that do not allow for reasonably safe travel.

The continued detention of a child under clause (i) or (ii) must be reported to the commissioner of corrections.

(d) If a child described in paragraph (c) is to be detained in a jail beyond 24 hours, excluding Saturdays, Sundays, and holidays, the judge or referee, in accordance with rules and procedures established by the commissioner of corrections, shall notify the commissioner of the place of the detention and the reasons therefor. The commissioner shall thereupon assist the court in the relocation of the child in an appropriate juvenile secure detention facility or approved jail within the county or elsewhere in the state, or in determining suitable alternatives. The commissioner shall direct that a child detained in a jail be detained after eight days from and including the date of the original detention order in an approved juvenile secure detention facility with the approval of the administrative authority of the facility. If the court refers the matter to the prosecuting authority pursuant to section 260B.125, notice to the commissioner shall not be required.

(e) When a child is detained for an alleged delinquent act in a state licensed juvenile facility or program, or when a child is detained in an adult jail or municipal lockup as provided in paragraph (c), the supervisor of the facility shall, if the child's parent or legal guardian consents, have a children's mental health screening conducted with a screening instrument approved by the commissioner of human services, unless a screening has been performed within the previous 180 days or the child is currently under the care of a mental health professional. The screening shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. The screening shall be conducted after the initial detention hearing has been held and the court has ordered the child continued in detention. The results of the screening may only be presented to the court at the dispositional phase of the court proceedings on the matter unless the parent or legal guardian consents to presentation at a different time. If the screening indicates a need for assessment, the local social services agency or probation officer, with the approval of the child's parent or legal guardian, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 16. Minnesota Statutes 2002, section 260B.178, subdivision 1, is amended to read:

Subdivision 1. **HEARING AND RELEASE REQUIREMENTS.** (a) The court shall hold a detention hearing:

(1) within 36 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, if the child is being held at a juvenile secure detention facility or shelter care facility; or

(2) within 24 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, if the child is being held at an adult jail or municipal lockup.

(b) Unless there is reason to believe that the child would endanger self or others, not return for a court hearing, run away from the child's parent, guardian, or custodian or otherwise not remain in the care or control of the person to whose lawful custody the child is released, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260B.157, subdivision 1, and a children's mental health screening as provided in section 260B.176, subdivision 2, paragraph (e). In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 17. Minnesota Statutes 2002, section 260B.193, subdivision 2, is amended to read:

Subd. 2. **CONSIDERATION OF REPORTS.** Before making a disposition in a case, or appointing a guardian for a child, the court may consider any report or recommendation made by the local social services agency, probation officer, licensed child-placing agency, foster parent, guardian ad litem, tribal representative, or other authorized advocate for the child or child's family, a school district concerning the effect on student transportation of placing a child in a school district in which the child is not a resident, or any other information deemed material by the court. In addition, the court may consider the results of the children's mental health screening provided in section 260B.157, subdivision 1.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 18. Minnesota Statutes 2002, section 260B.235, subdivision 6, is amended to read:

Subd. 6. **ALTERNATIVE DISPOSITION.** In addition to dispositional alternatives authorized by subdivision ~~3~~ 4, in the case of a third or subsequent finding by the court pursuant to an admission in court or after trial that a child has committed a juvenile alcohol or controlled substance offense, the juvenile court shall order a chemical dependency evaluation of the child and if warranted by the evaluation, the court may order participation by the child in an inpatient or outpatient chemical dependency treatment program, or any other treatment deemed appropriate by the court. In the case of a third or subsequent finding that a child has committed any juvenile petty offense, the court shall order a children's mental health screening be conducted as provided in section 260B.157, subdivision 1, and if indicated by the screening, to undergo a diagnostic assessment, including a functional assessment, as defined in section 245.4871.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 19. Minnesota Statutes 2002, section 260C.141, subdivision 2, is amended to read:

Subd. 2. **REVIEW OF FOSTER CARE STATUS.** The social services agency responsible for the placement of a child in a residential facility, as defined in section 260C.212, subdivision 1, pursuant to a voluntary release by the child's parent or parents must proceed in juvenile court to review the foster care status of the child in the manner provided in this section.

(a) Except for a child in placement due solely to the child's developmental disability or emotional disturbance, when a child continues in voluntary placement according to section 260C.212, subdivision 8, a petition shall be filed alleging the child to be in need of protection or services or seeking termination of parental rights or other permanent placement of the child away from the parent within 90 days of the date of the voluntary placement agreement. The petition shall state the reasons why the child is in placement, the progress on the out-of-home placement plan required under section 260C.212, subdivision 1, and the statutory basis for the petition under section 260C.007, subdivision 6, 260C.201, subdivision 11, or 260C.301.

(1) In the case of a petition alleging the child to be in need of protection or services filed under this paragraph, if all parties agree and the court finds it is in the best interests of the child, the court may find the petition states a prima facie case that:

(i) the child's needs are being met;

(ii) the placement of the child in foster care is in the best interests of the child;

(iii) reasonable efforts to reunify the child and the parent or guardian are being made; and

(iv) the child will be returned home in the next three months.

(2) If the court makes findings under paragraph (1), the court shall approve the voluntary arrangement and continue the matter for up to three more months to ensure the child returns to the parents' home. The responsible social services agency shall:

(i) report to the court when the child returns home and the progress made by the parent on the out-of-home placement plan required under section 260C.212, in which case the court shall dismiss jurisdiction;

(ii) report to the court that the child has not returned home, in which case the matter shall be returned to the court for further proceedings under section 260C.163; or

(iii) if any party does not agree to continue the matter under paragraph (1) and this paragraph, the matter shall proceed under section 260C.163.

(b) In the case of a child in voluntary placement due solely to the child's developmental disability or emotional disturbance according to section 260C.212, subdivision 9, the following procedures apply:

(1) **REPORT TO COURT.** (i) Unless the county attorney determines that a petition under subdivision 1 is appropriate, without filing a petition, a written report shall be forwarded to the court within 165 days of the date of the voluntary placement agreement. The written report shall contain necessary identifying information for the court to proceed, a copy of the out-of-home placement plan required under section 260C.212, subdivision 1, a written summary of the proceedings of any administrative review required under section 260C.212, subdivision 7, and any other information the responsible social services agency, parent or guardian, the child or the foster parent or other residential facility wants the court to consider.

(ii) The responsible social services agency, where appropriate, must advise the child, parent or guardian, the foster parent, or representative of the residential facility of the requirements of this section and of their right to submit information to the court. If the child, parent or guardian, foster parent, or representative of the residential facility wants to send information to the court, the responsible social services agency shall advise those persons of the reporting date and the identifying information necessary for the court administrator to accept the information and submit it to a judge with the agency's report. The responsible social services agency must also notify those persons that they have the right to be heard in person by the court and how to exercise that right. The responsible social services agency must also provide notice that an in-court hearing will not be held unless requested by a parent or guardian, foster parent, or the child.

(iii) After receiving the required report, the court has jurisdiction to make the following determinations and must do so within ten days of receiving the forwarded report: (A) whether or not the placement of the child is in the child's best interests; and (B) whether the parent and agency are appropriately planning for the child. Unless requested by a parent or guardian, foster parent, or child, no in-court hearing need be held in order for the court to make findings and issue an order under this paragraph.

(iv) If the court finds the placement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit, individualized findings to support its determination. The court shall send a copy of the order to the county attorney, the responsible social services agency, the parent or guardian, the child, and the foster parents. The court shall also send the parent or guardian, the child, and the foster parent notice of the required review under clause (2).

(v) If the court finds continuing the placement not to be in the child's best interests or that the agency or the parent or guardian is not appropriately planning for the child, the court shall notify the county attorney, the responsible social services agency, the parent or guardian, the foster parent, the child, and the county attorney of the court's determinations and the basis for the court's determinations.

(2) **PERMANENCY REVIEW BY PETITION.** If a child with a developmental disability or an emotional disturbance continues in out-of-home placement for 13

months from the date of a voluntary placement, a petition alleging the child to be in need of protection or services, for termination of parental rights, or for permanent placement of the child away from the parent under section 260C.201 shall be filed. The court shall conduct a permanency hearing on the petition no later than 14 months after the date of the voluntary placement. At the permanency hearing, the court shall determine the need for an order permanently placing the child away from the parent or determine whether there are compelling reasons that continued voluntary placement is in the child's best interests. A petition alleging the child to be in need of protection or services shall state the date of the voluntary placement agreement, the nature of the child's developmental disability or emotional disturbance, the plan for the ongoing care of the child, the parents' participation in the plan, the responsible social services agency's efforts to finalize a plan for the permanent placement of the child, and the statutory basis for the petition.

(i) If a petition alleging the child to be in need of protection or services is filed under this paragraph, the court may find, based on the contents of the sworn petition, and the agreement of all parties, including the child, where appropriate, that there are compelling reasons that the voluntary arrangement is in the best interests of the child and that the responsible social services agency has made reasonable efforts to finalize a plan for the permanent placement of the child, approve the continued voluntary placement, and continue the matter under the court's jurisdiction for the purpose of reviewing the child's placement as a continued voluntary arrangement every 12 months as long as the child continues in out-of-home placement. The matter must be returned to the court for further review every 12 months as long as the child remains in placement. The court shall give notice to the parent or guardian of the continued review requirements under this section. Nothing in this paragraph shall be construed to mean the court must order permanent placement for the child under section 260C.201, subdivision 11, as long as the court finds compelling reasons at the first review required under this section.

(ii) If a petition for termination of parental rights, for transfer of permanent legal and physical custody to a relative, for long-term foster care, or for foster care for a specified period of time is filed, the court must proceed under section 260C.201, subdivision 11.

(3) If any party, including the child, disagrees with the voluntary arrangement, the court shall proceed under section 260C.163.

Sec. 20. Minnesota Statutes 2002, section 626.559, subdivision 5, is amended to read:

Subd. 5. **REVENUE.** The commissioner of human services shall add the following funds to the funds appropriated under section 626.5591, subdivision 2, to develop and support training:

(a) The commissioner of human services shall submit claims for federal reimbursement earned through the activities and services supported through depart-

ment of human services child protection or child welfare training funds. Federal revenue earned must be used to improve and expand training services by the department. The department expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds.

(b) Each year, the commissioner of human services shall withhold from funds distributed to each county under Minnesota Rules, parts 9550.0300 to 9550.0370, an amount equivalent to 1.5 percent of each county's annual title XX allocation under section ~~256E.07~~ 256M.50. The commissioner must use these funds to ensure decentralization of training.

(c) The federal revenue under this subdivision is available for these purposes until the funds are expended.

Sec. 21. **MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED IN OUT-OF-HOME PLACEMENT SETTINGS.**

The commissioner of human services shall develop a plan in conjunction with the commissioner of corrections and representatives from counties, provider groups, and other stakeholders, to secure medical assistance funding for mental health-related services provided in out-of-home placement settings, including treatment foster care, group homes, and residential programs licensed under Minnesota Statutes, chapters 241 and 245A. The plan must include proposed legislation, fiscal implications, and other pertinent information.

Treatment foster care services must be provided by a child placing agency licensed under Minnesota Rules, parts 9543.0010 to 9543.0150 or 9545.0755 to 9545.0845.

The commissioner shall report to the legislature by January 15, 2004.

Sec. 22. **TRANSITION TO CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

Beginning July 1, 2003, the commissioner shall use the provider certification process under Minnesota Statutes, section 256B.0943, instead of the provider certification process required in Minnesota Rules, parts 9505.0324; 9505.0326; and 9505.0327.

Sec. 23. **REVISOR'S INSTRUCTION.**

For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 24. **REPEALER.**

(a) Minnesota Statutes 2002, sections 256B.0945, subdivision 10, is repealed.

(b) Minnesota Statutes 2002, section 256B.0625, subdivisions 35 and 36, are repealed effective July 1, 2004.

(c) Minnesota Rules, parts 9505.0324; 9505.0326; and 9505.0327, are repealed effective July 1, 2004.

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## ARTICLE 5

## OCCUPATIONAL LICENSES

Section 1. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 1a. **ACCREDITING ASSOCIATION.** "Accrediting association" means an organization recognized by the commissioner that evaluates schools and education programs of alcohol and drug counseling or is listed in Nationally Recognized Accrediting Agencies and Associations, Criteria and Procedures for Listing by the U.S. Secretary of Education and Current List (1996), which is incorporated by reference.

Sec. 2. Minnesota Statutes 2002, section 148C.01, subdivision 2, is amended to read:

Subd. 2. **ALCOHOL AND DRUG COUNSELOR.** "Alcohol and drug counselor" or "counselor" means a person who:

(1) uses, as a representation to the public, any title, initials, or description of services incorporating the words "alcohol and drug counselor";

(2) offers to render professional alcohol and drug counseling services relative to the abuse of or the dependency on alcohol or other drugs to the general public or groups, organizations, corporations, institutions, or government agencies for compensation, implying that the person is licensed and trained, experienced or expert in alcohol and drug counseling;

(3) holds a valid license issued under ~~sections 148C.01 to 148C.11~~ this chapter to engage in the practice of alcohol and drug counseling; or

(4) is an applicant for an alcohol and drug counseling license.

Sec. 3. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2a. **ALCOHOL AND DRUG COUNSELOR ACADEMIC COURSE WORK.** "Alcohol and drug counselor academic course work" means classroom education, which is directly related to alcohol and drug counseling and meets the requirements of section 148C.04, subdivision 5a, and is taken through an accredited school or educational program.

Sec. 4. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2b. **ALCOHOL AND DRUG COUNSELOR CONTINUING EDUCATION ACTIVITY.** "Alcohol and drug counselor continuing education activity" means clock hours that meet the requirements of section 148C.075 and Minnesota Rules, part 4747.1100, and are obtained by a licensee at educational programs of annual conferences, lectures, panel discussions, workshops, seminars, symposiums, employer-sponsored inservices, or courses taken through accredited schools or education programs, including home study courses. A home study course need not be provided by an accredited school or education program to meet continuing education requirements.

Sec. 5. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2c. **ALCOHOL AND DRUG COUNSELOR TECHNICIAN.** "Alcohol and drug counselor technician" means a person not licensed as an alcohol and drug counselor who is performing acts authorized under section 148C.045.

Sec. 6. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2d. **ALCOHOL AND DRUG COUNSELOR TRAINING.** "Alcohol and drug counselor training" means clock hours obtained by an applicant at educational programs of annual conferences, lectures, panel discussions, workshops, seminars, symposiums, employer-sponsored inservices, or courses taken through accredited schools or education programs, including home study courses. Clock hours obtained from accredited schools or education programs must be measured under Minnesota Rules, part 4747.1100, subpart 5.

Sec. 7. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2f. **CLOCK HOUR.** "Clock hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Sec. 8. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 2g. **CREDENTIAL.** "Credential" means a license, permit, certification, registration, or other evidence of qualification or authorization to engage in the practice of an occupation.

Sec. 9. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 4a. **LICENSEE.** "Licensee" means a person who holds a valid license under this chapter.

Sec. 10. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 11a. **STUDENT.** "Student" means a person enrolled in an alcohol and drug counselor education program at an accredited school or educational program and earning a minimum of nine semester credits per calendar year towards completion of an associate's, bachelor's, master's, or doctorate degree requirements that include an additional 18 semester credits or 270 clock hours of alcohol and drug counseling specific course work and 440 clock hours of practicum.

Sec. 11. Minnesota Statutes 2002, section 148C.01, subdivision 12, is amended to read:

Subd. 12. **SUPERVISED ALCOHOL AND DRUG ~~COUNSELING EXPERIENCE~~ COUNSELOR.** ~~Except during the transition period,~~ "Supervised alcohol and drug ~~counseling experience~~ counselor" means ~~practical experience gained by~~ a student, ~~volunteer, or~~ either before, during, or after the student completes a program from an accredited school or educational program of alcohol and drug counseling, an intern, ~~and~~ or a person issued a temporary permit under section 148C.04, subdivision 4, and who is supervised by a person either licensed under this chapter or exempt under its provisions; ~~either before, during, or after the student completes a program from an accredited school or educational program of alcohol and drug counseling~~.

Sec. 12. Minnesota Statutes 2002, section 148C.01, is amended by adding a subdivision to read:

Subd. 12a. **SUPERVISOR.** "Supervisor" means a licensed alcohol and drug counselor licensed under this chapter or other licensed professional practicing alcohol and drug counseling under section 148C.11 who monitors activities of and accepts legal liability for the person practicing under supervision. A supervisor shall supervise no more than three trainees practicing under section 148C.04, subdivision 6.

Sec. 13. Minnesota Statutes 2002, section 148C.03, subdivision 1, is amended to read:

Subdivision 1. **GENERAL.** The commissioner shall, after consultation with the advisory council or a committee established by rule:

(a) adopt and enforce rules for licensure of alcohol and drug counselors, including establishing standards and methods of determining whether applicants and licensees are qualified under section 148C.04. The rules must provide for examinations and establish standards for the regulation of professional conduct. The rules must be designed to protect the public;

(b) develop and, at least twice a year, administer an examination to assess applicants' knowledge and skills. The commissioner may contract for the administration of an examination with an entity designated by the commissioner. The examinations must be psychometrically valid and reliable; must be written and oral, with the oral examination based on a written case presentation; must minimize cultural bias;

and must be balanced in various theories relative to the practice of alcohol and drug counseling;

(c) issue licenses to individuals qualified under sections 148C.01 to 148C.11;

(d) issue copies of the rules for licensure to all applicants;

(e) adopt rules to establish and implement procedures, including a standard disciplinary process and rules of professional conduct;

(f) carry out disciplinary actions against licensees;

(g) establish, with the advice and recommendations of the advisory council, written internal operating procedures for receiving and investigating complaints and for taking disciplinary actions as appropriate;

(h) educate the public about the existence and content of the rules for alcohol and drug counselor licensing to enable consumers to file complaints against licensees who may have violated the rules;

(i) evaluate the rules in order to refine and improve the methods used to enforce the commissioner's standards; and

(j) ~~set,~~ collect~~, and adjust~~ license fees for alcohol and drug counselors ~~so that the total fees collected will as closely as possible equal anticipated expenditures during the biennium, as provided in section 16A.1285; fees for initial and renewal application and examinations; late fees for counselors who submit license renewal applications after the renewal deadline; and a surcharge fee. The surcharge fee must include an amount necessary to recover, over a five-year period, the commissioner's direct expenditures for the adoption of the rules providing for the licensure of alcohol and drug counselors. All fees received shall be deposited in the state treasury and credited to the special revenue fund~~.

Sec. 14. Minnesota Statutes 2002, section 148C.0351, subdivision 1, is amended to read:

Subdivision 1. **APPLICATION FORMS.** Unless exempted under section 148C.11, a person who practices alcohol and drug counseling in Minnesota must:

(1) apply to the commissioner for a license to practice alcohol and drug counseling on forms provided by the commissioner;

(2) include with the application a statement that the statements in the application are true and correct to the best of the applicant's knowledge and belief;

(3) include with the application a nonrefundable application fee specified ~~by the commissioner~~ in section 148C.12;

(4) include with the application information describing the applicant's experience, including the number of years and months the applicant has practiced alcohol and drug counseling as defined in section 148C.01;

(5) include with the application the applicant's business address and telephone number, or home address and telephone number if the applicant conducts business out of the home, and if applicable, the name of the applicant's supervisor, manager, and employer;

(6) include with the application a written and signed authorization for the commissioner to make inquiries to appropriate state regulatory agencies and private credentialing organizations in this or any other state where the applicant has practiced alcohol and drug counseling; and

(7) complete the application in sufficient detail for the commissioner to determine whether the applicant meets the requirements for filing. The commissioner may ask the applicant to provide additional information necessary to clarify incomplete or ambiguous information submitted in the application.

Sec. 15. Minnesota Statutes 2002, section 148C.0351, is amended by adding a subdivision to read:

Subd. 4. **INITIAL LICENSE; TERM.** (a) An initial license is effective on the date the commissioner indicates on the license certificate, with the license number, sent to the applicant upon approval of the application.

(b) An initial license is valid for a period beginning with the effective date in paragraph (a) and ending on the date specified by the commissioner on the license certificate placing the applicant in an existing two-year renewal cycle, as established under section 148C.05, subdivision 1.

Sec. 16. **[148C.0355] COMMISSIONER ACTION ON APPLICATIONS FOR LICENSURE.**

The commissioner shall act on each application for licensure within 90 days from the date the completed application and all required information is received by the commissioner. The commissioner shall determine if the applicant meets the requirements for licensure and whether there are grounds for denial of licensure under this chapter. If the commissioner denies an application on grounds other than the applicant's failure of an examination, the commissioner shall:

(1) notify the applicant, in writing, of the denial and the reason for the denial and provide the applicant 30 days from the date of the letter informing the applicant of the denial in which the applicant may provide additional information to address the reasons for the denial. If the applicant does not respond in writing to the commissioner within the 30-day period, the denial is final. If the commissioner receives additional information, the commissioner shall review it and make a final determination thereafter;

(2) notify the applicant that an application submitted following denial is a new application and must be accompanied by the appropriate fee as specified in section 148C.12; and

(3) notify the applicant of the right to request a hearing under chapter 14.

Sec. 17. Minnesota Statutes 2002, section 148C.04, is amended to read:

148C.04 **REQUIREMENTS FOR LICENSURE.**

Subdivision 1. **GENERAL REQUIREMENTS.** The commissioner shall issue licenses to the individuals qualified under ~~sections 148C.01 to 148C.11~~ this chapter to practice alcohol and drug counseling.

Subd. 2. **FEE.** Each applicant shall pay a nonrefundable fee ~~set by the commissioner pursuant to section 148C.03~~ as specified in section 148C.12. Fees paid to the commissioner shall be deposited in the special revenue fund.

Subd. 3. ~~**LICENSING**~~ **REQUIREMENTS FOR ~~THE FIRST FIVE YEARS~~ LICENSURE BEFORE JULY 1, 2008.** ~~For five years after the effective date of the rules authorized in section 148C.03, the~~ An applicant~~, unless qualified under section 148C.06 during the 25-month period authorized therein, under section 148C.07, or under subdivision 4,~~ for a license must furnish evidence satisfactory to the commissioner that the applicant has met all the requirements in clauses (1) to (3). The applicant must have:

(1) received an associate degree, or an equivalent number of credit hours, and a certificate in alcohol and drug counseling, including 18 semester credits or 270 clock hours of ~~alcohol and drug counseling classroom education~~ academic course work in accordance with subdivision 5a, paragraph (a), from an accredited school or educational program and 880 clock hours of supervised alcohol and drug counseling practicum;

(2) completed a written case presentation and satisfactorily passed an oral examination established by the commissioner that demonstrates competence in the core functions; and

(3) satisfactorily passed a written examination as established by the commissioner.

Subd. 4. ~~**LICENSING**~~ **REQUIREMENTS ~~AFTER FIVE YEARS~~ FOR LICENSURE AFTER JULY 1, 2008.** ~~Beginning five years after the effective date of the rules authorized in section 148C.03, subdivision 1~~ , An applicant for ~~licensure~~ a license must submit evidence to the commissioner that the applicant has met one of the following requirements:

(1) the applicant must have:

(i) received a bachelor's degree from an accredited school or educational program, including ~~480~~ 18 semester credits or 270 clock hours of ~~alcohol and drug counseling education~~ academic course work in accordance with subdivision 5a, paragraph (a), from an accredited school or educational program and 880 clock hours of supervised alcohol and drug counseling practicum;

(ii) completed a written case presentation and satisfactorily passed an oral examination established by the commissioner that demonstrates competence in the core functions; and

(iii) satisfactorily passed a written examination as established by the commissioner; or

(2) the applicant must meet the requirements of section 148C.07.

Subd. 5a. **ACADEMIC COURSE WORK.** (a) Minimum academic course work requirements for licensure as referred to under subdivision 3, clause (1), and subdivision 4, clause (1), item (i), must be in the following areas:

(1) overview of alcohol and drug counseling focusing on the transdisciplinary foundations of alcohol and drug counseling and providing an understanding of theories of chemical dependency, the continuum of care, and the process of change;

(2) pharmacology of substance abuse disorders and the dynamics of addiction;

(3) screening, intake, assessment, and treatment planning;

(4) counseling theory and practice, crisis intervention, orientation, and client education;

(5) case management, consultation, referral, treatment planning, reporting, record keeping, and professional and ethical responsibilities; and

(6) multicultural aspects of chemical dependency to include awareness of learning outcomes described in Minnesota Rules, part 4747.1100, subpart 2, and the ability to know when consultation is needed.

(b) Advanced academic course work includes, at a minimum, the course work required in paragraph (a) and additional course work in the following areas:

(1) advanced study in the areas listed in paragraph (a);

(2) chemical dependency and the family;

(3) treating substance abuse disorders in culturally diverse and identified populations;

(4) dual diagnoses/co-occurring disorders with substance abuse disorders; and

(5) ethics and chemical dependency.

Subd. 6. **TEMPORARY ~~PRACTICE~~ PERMIT REQUIREMENTS.** (a) A ~~person may temporarily~~ The commissioner shall issue a temporary permit to practice alcohol and drug counseling prior to being licensed under this chapter if the person:

(1) either:

(i) ~~meets the associate degree education and practicum requirements of subdivision 3, clause (1);~~

~~(ii) meets the bachelor's degree education and practicum requirements of subdivision 4, clause (1), item (i); or~~

~~(iii)~~ submits verification of a current and unrestricted credential for the practice of alcohol and drug counseling from a national certification body or a certification or

licensing body from another state, United States territory, or federally recognized tribal authority;

(ii) submits verification of the completion of at least 64 semester credits, including 270 clock hours or 18 semester credits of formal classroom education in alcohol and drug counseling and at least 880 clock hours of alcohol and drug counseling practicum from an accredited school or educational program; or

(iii) meets the requirements of section 148C.11, subdivision 6, clauses (1), (2), and (5);

(2) ~~requests~~ applies, in writing, ~~temporary practice status with the commissioner~~ on an application form ~~according to section 148C.0351~~ provided by the commissioner, which includes the nonrefundable ~~license~~ temporary permit fee as specified in section 148C.12 and an affirmation by the person's supervisor, as defined in paragraph ~~(b)~~ (c), clause (1), ~~and~~ which is signed and dated by the person and the person's supervisor; and

(3) has not been disqualified to practice temporarily on the basis of a background investigation under section 148C.09, subdivision 1a~~; and~~.

~~(4) has been notified~~ (b) The commissioner must notify the person in writing within 90 days from the date the completed application and all required information is received by the commissioner ~~that~~ whether the person is qualified to practice under this subdivision.

~~(b)~~ (c) A person practicing under this subdivision:

(1) may practice ~~only in a program licensed by the department of human services and~~ under tribal jurisdiction or under the direct~~, on-site~~ supervision of a person who is licensed under this chapter ~~and employed in that licensed program~~;

(2) is subject to the rules of professional conduct set by rule; and

(3) is not subject to the continuing education requirements of section ~~148C.05~~ 148C.075.

~~(c)~~ (d) A person practicing under this subdivision ~~may not~~ must use ~~with the public any~~ the title or description stating or implying that the person is ~~licensed to engage~~ a trainee engaged in the practice of alcohol and drug counseling.

~~(d)~~ (e) ~~The temporary status of~~ A person ~~applying for temporary practice~~ practicing under this subdivision ~~expires on the date the commissioner grants or denies licensing~~ must annually submit a renewal application on forms provided by the commissioner with the renewal fee required in section 148C.12, subdivision 3, and the commissioner may renew the temporary permit if the trainee meets the requirements of this subdivision. A trainee may renew a practice permit no more than five times.

(f) A temporary permit expires if not renewed, upon a change of employment of the trainee or upon a change in supervision, or upon the granting or denial by the commissioner of a license.

Subd. 7. **EFFECT AND SUSPENSION OF TEMPORARY ~~PRACTICE~~ PERMIT.** Approval of a person's application for temporary ~~practice~~ permit creates no rights to or expectation of approval from the commissioner for licensure as an alcohol and drug counselor. The commissioner may suspend or restrict a person's temporary ~~practice~~ permit status according to section 148C.09.

**EFFECTIVE DATE.** Subdivisions 1, 2, 3, 4, and 5a are effective January 28, 2003. Subdivision 6 is effective July 1, 2003.

Sec. 18. **[148C.045] ALCOHOL AND DRUG COUNSELOR TECHNICIAN.**

An alcohol and drug counselor technician may perform the services described in section 148C.01, subdivision 9, paragraphs (1), (2), and (3), while under the direct supervision of a licensed alcohol and drug counselor.

Sec. 19. Minnesota Statutes 2002, section 148C.05, subdivision 1, is amended to read:

Subdivision 1. **BIENNIAL RENEWAL ~~REQUIREMENTS.~~** ~~To renew a license, an applicant must:~~

~~(1) complete a renewal application every two years on a form provided by the commissioner and submit the biennial renewal fee by the deadline; and~~

~~(2) submit additional information if requested by the commissioner to clarify information presented in the renewal application. This information must be submitted within 30 days of the commissioner's request.~~ A license must be renewed every two years.

Sec. 20. Minnesota Statutes 2002, section 148C.05, is amended by adding a subdivision to read:

Subd. 1a. **RENEWAL REQUIREMENTS.** To renew a license, an applicant must submit to the commissioner:

(1) a completed and signed application for license renewal, including a signed consent authorizing the commissioner to obtain information about the applicant from third parties, including, but not limited to, employers, former employers, and law enforcement agencies;

(2) the renewal fee required under section 148C.12; and

(3) additional information as requested by the commissioner to clarify information presented in the renewal application. The licensee must submit information within 30 days of the date of the commissioner's request.

Sec. 21. Minnesota Statutes 2002, section 148C.05, is amended by adding a subdivision to read:

Subd. 5. **LICENSE RENEWAL NOTICE.** At least 60 calendar days before the renewal deadline date in subdivision 6, the commissioner shall mail a renewal notice to the licensee's last known address on file with the commissioner. The notice must

include an application for license renewal, the renewal deadline, and notice of fees required for renewal. The licensee's failure to receive notice does not relieve the licensee of the obligation to meet the renewal deadline and other requirements for license renewal.

Sec. 22. Minnesota Statutes 2002, section 148C.05, is amended by adding a subdivision to read:

Subd. 6. **RENEWAL DEADLINE AND LAPSE OF LICENSURE.** (a) Licensees must comply with paragraphs (b) to (d).

(b) Each license certificate must state an expiration date. An application for license renewal must be received by the commissioner or postmarked at least 30 calendar days before the expiration date. If the postmark is illegible, the application must be considered timely if received at least 21 calendar days before the expiration date.

(c) An application for license renewal not received within the time required under paragraph (b) must be accompanied by a late fee in addition to the renewal fee required in section 148C.12.

(d) A licensee's license lapses if the licensee fails to submit to the commissioner a license renewal application by the licensure expiration date. A licensee shall not engage in the practice of alcohol and drug counseling while the license is lapsed. A licensee whose license has lapsed may renew the license by complying with section 148C.055.

Sec. 23. **[148C.055] INACTIVE OR LAPSED LICENSE.**

Subdivision 1. **INACTIVE LICENSE STATUS.** Unless a complaint is pending against the licensee, a licensee whose license is in good standing may request, in writing, that the license be placed on the inactive list. If a complaint is pending against a licensee, a license may not be placed on the inactive list until action relating to the complaint is concluded. The commissioner must receive the request for inactive status before expiration of the license. A request for inactive status received after the license expiration date must be denied. A licensee may renew a license that is inactive under this subdivision by meeting the renewal requirements of subdivision 2, except that payment of a late renewal fee is not required. A licensee must not practice alcohol and drug counseling while the license is inactive.

Subd. 2. **RENEWAL OF INACTIVE LICENSE.** A licensee whose license is inactive shall renew the inactive status by the inactive status expiration date determined by the commissioner or the license will lapse. An application for renewal of inactive status must include evidence satisfactory to the commissioner that the licensee has completed 40 clock hours of continuing professional education required in section 148C.075, and be received by the commissioner at least 30 calendar days before the expiration date. If the postmark is illegible, the application must be considered timely if received at least 21 calendar days before the expiration date. Late

renewal of inactive status must be accompanied by a late fee as required in section 148C.12.

Subd. 3. **RENEWAL OF LAPSED LICENSE.** An individual whose license has lapsed for less than two years may renew the license by submitting:

(1) a completed and signed license renewal application;

(2) the inactive license renewal fee or the renewal fee and the late fee as required under section 148C.12; and

(3) proof of having met the continuing education requirements in section 148C.075 since the individual's initial licensure or last license renewal. The license issued is then effective for the remainder of the next two-year license cycle.

Subd. 4. **LICENSE RENEWAL FOR TWO YEARS OR MORE AFTER LICENSE EXPIRATION DATE.** An individual who submitted a license renewal two years or more after the license expiration date must submit the following:

(1) a completed and signed application for licensure, as required by section 148C.0351;

(2) the initial license fee as required in section 148C.12; and

(3) verified documentation of having achieved a passing score within the past year on an examination required by the commissioner.

Sec. 24. Minnesota Statutes 2002, section 148C.07, is amended to read:

148C.07 **RECIPROCITY.**

~~The commissioner shall issue an appropriate license to~~ (a) An individual who holds a current license or ~~other credential to engage in alcohol and drug counseling~~ national certification as an alcohol and drug counselor from another jurisdiction ~~if the commissioner finds that the requirements for that credential are substantially similar to the requirements in sections 148C.01 to 148C.11~~ must file with the commissioner a completed application for licensure by reciprocity containing the information required under this section.

(b) The applicant must request the credentialing authority of the jurisdiction in which the credential is held to send directly to the commissioner a statement that the credential is current and in good standing, the applicant's qualifications that entitled the applicant to the credential, and a copy of the jurisdiction's credentialing laws and rules that were in effect at the time the applicant obtained the credential.

(c) The commissioner shall issue a license if the commissioner finds that the requirements, which the applicant had to meet to obtain the credential from the other jurisdiction were substantially similar to the current requirements for licensure in this chapter, and the applicant is not otherwise disqualified under section 148C.09.

Sec. 25. **[148C.075] CONTINUING EDUCATION REQUIREMENTS.**

Subdivision 1. **GENERAL REQUIREMENTS.** The commissioner shall establish a two-year continuing education reporting schedule requiring licensees to report completion of the requirements of this section. Licensees must document completion of a minimum of 40 clock hours of continuing education activities each reporting period. A licensee may be given credit only for activities that directly relate to the practice of alcohol and drug counseling, the core functions, or the rules of professional conduct in Minnesota Rules, part 4747.1400. The continuing education reporting form must require reporting of the following information:

(1) the continuing education activity title;

(2) a brief description of the continuing education activity;

(3) the sponsor, presenter, or author;

(4) the location and attendance dates;

(5) the number of clock hours; and

(6) a statement that the information is true and correct to the best knowledge of the licensee.

Only continuing education obtained during the previous two-year reporting period may be considered at the time of reporting. Clock hours must be earned and reported in increments of one-half clock hour with a minimum of one clock hour for each continuing education activity.

Subd. 2. **CONTINUING EDUCATION REQUIREMENTS FOR LICENSEE'S FIRST FOUR YEARS.** A licensee must, as part of meeting the clock hour requirement of this section, obtain and document 18 hours of cultural diversity training within the first four years after the licensee's initial license effective date according to the commissioner's reporting schedule.

Subd. 3. **CONTINUING EDUCATION REQUIREMENTS AFTER LICENSEE'S INITIAL FOUR YEARS.** Beginning four years following a licensee's initial license effective date and according to the board's reporting schedule, a licensee must document completion of a minimum of six clock hours each reporting period of cultural diversity training. Licensees must also document completion of six clock hours in courses directly related to the rules of professional conduct in Minnesota Rules, part 4747.1400.

Subd. 4. **STANDARDS FOR APPROVAL.** In order to obtain clock hour credit for a continuing education activity, the activity must:

(1) constitute an organized program of learning;

(2) reasonably be expected to advance the knowledge and skills of the alcohol and drug counselor;

(3) pertain to subjects that directly relate to the practice of alcohol and drug counseling and the core functions of an alcohol and drug counselor, or the rules of

professional conduct in Minnesota Rules, part 4747.1400;

(4) be conducted by individuals who have education, training, and experience and are knowledgeable about the subject matter; and

(5) be presented by a sponsor who has a system to verify participation and maintains attendance records for three years, unless the sponsor provides dated evidence to each participant with the number of clock hours awarded.

Sec. 26. Minnesota Statutes 2002, section 148C.10, subdivision 1, is amended to read:

Subdivision 1. **PRACTICE.** ~~After the commissioner adopts rules,~~ No ~~individual~~ person, other than those individuals exempted under section 148C.11, or 148C.045, shall engage in alcohol and drug counseling ~~practice unless that individual holds a valid license~~ without first being licensed under this chapter as an alcohol and drug counselor. For purposes of this chapter, an individual engages in the practice of alcohol and drug counseling if the individual performs or offers to perform alcohol and drug counseling services as defined in section 148C.01, subdivision 10, or if the individual is held out as able to perform those services.

Sec. 27. Minnesota Statutes 2002, section 148C.10, subdivision 2, is amended to read:

Subd. 2. **USE OF TITLES.** ~~After the commissioner adopts rules,~~ No ~~individual~~ person shall present themselves or any other individual to the public by any title incorporating the words "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are licensed or otherwise qualified to practice alcohol and drug counseling unless that individual holds a valid license. ~~City, county, and state agency alcohol and drug counselors who are not licensed under sections 148C.01 to 148C.11 may use the title "city agency alcohol and drug counselor," "county agency alcohol and drug counselor," or "state agency alcohol and drug counselor." Hospital alcohol and drug counselors who are not licensed under sections 148C.01 to 148C.11 may use the title "hospital alcohol and drug counselor" while acting within the scope of their employment~~ Persons issued a temporary permit must use titles consistent with section 148C.04, subdivision 6, paragraph (c).

Sec. 28. Minnesota Statutes 2002, section 148C.11, is amended to read:

148C.11 **EXCEPTIONS TO LICENSE REQUIREMENT.**

Subdivision 1. **OTHER PROFESSIONALS.** (a) Nothing in ~~sections 148C.01 to 148C.10 shall prevent~~ this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to, licensed physicians, registered nurses, licensed practical nurses, licensed psychological practitioners, members of the clergy, American Indian medicine men and women, licensed attorneys, probation officers, licensed marriage and family therapists, licensed social workers, licensed professional

counselors, licensed school counselors, and registered occupational therapists or occupational therapy assistants.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the department of human services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt under this section but who elects to obtain a license under this chapter is subject to this chapter to the same extent as other licensees.

(d) These persons must not, however, use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are engaged in the practice of alcohol and drug counseling, or that they are licensed to engage in the practice of alcohol and drug counseling. Persons engaged in the practice of alcohol and drug counseling are not exempt from the commissioner's jurisdiction solely by the use of one of the above titles.

Subd. 2. **STUDENTS.** Nothing in sections 148C.01 to 148C.10 shall prevent students enrolled in an accredited school of alcohol and drug counseling from engaging in the practice of alcohol and drug counseling while under qualified supervision in an accredited school of alcohol and drug counseling.

Subd. 3. **FEDERALLY RECOGNIZED TRIBES; ETHNIC MINORITIES.** (a) Alcohol and drug counselors ~~licensed to practice~~ practicing alcohol and drug counseling according to standards established by federally recognized tribes, while practicing under tribal jurisdiction, are exempt from the requirements of this chapter. In practicing alcohol and drug counseling under tribal jurisdiction, individuals ~~licensed~~ practicing under that authority shall be afforded the same rights, responsibilities, and recognition as persons licensed pursuant to this chapter.

(b) The commissioner shall develop special licensing criteria for issuance of a license to alcohol and drug counselors who: (1) practice alcohol and drug counseling with a member of an ethnic minority population or with a person with a disability as defined by rule; or (2) are employed by agencies whose primary agency service focus addresses ethnic minority populations or persons with a disability as defined by rule. These licensing criteria may differ from the licensing ~~criteria~~ requirements specified in section 148C.04. To develop, implement, and evaluate the effect of these criteria, the commissioner shall establish a committee comprised of, but not limited to, representatives from the Minnesota commission serving deaf and hard-of-hearing people, the council on affairs of Chicano/Latino people, the council on Asian-Pacific Minnesotans, the council on Black Minnesotans, the council on disability, and the Indian affairs council. The committee does not expire.

(c) The commissioner shall issue a license to an applicant who (1) is an alcohol and drug counselor who is exempt under paragraph (a) from the requirements of this chapter; (2) has at least 2,000 hours of alcohol and drug counselor experience as defined by the core functions; and (3) meets the licensing requirements that are in effect

on the date of application under section 148C.04, subdivision 3 or 4, except the written case presentation and oral examination component under section 148C.04, subdivision 3, clause (2), or 4, clause (1), item (ii). When applying for a license under this paragraph, an applicant must follow the procedures for admission to licensure specified under section 148C.0351. A person who receives a license under this paragraph must complete the written case presentation and satisfactorily pass the oral examination component under section 148C.04, subdivision 3, clause (2), or 4, clause (1), item (ii), at the earliest available opportunity after the commissioner begins administering oral examinations. The commissioner may suspend or restrict a person's license according to section 148C.09 if the person fails to complete the written case presentation and satisfactorily pass the oral examination. This paragraph expires July 1, 2004.

Subd. 4. **HOSPITAL ALCOHOL AND DRUG COUNSELORS.** ~~The licensing of hospital alcohol and drug counselors shall be voluntary, while the counselor is employed by the hospital.~~ Effective January 1, 2006, hospitals employing alcohol and drug counselors shall ~~not~~ be required to employ licensed alcohol and drug counselors~~, nor shall they require their alcohol and drug counselors to be licensed, however, nothing in this chapter will prohibit hospitals from requiring their counselors to be eligible for licensure~~. An alcohol or drug counselor employed by a hospital must be licensed as an alcohol and drug counselor in accordance with this chapter.

Subd. 5. **CITY, COUNTY, AND STATE AGENCY ALCOHOL AND DRUG COUNSELORS.** ~~The licensing of city, county, and state agency alcohol and drug counselors shall be voluntary, while the counselor is employed by the city, county, or state agency.~~ Effective January 1, 2006, city, county, and state agencies employing alcohol and drug counselors shall ~~not~~ be required to employ licensed alcohol and drug counselors~~, nor shall they require their drug and alcohol counselors to be licensed~~. An alcohol and drug counselor employed by a city, county, or state agency must be licensed as an alcohol and drug counselor in accordance with this chapter.

Subd. 6. **TRANSITION PERIOD FOR HOSPITAL AND CITY, COUNTY, AND STATE AGENCY ALCOHOL AND DRUG COUNSELORS.** For the period between July 1, 2003, and January 1, 2006, the commissioner shall grant a license to an individual who is employed as an alcohol and drug counselor at a Minnesota hospital or a city, county, or state agency in Minnesota if the individual:

(1) was employed as an alcohol and drug counselor at a hospital or a city, county, or state agency before August 1, 2002;

(2) has 8,000 hours of alcohol and drug counselor work experience;

(3) has completed a written case presentation and satisfactorily passed an oral examination established by the commissioner;

(4) has satisfactorily passed a written examination as established by the commissioner; and

(5) meets the requirements in section 148C.0351.

Sec. 29. **[148C.12] FEES.**

Subdivision 1. **APPLICATION FEE.** The application fee is $295.

Subd. 2. **BIENNIAL RENEWAL FEE.** The license renewal fee is $295. If the commissioner changes the renewal schedule and the expiration date is less than two years, the fee must be prorated.

Subd. 3. **TEMPORARY PERMIT FEE.** The initial fee for applicants under section 148C.04, subdivision 6, paragraph (a), is $100. The fee for annual renewal of a temporary permit is $100.

Subd. 4. **EXAMINATION FEE.** The examination fee for the written examination is $95 and for the oral examination is $200.

Subd. 5. **INACTIVE RENEWAL FEE.** The inactive renewal fee is $150.

Subd. 6. **LATE FEE.** The late fee is 25 percent of the biennial renewal fee, the inactive renewal fee, or the annual fee for renewal of temporary practice status.

Subd. 7. **FEE TO RENEW AFTER EXPIRATION OF LICENSE.** The fee for renewal of a license that has expired for less than two years is the total of the biennial renewal fee, the late fee, and a fee of $100 for review and approval of the continuing education report.

Subd. 8. **FEE FOR LICENSE VERIFICATIONS.** The fee for license verification to institutions and other jurisdictions is $25.

Subd. 9. **SURCHARGE FEE.** Notwithstanding section 16A.1285, subdivision 2, a surcharge of $99 shall be paid at the time of initial application for or renewal of an alcohol and drug counselor license until June 30, 2013.

Subd. 10. **NONREFUNDABLE FEES.** All fees are nonrefundable.

Sec. 30. **REPEALER.**

(a) Minnesota Statutes 2002, sections 148C.0351, subdivision 2; 148C.05, subdivisions 2, 3, and 4; 148C.06; and 148C.10, subdivision 1a, are repealed.

(b) Minnesota Rules, parts 4747.0030, subparts 25, 28, and 30; 4747.0040, subpart 3, item A; 4747.0060, subpart 1, items A, B, and D; 4747.0070, subparts 4 and 5; 4747.0080; 4747.0090; 4747.0100; 4747.0300; 4747.0400, subparts 2 and 3; 4747.0500; 4747.0600; 4747.1000; 4747.1100, subpart 3; and 4747.1600, are repealed.

## ARTICLE 6

## HUMAN SERVICES LICENSING, COUNTY INITIATIVES, AND MISCELLANEOUS

Section 1. Minnesota Statutes 2002, section 69.021, subdivision 11, is amended to read:

Subd. 11. **EXCESS POLICE STATE-AID HOLDING ACCOUNT.** (a) The excess police state-aid holding account is established in the general fund. The excess police state-aid holding account must be administered by the commissioner.

(b) Excess police state aid determined according to subdivision 10, must be deposited in the excess police state-aid holding account.

(c) From the balance in the excess police state-aid holding account, ~~$1,000,000~~ $900,000 is appropriated to and must be transferred annually to the ambulance service personnel longevity award and incentive suspense account established by section 144E.42, subdivision 2.

(d) If a police officer stress reduction program is created by law and money is appropriated for that program, an amount equal to that appropriation must be transferred from the balance in the excess police state-aid holding account.

(e) On October 1, 1997, and annually on each subsequent October 1, one-half of the balance of the excess police state-aid holding account remaining after the deductions under paragraphs (c) and (d) is appropriated for additional amortization aid under section 423A.02, subdivision 1b.

(f) Annually, the remaining balance in the excess police state-aid holding account, after the deductions under paragraphs (c), (d), and (e), cancels to the general fund.

Sec. 2. Minnesota Statutes 2002, section 245.0312, is amended to read:

245.0312 **DESIGNATING SPECIAL UNITS AND REGIONAL CENTERS.**

Notwithstanding any provision of law to the contrary, during the biennium, the commissioner of human services, upon the approval of the governor after consulting with the legislative advisory commission, may designate portions of ~~hospitals for the mentally ill~~ state-operated services facilities under the commissioner's control as special care units ~~for mentally retarded or inebriate persons, or as nursing homes for persons over the age of 65, and may designate portions of the hospitals designated in Minnesota Statutes 1969, section 252.025, subdivision 1, as special care units for mentally ill or inebriate persons, and may plan to develop all hospitals for mentally ill, mentally retarded, or inebriate persons under the commissioner's control as multipurpose regional centers for programs related to all of the said problems.~~

~~If approved by the governor, the commissioner may rename the state hospital as a state regional center and appoint the hospital administrator as administrator of the~~

~~center, in accordance with section 246.0251.~~

~~The directors of the separate program units of regional centers shall be responsible directly to the commissioner at the discretion of the commissioner.~~

Sec. 3. **[245.945] REIMBURSEMENT TO OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION.**

The commissioner shall obtain federal financial participation for eligible activity by the ombudsman for mental health and mental retardation. The ombudsman shall maintain and transmit to the department of human services documentation that is necessary in order to obtain federal funds.

Sec. 4. Minnesota Statutes 2002, section 245A.035, subdivision 3, is amended to read:

Subd. 3. **REQUIREMENTS FOR EMERGENCY LICENSE.** Before an emergency license may be issued, the following requirements must be met:

(1) the county agency must conduct an initial inspection of the premises where the foster care is to be provided to ensure the health and safety of any child placed in the home. The county agency shall conduct the inspection using a form developed by the commissioner;

(2) at the time of the inspection or placement, whichever is earlier, the relative being considered for an emergency license shall receive an application form for a child foster care license;

(3) whenever possible, prior to placing the child in the relative's home, the relative being considered for an emergency license shall provide the information required by section 245A.04, subdivision 3, paragraph ~~(b)~~ (k); and

(4) if the county determines, prior to the issuance of an emergency license, that anyone requiring a background study may be disqualified under section 245A.04, and the disqualification is one which the commissioner cannot set aside, an emergency license shall not be issued.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2002, section 245A.04, subdivision 3, is amended to read:

Subd. 3. **BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.** (a) Individuals and organizations that are required in statute to initiate background studies under this section shall comply with the following requirements:

(1) Applicants for licensure, license holders, and other entities as provided in this section must submit completed background study forms to the commissioner before individuals specified in paragraph (c), clauses (1) to (4), (6), and (7), begin positions allowing direct contact in any licensed program.

(2) Applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this section must submit completed background study forms to the commissioner prior to the background study subject beginning in a position allowing direct contact in the licensed program, or where applicable, prior to being employed.

(3) Organizations required to initiate background studies under section 256B.0627 for individuals described in paragraph (c), clause (5), must submit a completed background study form to the commissioner before those individuals begin a position allowing direct contact with persons served by the organization. The commissioner shall recover the cost of these background studies through a fee of no more than $12 per study charged to the organization responsible for submitting the background study form. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Upon receipt of the background study forms from the entities in clauses (1) to (3), the commissioner shall complete the background study as specified under this section and provide notices required in subdivision 3a. Unless otherwise specified, the subject of a background study may have direct contact with persons served by a program after the background study form is mailed or submitted to the commissioner pending notification of the study results under subdivision 3a. A county agency may accept a background study completed by the commissioner under this section in place of the background study required under section 245A.16, subdivision 3, in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence and the subject of the study has been continuously affiliated with the license holder since the date of the commissioner's study.

(b) The definitions in this paragraph apply only to subdivisions 3 to 3e.

(1) "Background study" means the review of records conducted by the commissioner to determine whether a subject is disqualified from direct contact with persons served by a program, and where specifically provided in statutes, whether a subject is disqualified from having access to persons served by a program.

(2) "Continuous, direct supervision" means an individual is within sight or hearing of the supervising person to the extent that supervising person is capable at all times of intervening to protect the health and safety of the persons served by the program.

(3) "Contractor" means any person, regardless of employer, who is providing program services for hire under the control of the provider.

(4) "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.

(5) "Reasonable cause" means information or circumstances exist which provide the commissioner with articulable suspicion that further pertinent information may exist concerning a subject. The commissioner has reasonable cause when, but not

limited to, the commissioner has received a report from the subject, the license holder, or a third party indicating that the subject has a history that would disqualify the person or that may pose a risk to the health or safety of persons receiving services.

(6) "Subject of a background study" means an individual on whom a background study is required or completed.

(c) The applicant, license holder, registrant under section 144A.71, subdivision 1, bureau of criminal apprehension, commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. If a background study is initiated by an applicant or license holder and the applicant or license holder receives information about the possible criminal or maltreatment history of an individual who is the subject of the background study, the applicant or license holder must immediately provide the information to the commissioner. The individuals to be studied shall include:

(1) the applicant;

(2) persons age 13 and over living in the household where the licensed program will be provided;

(3) current employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) any person required under section 256B.0627 to have a background study completed under this section;

(6) persons ages 10 to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause; and

(7) persons who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from the program licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home when the commissioner has reasonable cause.

(d) According to paragraph (c), clauses (2) and (6), the commissioner shall review records from the juvenile courts. For persons under paragraph (c), clauses (1), (3), (4), (5), and (7), who are ages 13 to 17, the commissioner shall review records from the juvenile courts when the commissioner has reasonable cause. The juvenile courts shall help with the study by giving the commissioner existing juvenile court records on individuals described in paragraph (c), clauses (2), (6), and (7), relating to delinquency proceedings held within either the five years immediately preceding the background

study or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

(e) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than $8 per study, charged to the supplemental nursing services agency. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

(f) For purposes of this section, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(g) A study of an individual in paragraph (c), clauses (1) to (7), shall be conducted at least upon application for initial license for all license types or registration under section 144A.71, subdivision 1, and at reapplication for a license for family child care, child foster care, and adult foster care. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph (j) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results. For individuals who are required to have background studies under paragraph (c) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

(h) The commissioner may also conduct studies on individuals specified in paragraph (c), clauses (3) and (4), when the studies are initiated by:

(i) personnel pool agencies;

(ii) temporary personnel agencies;

(iii) educational programs that train persons by providing direct contact services in licensed programs; and

(iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

(i) Studies on individuals in paragraph (h), items (i) to (iv), must be initiated annually by these agencies, programs, and individuals. Except as provided in paragraph (a), clause (3), no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

(i) the facility makes this request using a form provided by the commissioner;

(ii) in making the request the facility informs the commissioner that either:

(A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or

(B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and

(iii) the facility provides notices to the individual as required in paragraphs (a) to (j), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

(j) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health, a facility serving children or youth licensed by the department of corrections, or ~~who is affiliated~~ with any type of

home care agency or provider of personal care assistance services, is convicted of a crime constituting a disqualification under subdivision 3d, the probation officer or corrections agent shall notify the commissioner of the conviction. For the purpose of this paragraph, "conviction" has the meaning given it in section 609.02, subdivision 5. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

(k) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name and all other names by which the individual has been known; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number or state identification number. The applicant or license holder shall provide this information about an individual in paragraph (c), clauses (1) to (7), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

(l) For programs directly licensed by the commissioner, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph (c) for persons listed in paragraph (c), clauses (2), (6), and (7), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph (c) for persons listed in paragraph (c), clauses (2), (6), and (7), and information from the bureau of criminal apprehension. For any background study completed under this section, the commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff,

county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph (c), clauses (1) to (7). The commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background study.

(m) For any background study completed under this section, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

(1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;

(2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(n) The failure or refusal of an applicant, license holder, or registrant under section 144A.71, subdivision 1, to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

(o) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

(p) No person in paragraph (c), clauses (1) to (7), who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program and no person in paragraph (c), clauses (2), (6), and (7), or as provided elsewhere in statute who is disqualified as a result of this section may be allowed access to persons served by the program, unless the commissioner has provided written notice to the agency stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in subdivision 3a, paragraph (b), clause (2) or (3);

(2) the individual's disqualification has been set aside for that agency as provided in subdivision 3b, paragraph (b); or

(3) the license holder has been granted a variance for the disqualified individual under subdivision 3e.

(q) Termination of affiliation with persons in paragraph (c), clauses (1) to (7), made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

(r) The commissioner may establish records to fulfill the requirements of this section.

(s) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

(t) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

(u) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(v) County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2002, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. **RECONSIDERATION OF DISQUALIFICATION.** (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. Upon showing that the information in clause (1) or (2) cannot be obtained within 30 days, the disqualified individual may request additional time, not to exceed 30 days, to obtain that information. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the

disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon in determining that the underlying conduct giving rise to the disqualification occurred, and for maltreatment, that the maltreatment was serious or recurring, is incorrect; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant, license holder, or registrant under section 144A.71, subdivision 1.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the individual does not pose a risk of harm to any person served by the applicant, license holder, or registrant under section 144A.71, subdivision 1. In determining that an individual does not pose a risk of harm, the commissioner shall consider the nature, severity, and consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the age and vulnerability of the victim at the time of the event, the harm suffered by the victim, the similarity between the victim and persons served by the program, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder, applicant, or registrant under section 144A.71, subdivision 1, over the interests of the license holder, applicant, or registrant under section 144A.71, subdivision 1. If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. The commissioner's set aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice, unless otherwise specified in the notice. The commissioner may rescind a previous set aside of a disqualification under this section based on new information that indicates the individual may pose a risk of harm to persons served by the applicant, license holder, or registrant. If the commissioner rescinds a set aside of a disqualification under this paragraph, the appeal rights under paragraphs (a) and (e) shall apply.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.165 (felon ineligible to possess firearm), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.223 or 609.2231 (assault in the third or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.255 (false imprisonment), 609.562 (arson in the second degree), 609.71 (riot), 609.498, subdivision 1 or ~~1a~~ 1b (aggravated first degree or first degree tampering with a witness), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749, subdivision 2 (gross misdemeanor harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a felony level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the involuntary termination of parental rights under section 260C.301 or the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.561 (arson in the first degree), 609.749, subdivision 3, 4, or 5 (felony-level harassment; stalking), 609.228 (great bodily harm caused by distribution of drugs), 609.221 or 609.222 (assault in the first or second degree), 609.66, subdivision 1e (drive-by shooting), 609.855, subdivision 5 (shooting in or at a public transit vehicle or facility), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322

(solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant, license holder, or registrant under section 144A.71, subdivision 1, residing in the applicant's or license holder's home, or the home of a registrant under section 144A.71, subdivision 1, the applicant, license holder, or registrant under section 144A.71, subdivision 1, may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration under section 144A.71, subdivision 1, because the license holder, applicant, or registrant under section 144A.71, subdivision 1, poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license

holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, if a disqualification for which reconsideration was requested is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in subdivision 3d, paragraph (a), clauses (1) to (4); for a determination under section 626.556 or 626.557 of substantiated maltreatment that was serious or recurring under subdivision 3d, paragraph (a), clause (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual, specifically, including a challenge to the accuracy and completeness of data under section 13.04. If the individual was disqualified based on a conviction or admission to any crimes listed in subdivision 3d, paragraph (a), clauses (1) to (4), the reconsideration decision under this subdivision is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045.

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. If the county agency has disqualified an individual on multiple bases, one of which is a county maltreatment determination for which the individual has a right to request reconsideration, the county shall conduct the reconsideration of all disqualifications. Except as provided under subdivision 3c, if an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and requests a fair hearing on the disqualification, which has not been set aside or rescinded under this subdivision, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, a fair hearing is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(g) In the notice from the commissioner that a disqualification has been set aside, the license holder must be informed that information about the nature of the disqualification and which factors under paragraph (b) were the bases of the decision to set aside the disqualification is available to the license holder upon request without

consent of the background study subject. With the written consent of a background study subject, the commissioner may release to the license holder copies of all information related to the background study subject's disqualification and the commissioner's decision to set aside the disqualification as specified in the written consent.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2002, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. **DISQUALIFICATION.** (a) Upon receipt of information showing, or when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an investigation results in an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder, entity identified in subdivision 3, paragraph (a), or registrant under section 144A.71, subdivision 1, and for individuals studied under section 245A.04, subdivision 3, paragraph (c), clauses (2), (6), and (7), the individual shall also be disqualified from access to a person receiving services from the license holder:

(1) regardless of how much time has passed since the involuntary termination of parental rights under section 260C.301 or the discharge of the sentence imposed for the offense, and unless otherwise specified, regardless of the level of the conviction, the individual was convicted of any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.221 or 609.222 (assault in the first or second degree); 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.561 (arson in the first degree); 609.749, subdivision 3, 4, or 5 (felony-level harassment; stalking); 609.66, subdivision 1e (drive-by shooting); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 609.322 (solicitation, inducement, and promotion of prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); a felony offense under 609.324, subdivision 1 (other prohibited acts); 617.246 (use of minors in sexual performance prohibited); 617.247 (possession of pictorial representations of minors); a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children; or attempt or conspiracy to commit any of these

offenses as defined in Minnesota Statutes, or an offense in any other state or country, where the elements are substantially similar to any of the offenses listed in this clause;

(2) if less than 15 years have passed since the discharge of the sentence imposed for the offense; and the individual has received a felony conviction for a violation of any of these offenses: sections 609.21 (criminal vehicular homicide and injury); 609.165 (felon ineligible to possess firearm); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.498, subdivision 1 or ~~1a~~ 1b (aggravated first degree or first degree tampering with a witness); 609.713 (terroristic threats); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.563 (arson in the third degree); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 609.71 (riot); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.2325 (criminal abuse of a vulnerable adult); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.52 (theft); 609.2335 (financial exploitation of a vulnerable adult); 609.521 (possession of shoplifting gear); 609.582 (burglary); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.27 (coercion); 609.275 (attempt to coerce); 609.687 (adulteration); 260C.301 (grounds for termination of parental rights); chapter 152 (drugs; controlled substance); and a felony level conviction involving alcohol or drug use. An attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses in this clause. If the individual studied is convicted of one of the felonies listed in this clause, but the sentence is a gross misdemeanor or misdemeanor disposition, the lookback period for the conviction is the period applicable to the disposition, that is the period for gross misdemeanors or misdemeanors;

(3) if less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has received a gross misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); violation of an order for protection under 518B.01, subdivision 14; 609.3451 (criminal sexual conduct in the fifth degree); repeat offenses under 609.746 (interference with privacy); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.71 (riot); 609.66 (dangerous weapons); 609.749, subdivision 2 (harassment; stalking); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined);

609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.265 (abduction); 609.378 (neglect or endangerment of a child); 609.377 (malicious punishment of a child); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.52 (theft); 609.582 (burglary); 609.631 (check forgery; offering a forged check); 609.275 (attempt to coerce); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause. If the defendant is convicted of one of the gross misdemeanors listed in this clause, but the sentence is a misdemeanor disposition, the lookback period for the conviction is the period applicable to misdemeanors; or

(4) if less than seven years have passed since the discharge of the sentence imposed for the offense; and the individual has received a misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 (domestic assault); violation of an order for protection under 518B.01 (Domestic Abuse Act); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.746 (interference with privacy); 609.79 (obscene or harassing phone calls); 609.795 (letter, telegram, or package; opening; harassment); 617.23 (indecent exposure; penalties); 609.2672 (assault of an unborn child in the third degree); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.66 (dangerous weapons); 609.665 (spring guns); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.52 (theft); 609.27 (coercion); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause; a determination or disposition of failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or a determination or disposition of substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

For the purposes of this section, "serious maltreatment" means sexual abuse; maltreatment resulting in death; or maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought; or abuse resulting in serious injury. For purposes of this section, "abuse resulting in serious injury" means: bruises, bites, skin laceration or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for

which complications are present; extensive second-degree or third-degree frostbite, and others for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyeball; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. For purposes of this section, "care of a physician" is treatment received or ordered by a physician, but does not include diagnostic testing, assessment, or observation. For the purposes of this section, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. For purposes of this section, "access" means physical access to an individual receiving services or the individual's personal property without continuous, direct supervision as defined in section 245A.04, subdivision 3.

(b) Except for background studies related to child foster care, adult foster care, or family child care licensure, when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the regulated person has been determined to have been responsible for substantiated maltreatment under section 626.556 or 626.557, instead of the commissioner making a decision regarding disqualification, the board shall make a determination whether to impose disciplinary or corrective action under chapter 214.

(1) The commissioner shall notify the health-related licensing board:

(i) upon completion of a background study that produces a record showing that the individual was determined to have been responsible for substantiated maltreatment;

(ii) upon the commissioner's completion of an investigation that determined the individual was responsible for substantiated maltreatment; or

(iii) upon receipt from another agency of a finding of substantiated maltreatment for which the individual was responsible.

(2) The commissioner's notice shall indicate whether the individual would have been disqualified by the commissioner for the substantiated maltreatment if the individual were not regulated by the board. The commissioner shall concurrently send this notice to the individual.

(3) Notwithstanding the exclusion from this subdivision for individuals who provide child foster care, adult foster care, or family child care, when the commissioner or a local agency has reason to believe that the direct contact services provided by the individual may fall within the jurisdiction of a health-related licensing board, a referral shall be made to the board as provided in this section.

(4) If, upon review of the information provided by the commissioner, a health-related licensing board informs the commissioner that the board does not have jurisdiction to take disciplinary or corrective action, the commissioner shall make the appropriate disqualification decision regarding the individual as otherwise provided in this chapter.

(5) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated persons practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated person from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated person poses an immediate risk of harm to persons receiving services in a licensed facility.

(6) A facility that allows a regulated person to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(7) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of noncompliance with requirements placed on a facility or upon a person regulated by the board.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2002, section 245A.09, subdivision 7, is amended to read:

Subd. 7. **REGULATORY METHODS.** (a) Where appropriate and feasible the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of another state or federal governmental agency or an independent accreditation body have been shown to ~~predict compliance with the rules~~ require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards, the commissioner shall consider compliance with the governmental or accreditation standards to be equivalent to partial compliance with the ~~rules~~ licensing standards; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

(b) If the commissioner accepts accreditation as documentation of compliance with a licensing standard under paragraph (a), the commissioner shall continue to investigate complaints related to noncompliance with all licensing standards. The commissioner may take a licensing action for noncompliance under this chapter and shall recognize all existing appeal rights regarding any licensing actions taken under this chapter.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and children, families, and learning in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of

licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and children, families, and learning in conducting joint agency inspections of programs.

~~(c)~~ (d) The commissioner shall work with the commissioners of health, public safety, administration, and children, families, and learning in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

~~(d)~~ (e) Unless otherwise specified in statute, the commissioner may ~~specify in rule periods of licensure up to two years~~ conduct routine inspections biennially.

Sec. 9. Minnesota Statutes 2002, section 245A.10, is amended to read:

245A.10 **FEES.**

Subdivision 1. **APPLICATION OR LICENSE FEE REQUIRED, PROGRAMS EXEMPT FROM FEE.** (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation of applications and inspection of programs~~, other than family day care and foster care,~~ which are licensed under this chapter. ~~The commissioner may charge a fee for the licensing of school age child care programs, in an amount sufficient to cover the cost to the state agency of processing the license.~~

(b) Except as provided under subdivision 2, no application or license fee shall be charged for child foster care, adult foster care, family and group family child 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. **COUNTY FEES FOR BACKGROUND STUDIES AND LICENSING INSPECTIONS IN FAMILY AND GROUP FAMILY CHILD CARE.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a fee to an applicant or license holder to recover the actual cost of licensing inspections, but in any case not to exceed $150 annually.

(b) A county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

Subd. 3. **APPLICATION FEE FOR INITIAL LICENSE OR CERTIFICATION.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $500 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to (3), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide waivered services to persons with developmental disabilities or related conditions, an applicant shall submit an application for each county in which the waivered services will be provided.

(2) For a license to provide semi-independent living services to persons with developmental disabilities or related conditions, an applicant shall submit a single application to provide services statewide.

(3) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

Subd. 4. **ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITH LICENSED CAPACITY.** (a) Child care centers and programs with a licensed capacity shall pay an annual nonrefundable license or certification fee based on the following schedule:

| Licensed Capacity | Child Care Center License Fee | Other Program License Fee |
|---|---|---|
| 1 to 24 persons | $300 | $400 |
| 25 to 49 persons | $450 | $600 |
| 50 to 74 persons | $600 | $800 |
| 75 to 99 persons | $750 | $1,000 |
| 100 to 124 persons | $900 | $1,200 |
| 125 to 149 persons | $1,200 | $1,400 |
| 150 to 174 persons | $1,400 | $1,600 |
| 175 to 199 persons | $1,600 | $1,800 |
| 200 to 224 persons | $1,800 | $2,000 |
| 225 or more persons | $2,000 | $2,500 |

(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. When a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

Subd. 5. **ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITHOUT A LICENSED CAPACITY.** (a) Except as provided in paragraph (b), a program without a stated licensed capacity shall pay a license or certification fee of $400.

(b) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870 shall pay a certification fee of $1,000 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Subd. 6. **LICENSE NOT ISSUED UNTIL LICENSE OR CERTIFICATION FEE IS PAID.** The commissioner shall not issue a license or certification until the license or certification fee is paid. The commissioner shall send a bill for the license or certification fee to the billing address identified by the license holder. If the license holder does not submit the license or certification fee payment by the due date, the commissioner shall send the license holder a past due notice. If the license holder fails to pay the license or certification fee by the due date on the past due notice, the commissioner shall send a final notice to the license holder informing the license holder that the program license will expire on December 31 unless the license fee is paid before December 31. If a license expires, the program is no longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2, must not operate after the expiration date. After a license expires, if the former license holder wishes to provide licensed services, the former license holder must submit a new license application and application fee under subdivision 3.

Sec. 10. Minnesota Statutes 2002, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **ADULT FOSTER CARE LICENSE CAPACITY.** (a) An adult foster care license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(b) The commissioner may grant variances to paragraph (a) to allow a foster care provider with a licensed capacity of five persons to admit an individual under the age

of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed foster care provider is located.

(c) The commissioner may grant variances to paragraph (a) to allow the use of a fifth bed for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed foster care provider is located.

(d) Notwithstanding paragraph (a), the commissioner may issue an adult foster care license with a capacity of five adults when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, 2003.

(e) The commissioner shall not issue a new adult foster care license under paragraph (d) after June 30, 2005. The commissioner shall allow a facility with an adult foster care license issued under paragraph (d) before June 30, 2005, to continue with a capacity of five or six adults if the license holder continues to comply with the requirements in paragraph (d).

Sec. 11. Minnesota Statutes 2002, section 245A.11, subdivision 2b, is amended to read:

Subd. 2b. **ADULT FOSTER CARE; FAMILY ADULT DAY CARE.** An adult foster care license holder licensed under the conditions in subdivision 2a may also provide family adult day care for adults age 55 or over if no persons in the adult foster or adult family day care program have a serious and persistent mental illness or a developmental disability. The maximum combined capacity for adult foster care and family adult day care is five adults, except that the commissioner may grant a variance for a family adult day care provider to admit up to seven individuals for day care services and one individual for respite care services, if all of the following require-

ments are met: (1) the variance complies with section 245A.04, subdivision 9; (2) a second caregiver is present whenever six or more clients are being served; and (3) the variance is recommended by the county social service agency in the county where the provider is located. A separate license is not required to provide family adult day care under this subdivision. Adult foster care homes providing services to five adults under this section shall not be subject to licensure by the commissioner of health under the provisions of chapter 144, 144A, 157, or any other law requiring facility licensure by the commissioner of health.

Sec. 12. Minnesota Statutes 2002, section 245A.11, is amended by adding a subdivision to read:

Subd. 7. **ADULT FOSTER CARE; VARIANCE FOR ALTERNATE OVERNIGHT SUPERVISION.** (a) The commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow for alternative methods of overnight supervision. The commissioner may grant the variance if the local county licensing agency recommends the variance and the county recommendation includes documentation verifying that:

(1) the county has approved the license holder's plan for alternative methods of providing overnight supervision and determined the plan protects the residents' health, safety, and rights;

(2) the license holder has obtained written and signed informed consent from each resident or each resident's legal representative documenting the resident's or legal representative's agreement with the alternative method of overnight supervision; and

(3) the alternative method of providing overnight supervision is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

(b) To be eligible for a variance under paragraph (a), the adult foster care license holder must not have had a licensing action under section 245A.06 or 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

Sec. 13. Minnesota Statutes 2002, section 245B.03, subdivision 2, is amended to read:

Subd. 2. **RELATIONSHIP TO OTHER STANDARDS GOVERNING SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.** (a) ICFs/MR are exempt from:

(1) section 245B.04;

(2) section 245B.06, subdivisions 4 and 6; and

(3) section 245B.07, subdivisions 4, paragraphs (b) and (c); 7; and 8, paragraphs (1), clause (iv), and (2).

(b) License holders also licensed under chapter 144 as a supervised living facility are exempt from section 245B.04.

(c) Residential service sites controlled by license holders licensed under chapter 245B for home and community-based waivered services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waivered services for four or fewer children are exempt from compliance with Minnesota Rules, parts 9545.0130; 9545.0140; 9545.0150; 9545.0170; 9545.0220, subparts 1, items C, F, and I, and 3; and 9545.0230.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

~~(e)~~ (f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

~~(f)~~ (g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without mental retardation or related conditions provided this chapter's standards are met as well as other relevant standards.

~~(g)~~ (h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Sec. 14. Minnesota Statutes 2002, section 245B.03, is amended by adding a subdivision to read:

Subd. 3. **CONTINUITY OF CARE.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and procedures under section 245B.07, subdivision 8, are substantially similar, the license holder is exempt from the requirements in sections 245B.06, subdivisions 2, paragraphs (e) and (f), and 4; and 245B.07, subdivision 9, clause (2).

(b) When a direct service staff person begins providing direct service under one or more licenses other than the license for which the staff person initially received the

staff orientation requirements under section 245B.07, subdivision 5, the license holder is exempt from all staff orientation requirements under section 245B.07, subdivision 5, except that:

(1) if the service provision location changes, the staff person must receive orientation regarding any policies or procedures under section 245B.07, subdivision 8, that are specific to the service provision location; and

(2) if the staff person provides direct service to one or more consumers for whom the staff person has not previously provided direct service, the staff person must review each consumer's: (i) service plans and risk management plan in accordance with section 245B.07, subdivision 5, paragraph (b), clause (1); and (ii) medication administration in accordance with section 245B.07, subdivision 5, paragraph (b), clause (6).

Sec. 15. Minnesota Statutes 2002, section 245B.04, subdivision 2, is amended to read:

Subd. 2. **SERVICE-RELATED RIGHTS.** A consumer's service-related rights include the right to:

(1) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(2) know, in advance, limits to the services available from the license holder;

(3) know conditions and terms governing the provision of services, including those related to initiation and termination;

(4) know what the charges are for services, regardless of who will be paying for the services, and be notified upon request of changes in those charges;

(5) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the consumer or other private party may have to pay; and

(6) receive licensed services from individuals who are competent and trained, who have professional certification or licensure, as required, and who meet additional qualifications identified in the individual service plan.

Sec. 16. Minnesota Statutes 2002, section 245B.06, subdivision 2, is amended to read:

Subd. 2. **RISK MANAGEMENT PLAN.** (a) The license holder must develop ~~and~~, document in writing, and implement a risk management plan that ~~incorporates the individual abuse prevention plan as required in section 245A.65~~ meets the requirements of this subdivision. License holders licensed under this chapter are exempt from sections 245A.65, subdivision 2, and 626.557, subdivision 14, if the requirements of this subdivision are met.

(b) The risk management plan must identify areas in which the consumer is vulnerable, based on an assessment, at a minimum, of the following areas:

(1) an adult consumer's susceptibility to physical, emotional, and sexual abuse as defined in section 626.5572, subdivision 2, and financial exploitation as defined in section 626.5572, subdivision 9; a minor consumer's susceptibility to sexual and physical abuse as defined in section 626.556, subdivision 2; and a consumer's susceptibility to self-abuse, regardless of age;

(2) the consumer's health needs, considering the consumer's physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment;

(3) the consumer's safety needs, considering the consumer's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;

(4) environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the consumer's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment; and

(5) the consumer's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion, as defined under section 245B.02, subdivision 10, clauses (6) and (7).

(c) When assessing a consumer's vulnerability, the license holder must consider only the consumer's skills and abilities, independent of staffing patterns, supervision plans, the environment, or other situational elements.

(d) License holders jointly providing services to a consumer shall coordinate and use the resulting assessment of risk areas for the development of ~~this~~ each license holder's risk management or the shared risk management plan. ~~Upon initiation of services, the license holder will have in place an initial risk management plan that identifies areas in which the consumer is vulnerable, including health, safety, and environmental issues and the supports the provider will have in place to protect the consumer and to minimize these risks. The plan must be changed based on the needs of the individual consumer and reviewed at least annually.~~ The license holder's plan must include the specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability areas. The specific actions must include the proactive measures being taken, training being provided, or a detailed description of actions a staff person will take when intervention is needed.

(e) Prior to or upon initiating services, a license holder must develop an initial risk management plan that is, at a minimum, verbally approved by the consumer or consumer's legal representative and case manager. The license holder must document the date the license holder receives the consumer's or consumer's legal representative's

and case manager's verbal approval of the initial plan.

(f) As part of the meeting held within 45 days of initiating service, as required under section 245B.06, subdivision 4, the license holder must review the initial risk management plan for accuracy and revise the plan if necessary. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in this plan review. If the license holder revises the plan, or if the consumer or consumer's legal representative and case manager have not previously signed and dated the plan, the license holder must obtain dated signatures to document the plan's approval.

(g) After plan approval, the license holder must review the plan at least annually and update the plan based on the individual consumer's needs and changes to the environment. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in the ongoing plan development. The license holder shall obtain dated signatures from the consumer or consumer's legal representative and case manager to document completion of the annual review and approval of plan changes.

Sec. 17. Minnesota Statutes 2002, section 245B.06, subdivision 5, is amended to read:

Subd. 5. **PROGRESS REVIEWS.** The license holder must participate in progress review meetings following stated time lines established in the consumer's individual service plan or as requested in writing by the consumer, the consumer's legal representative, or the case manager, at a minimum of once a year. The license holder must summarize the progress toward achieving the desired outcomes and make recommendations in a written report sent to the consumer or the consumer's legal representative and case manager prior to the review meeting. ~~For consumers under public guardianship, the license holder is required to provide quarterly written progress review reports to the consumer, designated family member, and case manager.~~

Sec. 18. Minnesota Statutes 2002, section 245B.07, subdivision 6, is amended to read:

Subd. 6. **STAFF TRAINING.** (a) ~~The~~ A license holder providing semi-independent living services shall ensure that direct service staff annually complete hours of training equal to ~~two~~ one percent of the number of hours the staff person worked ~~or one percent for license holders providing semi-independent living services~~. All other license holders shall ensure that direct service staff annually complete hours of training as follows:

(1) if the direct services staff have been employed for one to 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 40 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 30 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 20 training hours; or

(2) if the direct services staff have been employed for more than 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 20 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 15 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 12 training hours.

If direct service staff has received training from a license holder licensed under a program rule identified in this chapter or completed course work regarding disability-related issues from a post-secondary educational institute, that training may also count toward training requirements for other services and for other license holders.

(b) The license holder must document the training completed by each employee.

(c) Training shall address staff competencies necessary to address the consumer needs as identified in the consumer's individual service plan and ensure consumer health, safety, and protection of rights. Training may also include other areas identified by the license holder.

(d) For consumers requiring a 24-hour plan of care, the license holder shall provide training in cardiopulmonary resuscitation, from a qualified source determined by the commissioner, if the consumer's health needs as determined by the consumer's physician indicate trained staff would be necessary to the consumer.

Sec. 19. Minnesota Statutes 2002, section 245B.07, subdivision 9, is amended to read:

Subd. 9. **AVAILABILITY OF CURRENT WRITTEN POLICIES AND PROCEDURES.** The license holder shall:

(1) review and update, as needed, the written policies and procedures in this chapter ~~and inform all consumers or the consumer's legal representatives, case managers, and employees of the revised policies and procedures when they affect the service provision~~;

(2) inform consumers or the consumer's legal representatives of the written policies and procedures in this chapter upon service initiation. Copies must be available to consumers or the consumer's legal representatives, case managers, the county where services are located, and the commissioner upon request; ~~and~~

(3) provide all consumers or the consumers' legal representatives and case managers a copy and explanation of revisions to policies and procedures that affect consumers' service-related or protection-related rights under section 245B.04. Unless there is reasonable cause, the license holder must provide this notice at least 30 days

before implementing the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions;

(4) annually notify all consumers or the consumers' legal representatives and case managers of any revised policies and procedures under this chapter, other than those in clause (3). Upon request, the license holder must provide the consumer or consumer's legal representative and case manager copies of the revised policies and procedures;

(5) before implementing revisions to policies and procedures under this chapter, inform all employees of the revised policies and procedures; and

(6) document and maintain relevant information related to the policies and procedures in this chapter.

Sec. 20. Minnesota Statutes 2002, section 245B.08, subdivision 1, is amended to read:

Subdivision 1. **ALTERNATIVE METHODS OF DETERMINING COMPLIANCE.** (a) In addition to methods specified in chapter 245A, the commissioner may use alternative methods and new regulatory strategies to determine compliance with this section. The commissioner may use sampling techniques to ensure compliance with this section. Notwithstanding section 245A.09, subdivision 7, paragraph ~~(d)~~ (e), the commissioner may also extend periods of licensure, not to exceed five years, for license holders who have demonstrated substantial and consistent compliance with sections 245B.02 to 245B.07 and have consistently maintained the health and safety of consumers and have demonstrated by alternative methods in paragraph (b) that they meet or exceed the requirements of this section. For purposes of this section, "substantial and consistent compliance" means that during the current licensing period:

(1) the license holder's license has not been made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there have been no program deficiencies that have been identified that would jeopardize the health or safety of consumers being served; and

(4) the license holder is in substantial compliance with the other requirements of chapter 245A and other applicable laws and rules.

(b) To determine the length of a license, the commissioner shall consider:

(1) information from affected consumers, and the license holder's responsiveness to consumers' concerns and recommendations;

(2) self assessments and peer reviews of the standards of this section, corrective actions taken by the license holder, and sharing the results of the inspections with consumers, the consumers' families, and others, as requested;

(3) length of accreditation by an independent accreditation body, if applicable;

(4) information from the county where the license holder is located; and

(5) information from the license holder demonstrating performance that meets or exceeds the minimum standards of this chapter.

(c) The commissioner may reduce the length of the license if the license holder fails to meet the criteria in paragraph (a) and the conditions specified in paragraph (b).

Sec. 21. Minnesota Statutes 2002, section 246.014, is amended to read:

246.014 **SERVICES.**

The measure of services established and prescribed by section 246.012, are:

(a) The commissioner of human services shall develop and maintain state-operated services in a manner consistent with sections 245.461, 245.487, and 253.28, and chapters 252A, 254A, and 254B. State-operated services shall be provided in coordination with counties and other vendors. State-operated services shall include regional treatment centers, specialized inpatient or outpatient treatment programs, enterprise services, community-based services and programs, community preparation services, consultative services, and other services consistent with the mission of the department of human services. These services shall include crisis beds, waivered homes, intermediate care facilities, and day training and habilitation facilities. The administrative structure of state-operated services must be statewide in character. The state-operated services staff may deliver services at any location throughout the state.

(b) The commissioner of human services shall create and maintain forensic services programs. Forensic services shall be provided in coordination with counties and other vendors. Forensic services shall include specialized inpatient programs at secure treatment facilities as defined in section 253B.02, subdivision 18a, consultative services, aftercare services, community-based services and programs, transition services, or other services consistent with the mission of the department of human services.

(c) Community preparation services as identified in paragraphs (a) and (b) are defined as specialized inpatient or outpatient services or programs operated outside of a secure environment but are administered by a secured treatment facility.

(d) The commissioner of human services may establish policies and procedures which govern the operation of the services and programs under the direct administrative authority of the commissioner.

~~(1) There shall be served in state hospitals a single standard of food for patients and employees alike, which is nutritious and palatable together with special diets as prescribed by the medical staff thereof. There shall be a chief dietitian in the department of human services and at least one dietitian at each state hospital. There shall be adequate staff and equipment for processing, preparation, distribution and serving of food.~~

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

~~(2) There shall be a staff of persons, professional and lay, sufficient in number, trained in the diagnosis, care and treatment of persons with mental illness, physical illness, and including religious and spiritual counsel through qualified chaplains (who shall be in the unclassified service) adequate to take advantage of and put into practice modern methods of psychiatry, medicine and related field.~~

~~(3) There shall be a staff and facilities to provide occupational and recreational therapy, entertainment and other creative activities as are consistent with modern methods of treatment and well being.~~

~~(4) There shall be in each state hospital for the care and treatment of persons with mental illness facilities for the segregation and treatment of patients and residents who have communicable disease.~~

~~(5) The commissioner of human services shall provide modern and adequate psychiatric social case work service.~~

~~(6) The commissioner of human services shall make every effort to improve the accommodations for patients and residents so that the same shall be comfortable and attractive with adequate furnishings, clothing, and supplies.~~

~~(7) The commissioner of human services shall establish training programs for the training of personnel and may require the participation of personnel in such programs. Within the limits of the appropriations available the commissioner may establish professional training programs in the forms of educational stipends for positions for which there is a scarcity of applicants.~~

~~(8) The standards herein established shall be adapted and applied to the diagnosis, care and treatment of persons with chemical dependency or mental retardation who come within those terms as defined in the laws relating to the hospitalization and commitment of such persons, and of persons who have sexual psychopathic personalities or are sexually dangerous persons as defined in chapter 253B.~~

~~(9) The commissioner of human services shall establish a program of detection, diagnosis and treatment of persons with mental illness and persons described in clause (8), and within the limits of appropriations may establish clinics and staff the same with persons specially trained in psychiatry and related fields.~~

~~(10) The commissioner of employee relations may reclassify employees of the state hospitals from time to time, and assign classifications to such salary brackets as will adequately compensate personnel and reasonably assure a continuity of adequate staff.~~

~~(11) In addition to the chaplaincy services, provided in clause (2), the commissioner of human services shall open said state hospitals to members of the clergy and other spiritual leaders to the end that religious and spiritual counsel and services are made available to the patients and residents therein, and shall cooperate with all members of the clergy and other spiritual leaders in making said patients and residents available for religious and spiritual counsel, and shall provide such members of the~~

~~clergy and other spiritual leaders with meals and accommodations.~~

~~(12) Within the limits of the appropriations therefor, the commissioner of human services shall establish and provide facilities and equipment for research and study in the field of modern hospital management, the causes of mental and related illness and the treatment, diagnosis and care of persons with mental illness and funds provided therefor may be used to make available services, abilities and advice of leaders in these and related fields, and may provide them with meals and accommodations and compensate them for traveling expenses and services.~~

Sec. 22. Minnesota Statutes 2002, section 246.015, subdivision 3, is amended to read:

Subd. 3. ~~Within the limits of the appropriations available,~~ The commissioner of human services may authorize state-operated services to provide consultative services for courts, ~~and~~ state welfare agencies, and supervise the placement and aftercare of patients, on a fee-for-service basis as defined in section 246.50, provisionally or otherwise discharged from a ~~state hospital or institution,~~ state-operated services facility. State-operated services may also promote and conduct programs of education ~~for the people of the state~~ relating to ~~the problem of~~ mental health ~~and mental hygiene~~. The commissioner shall administer, expend, and distribute federal funds which may be made available to the state and other funds ~~other than those~~ not appropriated by the legislature, which may be made available to the state for mental health ~~and mental hygiene~~ purposes.

Sec. 23. Minnesota Statutes 2002, section 246.018, subdivision 2, is amended to read:

Subd. 2. **MEDICAL DIRECTOR.** The commissioner of human services shall appoint ~~a medical director,~~ and unless otherwise established by law, set the salary of a licensed physician to serve as medical director to assist in establishing and maintaining the medical policies of the department of human services. The commissioner may place the medical director's position in the unclassified service if the position meets the criteria of section 43A.08, subdivision 1a. The medical director must be a psychiatrist certified by the board of psychiatry.

Sec. 24. Minnesota Statutes 2002, section 246.018, subdivision 3, is amended to read:

Subd. 3. **DUTIES.** The medical director shall:

(1) oversee the clinical provision of inpatient mental health services provided in the state's regional treatment centers;

(2) recruit and retain psychiatrists to serve on the state medical staff established in subdivision 4;

(3) consult with the commissioner of human services, ~~the assistant commissioner of mental health,~~ community mental health center directors, and the ~~regional treatment center governing bodies~~ state-operated services governing body to develop standards

for treatment and care of patients in ~~regional treatment centers and outpatient~~ state-operated service programs;

(4) develop and oversee a continuing education program for members of the ~~regional treatment center~~ medical staff; and

(5) ~~consult with the commissioner on the appointment of the chief executive officers for regional treatment centers; and~~

~~(6)~~ participate and cooperate in the development and maintenance of a quality assurance program for ~~regional treatment centers~~ state-operated services that assures that residents receive quality inpatient care and continuous quality care once they are discharged or transferred to an outpatient setting.

Sec. 25. Minnesota Statutes 2002, section 246.018, subdivision 4, is amended to read:

Subd. 4. **~~REGIONAL TREATMENT CENTER~~ STATE-OPERATED SERVICES MEDICAL STAFF.** (a) The ~~commissioner of human services~~ medical director shall establish a ~~regional treatment center~~ state-operated service medical staff which shall be under the clinical direction of the office of medical director.

(b) The medical director, in conjunction with the ~~regional treatment center~~ medical staff, shall:

(1) establish standards and define qualifications for physicians who care for residents in ~~regional treatment centers~~ state-operated services;

(2) monitor the performance of physicians who care for residents in ~~regional treatment centers~~ state-operated services; and

(3) recommend to the commissioner changes in procedures for operating ~~regional treatment centers~~ state-operated service facilities that are needed to improve the provision of medical care in those facilities.

Sec. 26. Minnesota Statutes 2002, section 246.13, is amended to read:

246.13 **RECORD OF PATIENTS AND RESIDENTS; ~~DEPARTMENT OF HUMAN~~ IN STATE-OPERATED SERVICES.**

The commissioner of human services' office shall have, accessible only by consent of the commissioner or on the order of a judge or court of record, a record showing the residence, sex, age, nativity, occupation, civil condition, and date of entrance or commitment of every person, in the ~~state hospitals~~ state-operated services facilities as defined under section 246.014 under exclusive control of the commissioner~~,~~; the date of discharge and whether such discharge was final~~,~~; the condition of ~~such~~ the person when the person left the ~~state hospital,~~ state-operated services facility; and the date and cause of all deaths. The record shall state every transfer from one ~~state hospital~~ state-operated services facility to another, naming each state-operated services facility. This information shall be furnished to the commissioner of human services by each public ~~and private~~ agency, along with ~~such~~ other obtainable facts as the

commissioner may ~~from time to time~~ require. ~~The chief executive officer of each such state hospital, within ten days after the commitment or entrance thereto of a patient or resident, shall cause a true copy of an entrance record to be forwarded to the commissioner of human services.~~ When a patient or resident ~~leaves,~~ in a state-operated services facility is discharged ~~or~~, transferred, or dies ~~in any state hospital~~, the ~~chief executive officer, or other person in charge~~ head of the state-operated services facility or designee shall inform the commissioner of human services of these events within ten days ~~thereafter~~ on forms furnished by the commissioner.

~~The commissioner of human services may authorize the chief executive officer of any state hospital for persons with mental illness or mental retardation, to release to public or private medical personnel, hospitals, clinics, local social services agencies or other specifically designated interested persons or agencies any information regarding any patient or resident thereat, if, in the opinion of the commissioner, it will be for the benefit of the patient or resident.~~

Sec. 27. Minnesota Statutes 2002, section 246.15, is amended to read:

246.15 **MONEY OF ~~INMATES OF PUBLIC WELFARE INSTITUTIONS~~ PATIENTS OR RESIDENTS.**

Subdivision 1. **RECORD KEEPING OF MONEY.** The ~~chief executive officer of each institution~~ head of the state-operated services facility or designee under the jurisdiction of the commissioner of human services ~~shall~~ may have the care and custody of all money belonging to ~~inmates thereof~~ patients or residents which may come into the ~~chief executive officer's~~ head of the state-operated services facility or designee's hands~~,~~. The head of the state-operated services facility or designee shall keep accurate accounts ~~thereof~~ of the money, and pay them out under rules prescribed by law or by the commissioner of human services, taking vouchers ~~therefor~~ for the money. All ~~such~~ money received by any officer or employee shall be paid to the ~~chief executive officer forthwith~~ head of the state-operated services facility or designee immediately. Every ~~such executive officer~~ head of the state-operated services facility or designee, at the close of each month, or ~~oftener~~ earlier if required by the commissioner, shall forward to the commissioner a statement of the amount of all money ~~so~~ received and the names of the ~~inmates~~ patients or residents from whom received, accompanied by a check for the amount, payable to the state treasurer. On receipt of ~~such~~ the statement, the commissioner shall transmit the ~~same~~ statement along with a check to the commissioner of finance~~, together with such check~~, who shall deliver the ~~same~~ statement and check to the state treasurer. Upon the payment of ~~such~~ the check, the amount shall be credited to a fund to be known as "~~Inmates~~ Client Fund," for the institution from which the ~~same~~ check was received. All ~~such~~ funds shall be paid out by the state treasurer upon vouchers duly approved by the commissioner of human services ~~as in other cases~~. The commissioner may permit a contingent fund to remain in the hands of the ~~executive officer~~ head of the state-operated services facility or designee of ~~any such~~ the institution from which necessary ~~expenditure~~ expenditures may ~~from time to time~~ be made.

Subd. 2. **CORRECTIONAL INMATES FUND.** Any money in the inmates fund provided for in this section, belonging to inmates of state institutions under the jurisdiction of the commissioner of corrections shall ~~forthwith~~ be immediately transferred by the commissioner of human services to the correctional ~~inmates~~ inmates' fund created by section 241.08.

Sec. 28. Minnesota Statutes 2002, section 246.16, is amended to read:

246.16 **UNCLAIMED MONEY OR PERSONAL PROPERTY OF ~~INMATES~~ PATIENTS OR RESIDENTS.**

Subdivision 1. **UNCLAIMED MONEY.** When ~~there~~ money has ~~heretofore~~ accumulated ~~or shall hereafter accumulate~~ in the hands of the ~~superintendent of any state institution~~ head of the state-operated services facility or designee under the jurisdiction of the commissioner of human services money belonging to ~~inmates~~ patients or residents of ~~such~~ the institution who have died ~~therein~~ there, or disappeared ~~therefrom~~ from there, and for which ~~money~~ there is no claimant or person entitled ~~thereto~~ to the money known to the ~~superintendent, such~~ head of the state-operated services facility or designee the money may, at the discretion of ~~such superintendent~~ the head of the state-operated services facility or designee, ~~to~~ be expended under the direction of the ~~superintendent~~ head of the state-operated services facility or designee for the ~~amusement, entertainment, and general~~ benefit of the ~~inmates~~ patients or residents of ~~such~~ the institution. No money shall be ~~so~~ used until it ~~shall have~~ has remained unclaimed for at least five years. If, at any time after the expiration of the five years, the legal heirs of the ~~inmate shall~~ patients or residents appear and make proper proof of ~~such~~ heirship, they shall be entitled to receive from the state ~~treasurer such~~ the sum of money ~~as shall have been~~ expended by the ~~superintendent~~ head of the state-operated services facility or designee belonging to the ~~inmate~~ patient or resident.

Subd. 2. **UNCLAIMED PERSONAL PROPERTY.** When any ~~inmate~~ patient or resident of a ~~state institution~~ state-operated services facility under the jurisdiction of the commissioner of human services ~~has died or disappeared therefrom, or hereafter shall die or disappear therefrom~~ dies or disappears from the state-operated services facility, leaving personal property exclusive of money in the custody of the ~~superintendent thereof personal property, exclusive of money, which~~ head of the state-operated services facility or designee and the property remains unclaimed for a period of two years, ~~and there is~~ with no person entitled ~~thereto~~ to the property known to the ~~superintendent~~ head of the state-operated services or designee, the ~~superintendent or an agent~~ head of the state-operated services facility or designee may sell ~~such~~ the property at public auction. Notice of ~~such~~ the sale shall be published for two consecutive weeks in a legal newspaper in the county ~~wherein~~ where the ~~institution~~ state-operated services facility is located and shall state the time and place of ~~such~~ the sale. The proceeds of the sale, after deduction of the costs of publication and auction, may be expended, at the discretion of the ~~superintendent~~ head of the state-operated services facility or designee, for the ~~entertainment and~~ benefit of the ~~inmates~~ patients or residents of ~~such institution~~ the state-operated services facility. Any ~~inmate~~ patient or resident, or heir or representative of the ~~inmate~~ patient or resident, may file with, and make proof of

ownership to, the ~~superintendent~~ head of the state-operated services facility or designee of the ~~institution~~ state-operated services facility disposing of ~~such~~ the personal property within four years after ~~such~~ the sale, and, upon ~~proof~~ satisfactory proof to ~~such superintendent~~ the head of the state-operated services or designee, shall certify for payment to the state treasurer the amount received by the sale of ~~such~~ the property. No suit shall be brought for damages consequent to the disposal of personal property or use of money in accordance with this section against the state or any official, employee, or agent thereof.

Sec. 29. Minnesota Statutes 2002, section 246.57, subdivision 1, is amended to read:

Subdivision 1. **AUTHORIZED.** The commissioner of human services may authorize any ~~state~~ state-operated services ~~facility operated under the authority of the commissioner~~ to enter into agreement with other governmental entities and both nonprofit and for-profit organizations for participation in shared service agreements that would be of mutual benefit to the state, other governmental entities and organizations involved, and the public. ~~Notwithstanding section 16C.05, subdivision 2, the commissioner of human services may delegate the execution of shared services contracts to the chief executive officers of the regional centers or state operated nursing homes. No additional employees shall be added to the legislatively approved complement for any regional center or state nursing home as a result of entering into any shared service agreement. However,~~ Positions funded by a shared service agreement ~~may be~~ are authorized ~~by the commissioner of finance~~ for the duration of the shared service agreement. The charges for the services shall be on an actual cost basis. All receipts for shared services may be retained by the ~~regional treatment center or~~ state-operated ~~nursing home~~ service that provided the services~~, in addition to other funding the regional treatment center or state-operated nursing home receives~~.

Sec. 30. Minnesota Statutes 2002, section 246.57, subdivision 4, is amended to read:

Subd. 4. **SHARED STAFF OR SERVICES.** The commissioner of human services may authorize a ~~regional treatment center~~ state-operated services to provide staff or services to Camp Confidence in return for services to, or use of the camp's facilities by, residents of the ~~treatment center~~ facility who have mental retardation or a related condition.

Sec. 31. Minnesota Statutes 2002, section 246.57, subdivision 6, is amended to read:

Subd. 6. **DENTAL SERVICES.** The commissioner of human services shall authorize any ~~regional treatment center or~~ state-operated ~~nursing home~~ services facility under the commissioner's authority to provide dental services to disabled persons who are eligible for medical assistance and are not residing at the regional treatment center or state-operated nursing home, provided that the reimbursement received for these services is sufficient to cover actual costs. To provide these services, regional treatment

centers and state-operated nursing homes may participate under contract with health networks in their service area. ~~Notwithstanding section 16C.05, subdivision 2, the commissioner of human services may delegate the execution of these dental services contracts to the chief executive officers of the regional centers or state-operated nursing homes.~~ All receipts for these dental services shall be retained by the regional treatment center or state-operated nursing home that provides the services and shall be in addition to other funding the regional treatment center or state-operated nursing home receives.

Sec. 32. Minnesota Statutes 2002, section 246.71, subdivision 4, is amended to read:

Subd. 4. **EMPLOYEE OF A SECURE TREATMENT FACILITY OR EMPLOYEE.** "Employee of a secure treatment facility" or "employee" means an employee of the Minnesota security hospital or a secure treatment facility operated by the Minnesota ~~sexual psychopathic personality treatment center~~ sex offender program.

Sec. 33. Minnesota Statutes 2002, section 246.71, subdivision 5, is amended to read:

Subd. 5. **SECURE TREATMENT FACILITY.** "Secure treatment facility" means the Minnesota security hospital ~~or the Minnesota sexual psychopathic personality treatment center~~ and the Minnesota sex offender program facility in Moose Lake and any portion of the Minnesota sex offender program operated by the Minnesota sex offender program at the Minnesota security hospital.

Sec. 34. Minnesota Statutes 2002, section 246B.02, is amended to read:

246B.02 **ESTABLISHMENT OF MINNESOTA ~~SEXUAL PSYCHOPATHIC PERSONALITY TREATMENT CENTER~~ SEX OFFENDER PROGRAM.**

The commissioner of human services shall establish and maintain a secure facility located in Moose Lake. The facility ~~shall be known as~~ shall be operated by the Minnesota ~~Sexual Psychopathic Personality Treatment Center~~ sex offender program. The ~~facility~~ program shall provide care and treatment in secure treatment facilities to ~~100~~ persons committed by the courts as sexual psychopathic personalities or sexually dangerous persons, or persons admitted there with the consent of the commissioner of human services.

Sec. 35. Minnesota Statutes 2002, section 246B.03, is amended to read:

246B.03 **LICENSURE.**

The commissioner of human services shall apply to the commissioner of health to license the secure treatment facilities operated by the Minnesota ~~Sexual Psychopathic Personality Treatment Center~~ sex offender program as ~~a~~ supervised living ~~facility~~ facilities with applicable program licensing standards.

Sec. 36. Minnesota Statutes 2002, section 246B.04, is amended to read:

246B.04 **RULES; EVALUATION.**

The commissioner of human services shall adopt rules to govern the operation, maintenance, and licensure of ~~the~~ secure treatment facilities operated by the Minnesota sex offender program ~~established at the Minnesota Sexual Psychopathic Personality Treatment Center,~~ or at any other facility operated by the commissioner, for persons committed as a sexual psychopathic personality or sexually dangerous person. The commissioner shall establish an evaluation process to measure outcomes and behavioral changes as a result of treatment compared with incarceration without treatment, to determine the value, if any, of treatment in protecting the public.

Sec. 37. Minnesota Statutes 2002, section 252.025, subdivision 7, is amended to read:

Subd. 7. **MINNESOTA EXTENDED TREATMENT OPTIONS.** The commissioner shall develop by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have mental retardation and exhibit severe behaviors which present a risk to public safety. This program must provide specialized residential services ~~on the Cambridge campus~~ in Cambridge and an array of community support services statewide.

Sec. 38. Minnesota Statutes 2002, section 252.06, is amended to read:

252.06 **SHERIFF TO TRANSPORT PERSONS ~~WITH MENTAL RETARDATION.~~**

It shall be the duty of the sheriff of any county, upon the request of the commissioner of human services, to take charge of ~~and~~, transport, and deliver any person ~~with mental retardation~~ who has been committed by the district court of any county to the care and custody of the commissioner of human services to ~~such state hospital~~ a state-operated services facility as may be designated by the commissioner of human services ~~and there deliver such person to the chief executive officer of the state hospital~~.

Sec. 39. Minnesota Statutes 2002, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **CONTRIBUTION AMOUNT.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute monthly to the cost of services, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be ~~the greater of a minimum monthly fee of $25 for households with adjusted gross income of $30,000 and over, or an amount to be~~ computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents ~~that exceeds 150 percent of the federal poverty guidelines for the applicable household size, the following schedule of rates:~~

(1) ~~on the amount of adjusted gross income over 150 percent of poverty, but not over $50,000, ten percent~~ if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) ~~on~~ if the ~~amount of~~ adjusted gross income ~~over 150 percent of poverty and over $50,000 but not over $60,000, 12 percent~~ is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 375 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 375 percent of federal poverty guidelines;

(3) ~~on~~ if the ~~amount of~~ adjusted gross income ~~over 150~~ is greater than 375 percent of federal poverty~~, and over $60,000 but not over $75,000, 14 percent~~ guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income; ~~and~~

(4) ~~on all~~ if the adjusted gross income ~~amounts over 150~~ is equal to or greater than 675 percent of federal poverty~~, and over $75,000, 15 percent~~ guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be ten percent of adjusted gross income; and

(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the ~~parental contribution~~ annual adjusted gross income is reduced by ~~$200, except that the parent must pay the minimum monthly $25 fee under this paragraph~~ $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents under age 21, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a

monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a), ~~except that a~~. An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the ~~contribution~~ adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 40. Minnesota Statutes 2002, section 253.015, subdivision 1, is amended to read:

Subdivision 1. **~~STATE HOSPITALS~~ STATE-OPERATED SERVICES FOR PERSONS WITH MENTAL ILLNESS.** The ~~state hospitals~~ state-operated services facilities located at Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar~~, and Moose Lake until June 30, 1995,~~ shall constitute the ~~state hospitals~~ state-operated services facilities for persons with mental illness, and shall be maintained under the general management of the commissioner of human services. The commissioner of human services shall determine to what ~~state hospital~~ state-operated services facility persons with mental illness shall be committed from each county and notify the judge exercising probate jurisdiction thereof, and of changes made from time to time. ~~The chief executive officer of each hospital for persons with mental illness shall be known as the chief executive officer.~~

Sec. 41. Minnesota Statutes 2002, section 253.017, is amended to read:

253.017 **TREATMENT PROVIDED BY ~~REGIONAL TREATMENT CENTERS~~ STATE-OPERATED SERVICES.**

Subdivision 1. **ACTIVE PSYCHIATRIC TREATMENT.** The ~~regional treatment centers~~ state-operated services shall provide active psychiatric treatment according to contemporary professional standards. Treatment must be designed to:

(1) stabilize the individual and the symptoms that required hospital admission;

(2) restore individual functioning to a level permitting return to the community;

(3) strengthen family and community support; and

(4) facilitate discharge, after care, and follow-up as patients return to the community.

Subd. 2. **NEED FOR SERVICES.** The commissioner shall determine the need for the psychiatric services provided by the department based upon individual needs assessments of persons in the ~~regional treatment centers~~ state-operated services as required by section 245.474, subdivision 2, and an evaluation of: (1) ~~regional treatment center~~ state-operated service programs, (2) programs needed in the region for persons who require hospitalization, and (3) available epidemiologic data. Throughout its planning and implementation, the assessment process must be discussed with the state advisory council on mental health in accordance with its duties under section 245.697.

Continuing assessment of this information must be considered in planning for and implementing changes in state-operated programs and facilities for persons with mental illness. ~~By January 31, 1990, the commissioner shall submit a proposal for renovation or new construction of the facilities at Anoka, Brainerd, Moose Lake, and Fergus Falls.~~ Expansion may be considered only after a thorough analysis of need and in conjunction with a comprehensive mental health plan.

Subd. 3. **DISSEMINATION OF ADMISSION AND STAY CRITERIA.** The commissioner shall periodically disseminate criteria for admission and continued stay in a ~~regional treatment center and security hospital~~ state-operated services facility. The commissioner shall disseminate the criteria to the courts of the state and counties.

Sec. 42. Minnesota Statutes 2002, section 253.20, is amended to read:

253.20 **MINNESOTA SECURITY HOSPITAL.**

The commissioner of human services ~~is hereby authorized and directed to~~ shall erect, equip, and maintain in ~~connection with a state hospital at~~ St. Peter a suitable building to be known as the Minnesota Security Hospital, for the purpose of ~~holding in custody and caring for such persons with mental illness or mental retardation as~~ providing a secure treatment facility as defined in section 253B.02, subdivision 18a, for persons who may be committed ~~thereto~~ there by courts ~~of criminal jurisdiction~~, or otherwise, or transferred ~~thereto~~ there by the commissioner of human services, and for ~~such~~ persons ~~as may be declared insane~~ who are found to be mentally ill while confined in any ~~penal institution~~ correctional facility, or who may be found to be mentally ill and dangerous, and the commissioner shall supervise and manage the same as in the case of other state hospitals.

Sec. 43. Minnesota Statutes 2002, section 253.26, is amended to read:

253.26 **TRANSFERS OF PATIENTS OR RESIDENTS.**

~~When any person of the state hospital for patients with mental illness or residents with mental retardation is found by the commissioner of human services to have homicidal tendencies or to be under sentence or indictment or information the person may be transferred by the commissioner to the Minnesota Security Hospital for safekeeping and treatment~~ The commissioner of human services may transfer a committed patient to the Minnesota Security Hospital following a determination that the patient's behavior presents a danger to others and treatment in a secure treatment facility is necessary. The commissioner shall establish a written policy creating the transfer criteria.

Sec. 44. Minnesota Statutes 2002, section 253B.02, subdivision 18a, is amended to read:

Subd. 18a. **SECURE TREATMENT FACILITY.** "Secure treatment facility" means the Minnesota security hospital ~~or the Minnesota sexual psychopathic personality treatment center~~ and the Minnesota sex offender program facility in Moose Lake and any portion of the Minnesota sex offender program operated by the Minnesota sex

offender program at the Minnesota security hospital, but does not include services or programs administered by the secure treatment facility outside a secure environment.

Sec. 45. Minnesota Statutes 2002, section 253B.04, subdivision 1, is amended to read:

Subdivision 1. **VOLUNTARY ADMISSION AND TREATMENT.** (a) Voluntary admission is preferred over involuntary commitment and treatment. Any person 16 years of age or older may request to be admitted to a treatment facility as a voluntary patient for observation, evaluation, diagnosis, care and treatment without making formal written application. Any person under the age of 16 years may be admitted as a patient with the consent of a parent or legal guardian if it is determined by independent examination that there is reasonable evidence that (1) the proposed patient has a mental illness, or is mentally retarded or chemically dependent; and (2) the proposed patient is suitable for treatment. The head of the treatment facility shall not arbitrarily refuse any person seeking admission as a voluntary patient. In making decisions regarding admissions, the facility shall use clinical admission criteria consistent with the current applicable inpatient admission standards established by the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry. These criteria must be no more restrictive than, and must be consistent with, the requirements of section 62Q.53. The facility may not refuse to admit a person voluntarily solely because the person does not meet the criteria for involuntary holds under section 253B.05 or the definition of mental illness under section 253B.02, subdivision 13.

(b) In addition to the consent provisions of paragraph (a), a person who is 16 or 17 years of age who refuses to consent personally to admission may be admitted as a patient for mental illness or chemical dependency treatment with the consent of a parent or legal guardian if it is determined by an independent examination that there is reasonable evidence that the proposed patient is chemically dependent or has a mental illness and is suitable for treatment. The person conducting the examination shall notify the proposed patient and the parent or legal guardian of this determination.

(c) A person who is voluntarily participating in treatment for a mental illness is not subject to civil commitment under this chapter if the person:

(1) has given informed consent or, if lacking capacity, is a person for whom legally valid substitute consent has been given; and

(2) is participating in a medically appropriate course of treatment, including clinically appropriate and lawful use of neuroleptic medication and electroconvulsive therapy. The limitation on commitment in this paragraph does not apply if, based on clinical assessment, the court finds that it is unlikely that the person will remain in and cooperate with a medically appropriate course of treatment absent commitment and the standards for commitment are otherwise met. This paragraph does not apply to a person for whom commitment proceedings are initiated pursuant to rule 20.01 or 20.02 of the Rules of Criminal Procedure, or a person found by the court to meet the

requirements under section 253B.02, subdivision 17.

Legally valid substitute consent may be provided by a proxy under a health care directive, a guardian or conservator with authority to consent to mental health treatment, or consent to admission under subdivision 1a or 1b.

Sec. 46. Minnesota Statutes 2002, section 253B.05, subdivision 3, is amended to read:

Subd. 3. **DURATION OF HOLD.** (a) Any person held pursuant to this section may be held up to 72 hours, exclusive of Saturdays, Sundays, and legal holidays after admission. If a petition for the commitment of the person is filed in the district court in the county of the person's residence or of the county in which the treatment facility is located, the court may issue a judicial hold order pursuant to section 253B.07, subdivision 2b.

(b) During the 72-hour hold period, a court may not release a person held under this section unless the court has received a written petition for release and held a summary hearing regarding the release. The petition must include the name of the person being held, the basis for and location of the hold, and a statement as to why the hold is improper. The petition also must include copies of any written documentation under subdivision 1 or 2 in support of the hold, unless the person holding the petitioner refuses to supply the documentation. The hearing must be held as soon as practicable and may be conducted by means of a telephone conference call or similar method by which the participants are able to simultaneously hear each other. If the court decides to release the person, the court shall direct the release and shall issue written findings supporting the decision. The release may not be delayed pending the written order. Before deciding to release the person, the court shall make every reasonable effort to provide notice of the proposed release to:

(1) any specific individuals identified in a statement under subdivision 1 or 2 or individuals identified in the record who might be endangered if the person was not held;

(2) the examiner whose written statement was a basis for a hold under subdivision 1; and

(3) the peace or health officer who applied for a hold under subdivision 2.

(c) If a person is intoxicated in public and held under this section for detoxification, a treatment facility may release the person without providing notice under paragraph (d) as soon as the treatment facility determines the person is no longer a danger to themselves or others. Notice must be provided to the peace officer or health officer who transported the person, or the appropriate law enforcement agency, if the officer or agency requests notification.

~~(c)~~ (d) If a treatment facility releases a person during the 72-hour hold period, the head of the treatment facility shall immediately notify the agency which employs the

peace or health officer who transported the person to the treatment facility under this section.

(e) A person held under a 72-hour emergency hold must be released by the facility within 72 hours unless a court order to hold the person is obtained. A consecutive emergency hold order under this section may not be issued.

Sec. 47. Minnesota Statutes 2002, section 253B.09, subdivision 1, is amended to read:

Subdivision 1. **STANDARD OF PROOF.** (a) If the court finds by clear and convincing evidence that the proposed patient is a person who is mentally ill, mentally retarded, or chemically dependent and after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, voluntary admission to a treatment facility, appointment of a guardian or conservator, or release before commitment as provided for in subdivision 4, it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs consistent with section 253B.03, subdivision 7.

(b) In deciding on the least restrictive program, the court shall consider a range of treatment alternatives including, but not limited to, community-based nonresidential treatment, community residential treatment, partial hospitalization, acute care hospital, and regional treatment center services. The court shall also consider the proposed patient's treatment preferences and willingness to participate voluntarily in the treatment ordered. The court may not commit a patient to a facility or program that is not capable of meeting the patient's needs.

(c) If the commitment as mentally ill, chemically dependent, or mentally retarded is to a service facility provided by the commissioner of human services, the court shall order the commitment to the commissioner. The commissioner shall designate the placement of the person to the court.

(d) If the court finds a proposed patient to be a person who is mentally ill under section 253B.02, subdivision 13, paragraph (a), clause (2) or (4), the court shall commit to a community-based program that meets the proposed patient's needs. For purposes of this paragraph, a community-based program may include inpatient mental health services at a community hospital.

Sec. 48. Minnesota Statutes 2002, section 256.012, is amended to read:

256.012 **MINNESOTA MERIT SYSTEM.**

Subdivision 1. **MINNESOTA MERIT SYSTEM.** The commissioner of human services shall promulgate by rule personnel standards on a merit basis in accordance with federal standards for a merit system of personnel administration for all employees of county boards engaged in the administration of community social services or income maintenance programs, all employees of human services boards that have

adopted the rules of the Minnesota merit system, and all employees of local social services agencies.

Excluded from the rules are employees of institutions and hospitals under the jurisdiction of the aforementioned boards and agencies; employees of county personnel systems otherwise provided for by law that meet federal merit system requirements; duly appointed or elected members of the aforementioned boards and agencies; and the director of community social services and employees in positions that, upon the request of the appointing authority, the commissioner chooses to exempt, provided the exemption accords with the federal standards for a merit system of personnel administration.

Subd. 2. **PAYMENT FOR SERVICES PROVIDED.** (a) The cost of merit system operations shall be paid by counties and other entities that utilize merit system services. Total costs shall be determined by the commissioner annually and must be set at a level that neither significantly overrecovers nor underrecovers the costs of providing the service. The costs of merit system services shall be prorated among participating counties in accordance with an agreement between the commissioner and these counties. Participating counties will be billed quarterly in advance and shall pay their share of the costs upon receipt of the billing.

(b) This subdivision does not apply to counties with personnel systems otherwise provided by law that meet federal merit system requirements. A county that applies to withdraw from the merit system must notify the commissioner of the county's intent to develop its own personnel system. This notice must be provided in writing by December 31 of the year preceding the year of final participation in the merit system. The county may withdraw after the commissioner has certified that its personnel system meets federal merit system requirements.

(c) A county merit system operations account is established in the special revenue fund. Payments received by the commissioner for merit system costs must be deposited in the merit system operations account and must be used for the purpose of providing the services and administering the merit system.

(d) County payment of merit system costs is effective July 1, 2003, however payment for the period from July 1, 2003 through December 31, 2003, shall be made no later than January 31, 2004.

Subd. 3. **PARTICIPATING COUNTY CONSULTATION.** The commissioner shall ensure that participating counties are consulted regularly and offered the opportunity to provide input on the management of the merit system to ensure effective use of resources and to monitor system performance.

Sec. 49. **[256.0451] HEARING PROCEDURES.**

Subdivision 1. **SCOPE.** The requirements in this section apply to all fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (1), (2), (3), (5), (6), and (7). Except as provided in subdivisions 3 and 19, the requirements under

this section apply to fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9).

The term "person" is used in this section to mean an individual who, on behalf of themselves or their household, is appealing or disputing or challenging an action, a decision, or a failure to act, by an agency in the human services system. When a person involved in a proceeding under this section is represented by an attorney or by an authorized representative, the term "person" also refers to the person's attorney or authorized representative. Any notice sent to the person involved in the hearing must also be sent to the person's attorney or authorized representative.

The term "agency" includes the county human services agency, the state human services agency, and, where applicable, any entity involved under a contract, subcontract, grant, or subgrant with the state agency or with a county agency, that provides or operates programs or services in which appeals are governed by section 256.045.

Subd. 2. **ACCESS TO FILES.** A person involved in a fair hearing appeal has the right of access to the person's complete case files and to examine all private welfare data on the person which has been generated, collected, stored, or disseminated by the agency. A person involved in a fair hearing appeal has the right to a free copy of all documents in the case file involved in a fair hearing appeal. "Case file" means the information, documents, and data, in whatever form, which have been generated, collected, stored, or disseminated by the agency in connection with the person and the program or service involved.

Subd. 3. **AGENCY APPEAL SUMMARY.** (a) Except in fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), the agency involved in an appeal must prepare a state agency appeal summary for each fair hearing appeal. The state agency appeal summary shall be mailed or otherwise delivered to the person who is involved in the appeal at least three working days before the date of the hearing. The state agency appeal summary must also be mailed or otherwise delivered to the department's appeals office at least three working days before the date of the fair hearing appeal.

(b) In addition, the appeals referee shall confirm that the state agency appeal summary is mailed or otherwise delivered to the person involved in the appeal as required under paragraph (a). The person involved in the fair hearing should be provided, through the state agency appeal summary or other reasonable methods, appropriate information about the procedures for the fair hearing and an adequate opportunity to prepare. These requirements apply equally to the state agency or an entity under contract when involved in the appeal.

(c) The contents of the state agency appeal summary must be adequate to inform the person involved in the appeal of the evidence on which the agency relies and the legal basis for the agency's action or determination.

Subd. 4. **ENFORCING ACCESS TO FILES.** A person involved in a fair hearing appeal may enforce the right of access to data and copies of the case file by making a

request to the appeals referee. The appeals referee will make an appropriate order enforcing the person's rights under the Minnesota Government Data Practices Act, including but not limited to, ordering access to files, data, and documents; continuing a hearing to allow adequate time for access to data; or prohibiting use by the agency of files, data, or documents which have been generated, collected, stored, or disseminated without compliance with the Minnesota Government Data Practices Act and which have not been provided to the person involved in the appeal.

Subd. 5. **PREHEARING CONFERENCES.** (a) The appeals referee prior to a fair hearing appeal may hold a prehearing conference to further the interests of justice or efficiency and must include the person involved in the appeal. A person involved in a fair hearing appeal or the agency may request a prehearing conference. The prehearing conference may be conducted by telephone, in person, or in writing. The prehearing conference may address the following:

(1) disputes regarding access to files, evidence, subpoenas, or testimony;

(2) the time required for the hearing or any need for expedited procedures or decision;

(3) identification or clarification of legal or other issues that may arise at the hearing;

(4) identification of and possible agreement to factual issues; and

(5) scheduling and any other matter which will aid in the proper and fair functioning of the hearing.

(b) The appeals referee shall make a record or otherwise contemporaneously summarize the prehearing conference in writing, which shall be sent to both the person involved in the hearing, the person's attorney or authorized representative, and the agency.

Subd. 6. **APPEAL REQUEST FOR EMERGENCY ASSISTANCE OR URGENT MATTER.** (a) When an appeal involves an application for emergency assistance, the agency involved shall mail or otherwise deliver the state agency appeal summary to the department's appeals office within two working days of receiving the request for an appeal. A person may also request that a fair hearing be held on an emergency basis when the issue requires an immediate resolution. The appeals referee shall schedule the fair hearing on the earliest available date according to the urgency of the issue involved. Issuance of the recommended decision after an emergency hearing shall be expedited.

(b) The commissioner shall issue a written decision within five working days of receiving the recommended decision, shall immediately inform the parties of the outcome by telephone, and shall mail the decision no later than two working days following the date of the decision.

Subd. 7. **CONTINUANCE, RESCHEDULING, OR ADJOURNING A HEARING.** (a) A person involved in a fair hearing, or the agency, may request a

continuance, a rescheduling, or an adjournment of a hearing for a reasonable period of time. The grounds for granting a request for a continuance, a rescheduling, or adjournment of a hearing include, but are not limited to, the following:

(1) to reasonably accommodate the appearance of a witness;

(2) to ensure that the person has adequate opportunity for preparation and for presentation of evidence and argument;

(3) to ensure that the person or the agency has adequate opportunity to review, evaluate, and respond to new evidence, or where appropriate, to require that the person or agency review, evaluate, and respond to new evidence;

(4) to permit the person involved and the agency to negotiate toward resolution of some or all of the issues where both agree that additional time is needed;

(5) to permit the agency to reconsider a previous action or determination;

(6) to permit or to require the performance of actions not previously taken; and

(7) to provide additional time or to permit or require additional activity by the person or agency as the interests of fairness may require.

(b) Requests for continuances or for rescheduling may be made orally or in writing. The person or agency requesting the continuance or rescheduling must first make reasonable efforts to contact the other participants in the hearing or their representatives, and seek to obtain an agreement on the request. Requests for continuance or rescheduling should be made no later than three working days before the scheduled date of the hearing, unless there is a good cause as specified in subdivision 13. Granting a continuance or rescheduling may be conditioned upon a waiver by the requester of applicable time limits, but should not cause unreasonable delay.

Subd. 8. **SUBPOENAS.** A person involved in a fair hearing or the agency may request a subpoena for a witness, for evidence, or for both. A reasonable number of subpoenas shall be issued to require the attendance and the testimony of witnesses, and the production of evidence relating to any issue of fact in the appeal hearing. The request for a subpoena must show a need for the subpoena and the general relevance to the issues involved. The subpoena shall be issued in the name of the department and shall be served and enforced as provided in section 357.22 and the Minnesota Rules of Civil Procedure.

An individual or entity served with a subpoena may petition the appeals referee in writing to vacate or modify a subpoena. The appeals referee shall resolve such a petition in a prehearing conference involving all parties and shall make a written decision. A subpoena may be vacated or modified if the appeals referee determines that the testimony or evidence sought does not relate with reasonable directness to the issues of the fair hearing appeal; that the subpoena is unreasonable, over broad, or oppressive; that the evidence sought is repetitious or cumulative; or that the subpoena

has not been served reasonably in advance of the time when the appeal hearing will be held.

Subd. 9. **NO EX PARTE CONTACT.** The appeals referee shall not have ex parte contact on substantive issues with the agency or with any person or witness in a fair hearing appeal. No employee of the department or agency shall review, interfere with, change, or attempt to influence the recommended decision of the appeals referee in any fair hearing appeal, except through the procedure allowed in subdivision 18. The limitations in this subdivision do not affect the commissioner's authority to review or reconsider decisions or make final decisions.

Subd. 10. **TELEPHONE OR FACE-TO-FACE HEARING.** A fair hearing appeal may be conducted by telephone, by other electronic media, or by an in-person, face-to-face hearing. At the request of the person involved in a fair hearing appeal or their representative, a face-to-face hearing shall be conducted with all participants personally present before the appeals referee.

Subd. 11. **HEARING FACILITIES AND EQUIPMENT.** The appeals referee shall conduct the hearing in the county where the person involved resides, unless an alternate location is mutually agreed upon before the hearing, or unless the person has agreed to a hearing by telephone. Hearings under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), must be conducted in the county where the determination was made, unless an alternate location is mutually agreed upon before the hearing. The hearing room shall be of sufficient size and layout to adequately accommodate both the number of individuals participating in the hearing and any identified special needs of any individual participating in the hearing. The appeals referee shall ensure that all communication and recording equipment that is necessary to conduct the hearing and to create an adequate record is present and functioning properly. If any necessary communication or recording equipment fails or ceases to operate effectively, the appeals referee shall take any steps necessary, including stopping or adjourning the hearing, until the necessary equipment is present and functioning properly. All reasonable efforts shall be undertaken to prevent and avoid any delay in the hearing process caused by defective communication or recording equipment.

Subd. 12. **INTERPRETER AND TRANSLATION SERVICES.** The appeals referee has a duty to inquire and to determine whether any participant in the hearing needs the services of an interpreter or translator in order to participate in or to understand the hearing process. Necessary interpreter or translation services must be provided at no charge to the person involved in the hearing. If it appears that interpreter or translation services are needed but are not available for the scheduled hearing, the appeals referee shall continue or postpone the hearing until appropriate services can be provided.

Subd. 13. **FAILURE TO APPEAR; GOOD CAUSE.** If a person involved in a fair hearing appeal fails to appear at the hearing, the appeals referee may dismiss the appeal. The person may reopen the appeal if within ten working days the person

submits information to the appeals referee to show good cause for not appearing. Good cause can be shown when there is:

(1) a death or serious illness in the person's family;

(2) a personal injury or illness which reasonably prevents the person from attending the hearing;

(3) an emergency, crisis, or unforeseen event which reasonably prevents the person from attending the hearing;

(4) an obligation or responsibility of the person which a reasonable person, in the conduct of one's affairs, could reasonably determine takes precedence over attending the hearing;

(5) lack of or failure to receive timely notice of the hearing in the preferred language of the person involved in the hearing; and

(6) excusable neglect, excusable inadvertence, excusable mistake, or other good cause as determined by the appeals referee.

Subd. 14. **COMMENCEMENT OF HEARING.** The appeals referee shall begin each hearing by describing the process to be followed in the hearing, including the swearing-in of witnesses, how testimony and evidence are presented, the order of examining and cross-examining witnesses, and the opportunity for an opening statement and a closing statement. The appeals referee shall identify for the participants the issues to be addressed at the hearing and shall explain to the participants the burden of proof which applies to the person involved and the agency. The appeals referee shall confirm, prior to proceeding with the hearing, that the state agency appeal summary, if required under subdivision 3, has been properly completed and provided to the person involved in the hearing, and that the person has been provided documents and an opportunity to review the case file, as provided in this section.

Subd. 15. **CONDUCT OF THE HEARING.** The appeals referee shall act in a fair and impartial manner at all times. At the beginning of the hearing the agency must designate one person as their representative who shall be responsible for presenting the agency's evidence and questioning any witnesses. The appeals referee shall make sure that the person and the agency are provided sufficient time to present testimony and evidence, to confront and cross-examine all adverse witnesses, and to make any relevant statement at the hearing. The appeals referee shall make reasonable efforts to explain the hearing process to persons who are not represented, and shall ensure that the hearing is conducted fairly and efficiently. Upon the reasonable request of the person or the agency involved, the appeals referee may direct witnesses to remain outside the hearing room, except during their individual testimony. The appeals referee shall not terminate the hearing before affording the person and the agency a complete opportunity to submit all admissible evidence, and reasonable opportunity for oral or written statement. When a hearing extends beyond the time which was anticipated, the hearing shall be rescheduled or continued from day-to-day until completion. Hearings

that have been continued shall be timely scheduled to minimize delay in the disposition of the appeal.

Subd. 16. **SCOPE OF ISSUES ADDRESSED AT THE HEARING.** The hearing shall address the correctness and legality of the agency's action and shall not be limited simply to a review of the propriety of the agency's action. The person involved may raise and present evidence on all legal claims or defenses arising under state or federal law as a basis for appealing or disputing an agency action, but not constitutional claims beyond the jurisdiction of the fair hearing. The appeals referee may take official notice of adjudicative facts.

Subd. 17. **BURDEN OF PERSUASION.** The burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. If there is no specific law, then the participant in the hearing who asserts the truth of a claim is under the burden to persuade the appeals referee that the claim is true.

Subd. 18. **INVITING COMMENT BY DEPARTMENT.** The appeals referee or the commissioner may determine that a written comment by the department about the policy implications of a specific legal issue could help resolve a pending appeal. Such a written policy comment from the department shall be obtained only by a written request that is also sent to the person involved and to the agency or its representative. When such a written comment is received, both the person involved in the hearing and the agency shall have adequate opportunity to review, evaluate, and respond to the written comment, including submission of additional testimony or evidence, and cross-examination concerning the written comment.

Subd. 19. **DEVELOPING THE RECORD.** The appeals referee shall accept all evidence, except evidence privileged by law, that is commonly accepted by reasonable people in the conduct of their affairs as having probative value on the issues to be addressed at the hearing. Except in fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), and (9), in cases involving medical issues such as a diagnosis, a physician's report, or a review team's decision, the appeals referee shall consider whether it is necessary to have a medical assessment other than that of the individual making the original decision. When necessary, the appeals referee shall require an additional assessment be obtained at agency expense and made part of the hearing record. The appeals referee shall ensure for all cases that the record is sufficiently complete to make a fair and accurate decision.

Subd. 20. **UNREPRESENTED PERSONS.** In cases involving unrepresented persons, the appeals referee shall take appropriate steps to identify and develop in the hearing relevant facts necessary for making an informed and fair decision. These steps may include, but are not limited to, asking questions of witnesses, and referring the person to a legal services office. An unrepresented person shall be provided an adequate opportunity to respond to testimony or other evidence presented by the agency at the hearing. The appeals referee shall ensure that an unrepresented person has a full and reasonable opportunity at the hearing to establish a record for appeal.

Subd. 21. **CLOSING OF THE RECORD.** The agency must present its evidence prior to or at the hearing. The agency shall not be permitted to submit evidence after

the hearing except by agreement at the hearing between the person involved, the agency, and the appeals referee. If evidence is submitted after the hearing, based on such an agreement, the person involved and the agency must be allowed sufficient opportunity to respond to the evidence. When necessary, the record shall remain open to permit a person to submit additional evidence on the issues presented at the hearing.

Subd. 22. **DECISIONS.** A timely, written decision must be issued in every appeal. Each decision must contain a clear ruling on the issues presented in the appeal hearing, and should contain a ruling only on questions directly presented by the appeal and the arguments raised in the appeal.

(a) **TIMELINESS.** A written decision must be issued within 90 days of the date the person involved requested the appeal unless a shorter time is required by law. An additional 30 days is provided in those cases where the commissioner refuses to accept the recommended decision.

(b) **CONTENTS OF HEARING DECISION.** The decision must contain both findings of fact and conclusions of law, clearly separated and identified. The findings of fact must be based on the entire record. Each finding of fact made by the appeals referee shall be supported by a preponderance of the evidence unless a different standard is required under the regulations of a particular program. The "preponderance of the evidence" means, in light of the record as a whole, the evidence leads the appeals referee to believe that the finding of fact is more likely to be true than not true. The legal claims or arguments of a participant do not constitute either a finding of fact or a conclusion of law, except to the extent the appeals referee adopts an argument as a finding of fact or conclusion of law.

The decision shall contain at least the following:

(1) a listing of the date and place of the hearing and the participants at the hearing;

(2) a clear and precise statement of the issues, including the dispute under consideration and the specific points which must be resolved in order to decide the case;

(3) a listing of the material, including exhibits, records, reports, placed into evidence at the hearing, and upon which the hearing decision is based;

(4) the findings of fact based upon the entire hearing record. The findings of fact must be adequate to inform the participants and any interested person in the public of the basis of the decision. If the evidence is in conflict on an issue which must be resolved, the findings of fact must state the reasoning used in resolving the conflict;

(5) conclusions of law that address the legal authority for the hearing and the ruling, and which give appropriate attention to the claims of the participants to the hearing;

(6) a clear and precise statement of the decision made resolving the dispute under consideration in the hearing; and

(7) written notice of the right to appeal to district court or to request reconsideration, and of the actions required and the time limits for taking appropriate action to appeal to district court or to request a reconsideration.

(c) **NO INDEPENDENT INVESTIGATION.** The appeals referee shall not independently investigate facts or otherwise rely on information not presented at the hearing. The appeals referee may not contact other agency personnel, except as provided in subdivision 18. The appeals referee's recommended decision must be based exclusively on the testimony and evidence presented at the hearing, and legal arguments presented, and the appeals referee's research and knowledge of the law.

(d) **RECOMMENDED DECISION.** The commissioner will review the recommended decision and accept or refuse to accept the decision according to section 256.045, subdivision 5.

Subd. 23. **REFUSAL TO ACCEPT RECOMMENDED ORDERS.** (a) If the commissioner refuses to accept the recommended order from the appeals referee, the person involved, the person's attorney or authorized representative, and the agency shall be sent a copy of the recommended order, a detailed explanation of the basis for refusing to accept the recommended order, and the proposed modified order.

(b) The person involved and the agency shall have at least ten business days to respond to the proposed modification of the recommended order. The person involved and the agency may submit a legal argument concerning the proposed modification, and may propose to submit additional evidence that relates to the proposed modified order.

Subd. 24. **RECONSIDERATION.** Reconsideration may be requested within 30 days of the date of the commissioner's final order. If reconsideration is requested, the other participants in the appeal shall be informed of the request. The person seeking reconsideration has the burden to demonstrate why the matter should be reconsidered. The request for reconsideration may include legal argument and may include proposed additional evidence supporting the request. The other participants shall be sent a copy of all material submitted in support of the request for reconsideration and must be given ten days to respond.

(a) **FINDINGS OF FACT.** When the requesting party raises a question as to the appropriateness of the findings of fact, the commissioner shall review the entire record.

(b) **CONCLUSIONS OF LAW.** When the requesting party questions the appropriateness of a conclusion of law, the commissioner shall consider the recommended decision, the decision under reconsideration, and the material submitted in connection with the reconsideration. The commissioner shall review the remaining record as necessary to issue a reconsidered decision.

(c) **WRITTEN DECISION.** The commissioner shall issue a written decision on reconsideration in a timely fashion. The decision must clearly inform the parties that this constitutes the final administrative decision, advise the participants of the right to seek judicial review, and the deadline for doing so.

Subd. 25. **ACCESS TO APPEAL DECISIONS.** Appeal decisions must be maintained in a manner so that the public has ready access to previous decisions on particular topics, subject to appropriate procedures for safeguarding names, personal identifying information, and other private data on the individual persons involved in the appeal.

Sec. 50. Minnesota Statutes 2002, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **FEDERAL WAIVERS.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with mental retardation or a related condition. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The individual service plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, and protection needs will be met by frequent and regular contact with persons other than the residential service provider.

Sec. 51. Minnesota Statutes 2002, section 256B.092, is amended by adding a subdivision to read:

Subd. 5a. **INCREASING ADULT FOSTER CARE CAPACITY TO SERVE FIVE PERSONS.** (a) When an adult foster care provider increases the capacity of an existing home licensed to serve four persons to serve a fifth person under this section, the county agency shall reduce the contracted per diem cost for room and board and the mental retardation or a related condition waiver services of the existing foster care

home by an average of 14 percent for all individuals living in that home. A county agency may average the required per diem rate reductions across several adult foster care homes that expand capacity under this section, to achieve the necessary overall per diem reduction.

(b) Following the contract changes in paragraph (a), the commissioner shall adjust:

(1) individual county allocations for mental retardation or a related condition waivered services by the amount of savings that results from the changes made for mental retardation or a related condition waiver recipients for whom the county is financially responsible; and

(2) group residential housing rate payments to the adult foster home by the amount of savings that results from the changes made.

(c) Effective July 1, 2003, when a new five-person adult foster care home is licensed under this section, county agencies shall not establish group residential housing room and board rates and mental retardation or a related condition waiver service rates for the new home that exceed 86 percent of the average per diem room and board and mental retardation or a related condition waiver services costs of four-person homes serving persons with comparable needs and in the same geographic area. A county agency developing more than one new five-person adult foster care home may average the required per diem rates across the homes to achieve the necessary overall per diem reductions.

(d) The commissioner shall reduce the individual county allocations for mental retardation or a related condition waivered services by the savings resulting from the per diem limits on adult foster care recipients for whom the county is financially responsible, and shall limit the group residential housing rate for a new five-person adult foster care home.

Sec. 52. Minnesota Statutes 2002, section 257.0769, is amended to read:

257.0769 **FUNDING FOR THE OMBUDSPERSON PROGRAM.**

Subdivision 1. **APPROPRIATIONS.** (a) Money is appropriated from the special fund authorized by section 256.01, subdivision 2, clause (15), to the Indian affairs council for the purposes of sections 257.0755 to 257.0768.

(b) Money is appropriated from the special fund authorized by section 256.01, subdivision 2, clause (15), to the council on affairs of Chicano/Latino people for the purposes of sections 257.0755 to 257.0768.

(c) Money is appropriated from the special fund authorized by section 256.01, subdivision 2, clause (15), to the Council of Black Minnesotans for the purposes of sections 257.0755 to 257.0768.

(d) Money is appropriated from the special fund authorized by section 256.01, subdivision 2, clause (15), to the Council on Asian-Pacific Minnesotans for the purposes of sections 257.0755 to 257.0768.

Subd. 2. **TITLE IV-E REIMBURSEMENT.** The commissioner shall obtain federal title IV-E financial participation for eligible activity by the ombudsperson for families under section 257.0755. The ombudsperson for families shall maintain and transmit to the department of human services documentation that is necessary in order to obtain federal funds.

Sec. 53. Minnesota Statutes 2002, section 259.21, subdivision 6, is amended to read:

Subd. 6. **AGENCY.** "Agency" means an organization or department of government designated or authorized by law to place children for adoption or any person, group of persons, organization, association or society licensed or certified by the commissioner of human services to place children for adoption, including a Minnesota federally recognized tribe.

Sec. 54. Minnesota Statutes 2002, section 259.67, subdivision 7, is amended to read:

Subd. 7. **REIMBURSEMENT OF COSTS.** (a) Subject to rules of the commissioner, and the provisions of this subdivision a child-placing agency licensed in Minnesota or any other state, or local or tribal social services agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing adoption services for a child certified as eligible for adoption assistance under subdivision 4. Such assistance may include adoptive family recruitment, counseling, and special training when needed. A child-placing agency licensed in Minnesota or any other state shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A local or tribal social services agency shall receive such reimbursement only for adoption services it purchases for an eligible child.

(b) A child-placing agency licensed in Minnesota or any other state or local or tribal social services agency seeking reimbursement under this subdivision shall enter into a reimbursement agreement with the commissioner before providing adoption services for which reimbursement is sought. No reimbursement under this subdivision shall be made to an agency for services provided prior to entering a reimbursement agreement. Separate reimbursement agreements shall be made for each child and separate records shall be kept on each child for whom a reimbursement agreement is made. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(c) When a local or tribal social services agency uses a purchase of service agreement to provide services reimbursable under a reimbursement agreement, the commissioner may make reimbursement payments directly to the agency providing the service if direct reimbursement is specified by the purchase of service agreement, and if the request for reimbursement is submitted by the local or tribal social services agency along with a verification that the service was provided.

Sec. 55. Minnesota Statutes 2002, section 393.07, subdivision 1, is amended to read:

Subdivision 1. **PUBLIC CHILD WELFARE PROGRAM.** (a) To assist in carrying out the child protection, delinquency prevention and family assistance responsibilities of the state, the local social services agency shall administer a program of social services and financial assistance to be known as the public child welfare program. The public child welfare program shall be supervised by the commissioner of human services and administered by the local social services agency in accordance with law and with rules of the commissioner.

(b) The purpose of the public child welfare program is to assure protection for and financial assistance to children who are confronted with social, physical, or emotional problems requiring protection and assistance. These problems include, but are not limited to the following:

(1) mental, emotional, or physical handicap;

(2) birth of a child to a mother who was not married to the child's father when the child was conceived nor when the child was born, including but not limited to costs of prenatal care, confinement and other care necessary for the protection of a child born to a mother who was not married to the child's father at the time of the child's conception nor at the birth;

(3) dependency, neglect;

(4) delinquency;

(5) abuse or rejection of a child by its parents;

(6) absence of a parent or guardian able and willing to provide needed care and supervision;

(7) need of parents for assistance with child rearing problems, or in placing the child in foster care.

(c) A local social services agency shall make the services of its public child welfare program available as required by law, by the commissioner, or by the courts and shall cooperate with other agencies, public or private, dealing with the problems of children and their parents as provided in this subdivision.

~~The public child welfare program shall be available in divorce cases for investigations of children and home conditions and for supervision of children when directed by the court hearing the divorce.~~

(d) A local social services agency may rent, lease, or purchase property, or in any other way approved by the commissioner, contract with individuals or agencies to provide needed facilities for foster care of children. It may purchase services or child care from duly authorized individuals, agencies or institutions when in its judgment the needs of a child or the child's family can best be met in this way.

Sec. 56. Minnesota Statutes 2002, section 393.07, subdivision 5, is amended to read:

Subd. 5. **COMPLIANCE WITH FEDERAL SOCIAL SECURITY ACT; MERIT SYSTEM.** The commissioner of human services shall have authority to require such methods of administration as are necessary for compliance with requirements of the federal Social Security Act, as amended, and for the proper and efficient operation of all welfare programs. This authority to require methods of administration includes methods relating to the establishment and maintenance of personnel standards on a merit basis as concerns all employees of local social services agencies except those employed in an institution, sanitarium, or hospital. The commissioner of human services shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods. The adoption of methods relating to the establishment and maintenance of personnel standards on a merit basis of all such employees of the local social services agencies and the examination thereof, and the administration thereof shall be directed and controlled exclusively by the commissioner of human services.

Notwithstanding the provisions of any other law to the contrary, every employee of every local social services agency who occupies a position which requires as prerequisite to eligibility therefor graduation from an accredited four year college or a certificate of registration as a registered nurse under section 148.231, must be employed in such position under the merit system established under authority of this subdivision. Every such employee now employed by a local social services agency and who is not under said merit system is transferred, as of January 1, 1962, to a position of comparable classification in the merit system with the same status therein as the employee had in the county of employment prior thereto and every such employee shall be subject to and have the benefit of the merit system, including seniority within the local social services agency, as though the employee had served thereunder from the date of entry into the service of the local social services agency.

~~By March 1, 1996, the commissioner of human services shall report to the chair of the senate health care and family services finance division and the chair of the house health and human services finance division on options for the delivery of merit-based employment services by entities other than the department of human services in order to reduce the administrative costs to the state while maintaining compliance with applicable federal regulations.~~

Sec. 57. Minnesota Statutes 2002, section 518.167, subdivision 1, is amended to read:

Subdivision 1. **COURT ORDER.** In contested custody proceedings, and in other custody proceedings if a parent or the child's custodian requests, the court may order an investigation and report concerning custodial arrangements for the child. If the county elects to conduct an investigation, the county may charge a fee. The investigation and report may be made by the county welfare agency or department of court services.

Sec. 58. Minnesota Statutes 2002, section 518.551, subdivision 7, is amended to read:

Subd. 7. ~~**SERVICE FEE**~~ **FEES AND COST RECOVERY FEES FOR IV-D SERVICES.** ~~When the public agency responsible for child support enforcement provides child support collection services either to a public assistance recipient or to a party who does not receive public assistance, the public agency may upon written notice to the obligor charge a monthly collection fee equivalent to the full monthly cost to the county of providing collection services, in addition to the amount of the child support which was ordered by the court. The fee shall be deposited in the county general fund. The service fee assessed is limited to ten percent of the monthly court ordered child support and shall not be assessed to obligors who are current in payment of the monthly court ordered child support.~~ (a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) An application fee of $25 shall be paid by the person who applies for child support and maintenance collection services, except persons who are receiving public assistance as defined in section 256.741 and, if enacted, the diversionary work program under section 256J.95, persons who transfer from public assistance to nonpublic assistance status, and minor parents and parents enrolled in a public secondary school, area learning center, or alternative learning program approved by the commissioner of children, families, and learning.

(c) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of one percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741, before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(d) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of one percent of the monthly court ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(e) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(f) Cost recovery fees collected under paragraphs (c) and (d) shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the cost recovery fee account established under paragraph (h). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

~~However,~~ (g) The limitations of this subdivision on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under Title IV-A and Title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(h) The commissioner of human services is authorized to establish a special revenue fund account to receive child support cost recovery fees. A portion of the nonfederal share of these fees may be retained for expenditures necessary to administer the fee, and must be transferred to the child support system special revenue account. The remaining nonfederal share of the cost recovery fee must be retained by the commissioner and dedicated to the child support general fund county performance based grant account authorized under sections 256.979 and 256.9791.

**EFFECTIVE DATE.** This section is effective July 1, 2004, except paragraph (d) is effective July 1, 2005.

Sec. 59. Minnesota Statutes 2002, section 518.6111, subdivision 2, is amended to read:

Subd. 2. **APPLICATION.** This section applies to all support orders issued by a court or an administrative tribunal and orders for or notices of withholding issued by the public authority ~~according to section 518.5513, subdivision 5, paragraph (a), clause (5)~~.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 60. Minnesota Statutes 2002, section 518.6111, subdivision 3, is amended to read:

Subd. 3. **ORDER.** Every support order must address income withholding. Whenever a support order is initially entered or modified, the full amount of the support order must be ~~withheld~~ subject to income withholding from the income of the obligor. If the obligee or obligor applies for either full IV-D services or for income withholding only services from the public authority responsible for child support

enforcement, the full amount of the support order must be withheld from the income of the obligor and forwarded to the public authority. Every order for support or maintenance shall provide for a conspicuous notice of the provisions of this section that complies with section 518.68, subdivision 2. An order without this notice remains subject to this section. This section applies regardless of the source of income of the person obligated to pay the support or maintenance.

A payor of funds shall implement income withholding according to this section upon receipt of an order for or notice of withholding. The notice of withholding shall be on a form provided by the commissioner of human services.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 61. Minnesota Statutes 2002, section 518.6111, subdivision 4, is amended to read:

Subd. 4. **COLLECTION SERVICES.** (a) The commissioner of human services shall prepare and make available to the courts a notice of services that explains child support and maintenance collection services available through the public authority, including income withholding, and the fees for such services. Upon receiving a petition for dissolution of marriage or legal separation, the court administrator shall promptly send the notice of services to the petitioner and respondent at the addresses stated in the petition.

(b) Either the obligee or obligor may at any time apply to the public authority for either full IV-D services or for income withholding only services.

~~Upon receipt of a support order requiring income withholding, a petitioner or respondent, who is not a recipient of public assistance and does not receive child support services from the public authority, shall apply to the public authority for either full child support collection services or for income withholding only services.~~

(c) For those persons applying for income withholding only services, a monthly service fee of $15 must be charged to the obligor. This fee is in addition to the amount of the support order and shall be withheld through income withholding. The public authority shall explain the service options in this section to the affected parties and encourage the application for full child support collection services.

(d) If the obligee is not a current recipient of public assistance as defined in section 256.741, the person who applied for services may at any time choose to terminate either full IV-D services or income withholding only services regardless of whether income withholding is currently in place. The obligee or obligor may reapply for either full IV-D services or income withholding only services at any time. Unless the applicant is a recipient of public assistance as defined in section 256.741, a $25 application fee shall be charged at the time of each application.

(e) When a person terminates IV-D services, if an arrearage for public assistance as defined in section 256.741 exists, the public authority may continue income withholding, as well as use any other enforcement remedy for the collection of child

support, until all public assistance arrears are paid in full. Income withholding shall be in an amount equal to 20 percent of the support order in effect at the time the services terminated.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 62. Minnesota Statutes 2002, section 518.6111, subdivision 16, is amended to read:

Subd. 16. **WAIVER.** (a) If the public authority is providing child support and maintenance enforcement services and child support or maintenance is not assigned under section 256.741, the court may waive the requirements of this section if ~~the court finds there is no arrearage in child support and maintenance as of the date of the hearing and~~:

(1) one party demonstrates and the court ~~finds~~ determines there is good cause to waive the requirements of this section or to terminate an order for or notice of income withholding previously entered under this section. The court must make written findings to include the reasons income withholding would not be in the best interests of the child. In cases involving a modification of support, the court must also make a finding that support payments have been timely made; or

(2) ~~all parties reach an~~ the obligee and obligor sign a written agreement ~~and the agreement~~ providing for an alternative payment arrangement which is ~~approved~~ reviewed and entered in the record by the court ~~after a finding that the agreement is likely to result in regular and timely payments. The court's findings waiving the requirements of this paragraph shall include a written explanation of the reasons why income withholding would not be in the best interests of the child~~.

~~In addition to the other requirements in this subdivision, if the case involves a modification of support, the court shall make a finding that support has been timely made.~~

(b) If the public authority is not providing child support and maintenance enforcement services and child support or maintenance is not assigned under section 256.741, the court may waive the requirements of this section if the parties sign a written agreement.

(c) If the court waives income withholding, the obligee or obligor may at any time request income withholding under subdivision 7.

**EFFECTIVE DATE.** This section is effective July 1, 2004.

Sec. 63. **STATE-OPERATED SERVICES STUDY.**

The commissioner of human services shall study the services provided to persons with developmental disabilities who have complex care needs. The commissioner shall analyze:

(1) the needs of the target population;

(2) the methods of providing services to the target population;

(3) the costs and cost-effectiveness of providing services to the target population;

(4) factors that encourage and inhibit vendors, including state-operated community services (SOCS), to provide services to the target population;

(5) alternative populations that could be served by state-operated residential facilities; and

(6) the population served by Minnesota extended treatment options and the cost-effectiveness of these services.

The commissioner shall report on the results of the study under this section to the chairs of the house and senate committees with jurisdiction over state-operated services by January 15, 2004.

Sec. 64. **STATE-OPERATED SERVICES REFINANCING STRATEGY.**

Subdivision 1. **REDESIGN OF MENTAL HEALTH SAFETY NET.** (a) Pursuant to Minnesota Statutes, sections 246.0135, 251.011, and 251.013, the commissioner of human services must seek specific legislative authorization to close any regional treatment center or state-operated nursing home or any program at a regional treatment center or state-operated nursing home.

(b) In developing and seeking legislative authorization for any proposals to restructure state-operated services under this subdivision, the commissioner must consider:

(1) the needs and preferences of the individuals served by affected state-operated services programs and their families;

(2) the location of necessary support services, as identified in the service or treatment plans of individuals served by affected state-operated services programs;

(3) the appropriate grouping of individuals served by a community-based state-operated services program;

(4) the availability of qualified staff to provide services in community-based state-operated services programs;

(5) the need for state-operated services programs in certain geographical regions in the state; and

(6) whether commuting distance to the program for staff and families is reasonable.

(c) The commissioner's proposals to close a regional treatment center, state-operated nursing home or program operated by a regional treatment center or state-operated nursing home under this subdivision must not result in a net reduction in the total number of services in any catchment area in the state and must ensure that any new community-based programs are located in areas that are convenient to the individuals receiving services and their families.

(d) Legislative authorization as required by Minnesota Statutes, sections 246.0135, 251.011, and 251.013, shall mean language specifically authorizing the commissioner's proposals, the authorization to transfer land on which a regional treatment center is located to a nonstate entity, or the authorization to demolish buildings in which programs are or were housed.

Subd. 2. **REDEVELOPMENT PLAN.** (a) In closing any regional treatment center or state-operated nursing home, the commissioner shall develop or aid in the development of a comprehensive redevelopment plan for any facilities or land vacated as a result of the proposal in consultation with the local governmental entity in the jurisdiction in which the facility is located. If a local government entity cannot be secured for facility redevelopment, then the commissioner shall develop the plan in collaboration with affected communities. The plan must include specific information on the redevelopment of the affected facilities or land, specific information about the implementation schedule for the plan, proposed legislation, and letters of commitment regarding the reuse and redevelopment of the facilities or land vacated as a result of the proposal.

(b) The commissioner shall not implement a redevelopment plan under this subdivision until a local governmental entity in which any regional treatment center is located that is affected by the commissioner's redevelopment plan approves the plan.

Subd. 3. **STAFFING.** When closing or restructuring a regional treatment center or state-operated nursing home or a program at a regional treatment center or state-operated nursing home, the commissioner shall comply with the provisions of the applicable collective bargaining agreements or future negotiated agreements, and the agreement authorized under Minnesota Statutes, section 252.50, subdivision 11.

Subd. 4. **STATE-OPERATED SERVICES COSTS.** (a) Programs that remain at a regional treatment center campus during and after the restructuring of state-operated services shall not be assessed any disproportional increase in fees, charges, or other costs associated with operating and maintaining the campus. Increased costs associated with inflation are permissible.

(b) There shall be no increase in the county share of the cost of care provided in state-operated services without legislative authority.

Subd. 5. **REQUEST FOR FEDERAL WAIVER.** By January 1, 2004, the commissioner of human services shall apply to the federal government for a waiver from Medicaid requirements to permit medical assistance coverage for:

(1) mental health treatment services provided by an existing program located at a regional treatment center with a capacity of more than 15 beds; and

(2) mental health treatment services provided by a new program at a facility with a capacity of more than 15 beds.

Sec. 65. **FEDERAL GRANTS TO MAINTAIN INDEPENDENCE AND EMPLOYMENT.**

(a) The commissioner of human services shall seek federal funding to participate in grant activities authorized under Public Law 106-170, the Ticket to Work and Work Incentives Improvement Act of 1999. The purpose of the federal grant funds are to establish:

(1) a demonstration project to improve the availability of health care services and benefits to workers with potentially severe physical or mental impairments that are likely to lead to disability without access to Medicaid services; and

(2) a comprehensive initiative to remove employment barriers that includes linkages with non-Medicaid programs, including those administered by the Social Security Administration and the Department of Labor.

(b) The state's proposal for a demonstration project in paragraph (a), clause (1), shall focus on assisting workers with:

(1) a serious mental illness as defined by the federal Center for Mental Health Services;

(2) concurrent mental health and chemical dependency conditions; and

(3) young adults up to the age of 24 who have a physical or mental impairment that is severe and will potentially lead to a determination of disability by the Social Security Administration or state medical review team.

(c) The commissioner is authorized to take the actions necessary to design and implement the demonstration project in paragraph (a), clause (1), that include:

(1) establishing work-related requirements for participation in the demonstration project;

(2) working with stakeholders to establish methods that identify the population that will be served in the demonstration project;

(3) seeking funding for activities to design, implement, and evaluate the demonstration project;

(4) taking necessary administrative actions to implement the demonstration project by July 1, 2004, or within 180 days of receiving formal notice from the Centers for Medicare and Medicaid Services that a grant has been awarded;

(5) establishing limits on income and resources;

(6) establishing a method to coordinate health care benefits and payments with other coverage that is available to the participants;

(7) establishing premiums based on guidelines that are consistent with those found in Minnesota Statutes, section 256B.057, subdivision 9, for employed persons with disabilities;

(8) notifying local agencies of potentially eligible individuals in accordance with Minnesota Statutes, section 256B.19, subdivision 2c; and

(9) limiting the caseload of qualifying individuals participating in the demonstration project.

(d) The state's proposal for the comprehensive employment initiative in paragraph (a), clause (2), shall focus on:

(1) infrastructure development that creates incentives for greater work effort and participation by people with disabilities or workers with severe physical or mental impairments;

(2) consumer access to information and benefit assistance that enables the person to maximize employment and career advancement potential;

(3) improved consumer access to essential assistance and support;

(4) enhanced linkages between state and federal agencies to decrease the barriers to employment experienced by persons with disabilities or workers with severe physical or mental impairments; and

(5) research efforts to provide useful information to guide future policy development on both the state and federal levels.

(e) Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

(f) The commissioner shall report to the chairs of the senate and house of representatives finance divisions having jurisdiction over health care issues on the federal approval of the waiver under this section and the projected savings in the November and February forecasts.

The commissioner must consider using the savings to increase GAMC hospital rates to the July 1, 2003, levels as a supplemental budget proposal in the 2004 legislative session.

Sec. 66. **CONVEYANCE OF SURPLUS STATE LAND; CASS COUNTY.**

(a) Notwithstanding Minnesota Statutes, chapter 94, or other law, administrative rule, or commissioner's order to the contrary, the commissioner of administration may convey to Cass county or a regional jail authority for no consideration all the buildings and land that are described in paragraph (c), except the land described in paragraph (d).

(b) The conveyance shall be in a form approved by the attorney general and subject to Minnesota Statutes, section 16A.695. The commissioner of administration shall have a registered land surveyor prepare a legal description of the property to be conveyed. The attorney general may make necessary changes in the legal description to correct errors and ensure accuracy.

(c) The land and buildings of the Ah-Gwah-Ching property that may be conveyed to Cass county or a regional jail authority are located in that part of the South Half,

Section 35, Township 142 North, Range 31 West and that part of Government Lot 6, Section 2, Township 141 North, Range 31 West, in Cass county, depicted on the certificate of survey prepared by Landecker and Associates, Inc. dated April 25, 2002. The land described in paragraph (d) is excepted from the conveyance.

(d) That portion of the Ah-Gwah-Ching property to be excepted from the conveyance to Cass county or a regional jail authority is the land located between the shoreline and the top of the bluff line and is approximately described as follows:

(1) all that part of the Southeast Quarter of Southwest Quarter, Section 35, Township 142 North, Range 31 West, lying southeasterly of a line that lies 450 feet southeasterly of and parallel with Minnesota Highway No. 290;

(2) Government Lot 4, Section 35, Township 142 North, Range 31 West;

(3) that part of Government Lot 3, Section 35, Township 142 North, Range 31 West, lying southerly of Minnesota Highway No. 290 and westerly of Minnesota Highway No. 371; and

(4) that part of Government Lot 6, Section 2, Township 141 North, Range 31 West, lying southeasterly of the 1,410 foot contour.

The commissioner of administration shall determine the exact legal description upon further site analysis and the preparation of the surveyor's legal description described in paragraph (b).

(e) Notwithstanding anything herein to the contrary, a conveyance under this section to Cass county or a regional jail authority may include a conveyance by a bill of sale of the water treatment facilities located within the land described in paragraph (d) and a nonexclusive appurtenant easement for such facilities over the land upon which such facilities are located, including ingress and egress as determined by the commissioner. The easement shall be in a form approved by the attorney general.

(f) At the option of the state, Cass county or the regional jail authority must, for a period of at least two years, allow the state to lease the space necessary to operate its programs for the cost of utilities for the leased space. During the term of the lease, the state shall be responsible for any and all maintenance and repairs the state determines are necessary for its use of the leased space.

Sec. 67. **REVISOR'S INSTRUCTION.**

For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 68. **REPEALER.**

(a) Minnesota Statutes 2002, sections 246.017, subdivision 2; 246.022; 246.06; 246.07; 246.08; 246.11; 246.19; 246.42; 252.025, subdivisions 1, 2, 4, 5, and 6; 252.032; 252.10; 253.015, subdivisions 2 and 3; 253.10; 253.19; 253.201; 253.202;

253.25; 253.27; 256.05; 256.06; 256.08; 256.09; 256.10; and 268A.08, are repealed.

(b) Minnesota Rules, parts 9545.2000; 9545.2010; 9545.2020; 9545.2030; and 9545.2040, are repealed.

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## ARTICLE 7

## HEALTH MISCELLANEOUS

Section 1. Minnesota Statutes 2002, section 41A.09, subdivision 2a, is amended to read:

Subd. 2a. **DEFINITIONS.** For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(a) "Ethanol" means fermentation ethyl alcohol derived from agricultural products, including potatoes, cereal, grains, cheese whey, and sugar beets; forest products; or other renewable resources, including residue and waste generated from the production, processing, and marketing of agricultural products, forest products, and other renewable resources, that:

(1) meets all of the specifications in ASTM specification ~~D 4806-88~~ D4806-01; and

(2) is denatured as specified in Code of Federal Regulations, title 27, parts 20 and 21.

(b) "Wet alcohol" means agriculturally derived fermentation ethyl alcohol having a purity of at least 50 percent but less than 99 percent.

(c) "Anhydrous alcohol" means fermentation ethyl alcohol derived from agricultural products as described in paragraph (a), but that does not meet ASTM specifications or is not denatured and is shipped in bond for further processing.

(d) "Ethanol plant" means a plant at which ethanol, anhydrous alcohol, or wet alcohol is produced.

Sec. 2. Minnesota Statutes 2002, section 62A.31, subdivision 1f, is amended to read:

Subd. 1f. **SUSPENSION BASED ON ENTITLEMENT TO MEDICAL ASSISTANCE.** (a) The policy or certificate must provide that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer

of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) The policy must provide that upon reinstatement (1) there is no additional waiting period with respect to treatment of preexisting conditions, (2) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (3) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

Sec. 3. Minnesota Statutes 2002, section 62A.31, subdivision 1u, is amended to read:

Subd. 1u. **GUARANTEED ISSUE FOR ELIGIBLE PERSONS.** (a)(1) Eligible persons are those individuals described in paragraph (b) who ~~apply to enroll under the Medicare supplement policy not later than 63 days after the date of the termination of enrollment described in paragraph (b),~~ seek to enroll under the policy during the period specified in paragraph (c), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) the individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Medicare part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

(i) the organization's or plan's certification under Medicare part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare ~~risk or~~ cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Medicare part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare ~~risk or~~ cost); any similar organization operating under demonstration project authority; ~~an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan);~~ any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under ~~paragraph (a)~~ item (i) is terminated by the enrollee during any period within the first 12 months of ~~such~~ the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act; or

(6) the individual, upon first enrolling for benefits under Medicare part B, enrolls in a Medicare+Choice plan under Medicare part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and ends 63 days after the date of the applicable notice.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer;

(3) paragraph (b), clause (6), shall include any Medicare supplement policy offered by any issuer.

~~(d)~~ (f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the

obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

~~(e)~~ (g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

~~(f)~~ (h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

Sec. 4. Minnesota Statutes 2002, section 62A.31, is amended by adding a subdivision to read:

Subd. 7. **MEDICARE PRESCRIPTION DRUG BENEFIT.** If Congress enacts legislation creating a prescription drug benefit in the Medicare program, nothing in this section or any other section shall prohibit an issuer of a Medicare supplement policy from offering this prescription drug benefit consistent with the applicable federal law or regulations. If an issuer offers the federal benefit, such an offer shall be deemed to meet the issuer's mandatory offer obligations under this section and may, at the discretion of the issuer, constitute replacement coverage as defined in subdivision 1i for any existing policy containing a prescription drug benefit.

Sec. 5. Minnesota Statutes 2002, section 62A.315, is amended to read:

62A.315 **EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

(1) coverage for all of the Medicare part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the ~~copayment~~ coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Medicare part B regardless of hospital confinement, and the Medicare part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country, and prescription drug expenses, not covered by Medicare;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;

(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) for purposes of this benefit, the following definitions shall apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are

normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers.

Sec. 6. Minnesota Statutes 2002, section 62A.316, is amended to read:

62A.316 **BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare part A deductible;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the ~~copayment~~ coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

(4) 80 percent of the hospital and medical expenses and supplies incurred during travel outside the United States as a result of a medical emergency;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears; and

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I, or type II diabetes.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

(3) coverage for all of the Medicare part B annual deductible;

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses;

(5) coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare;

(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

Sec. 7. Minnesota Statutes 2002, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **SHORT-TERM COVERAGE.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of ~~185~~ 365 days out of any ~~365-day~~ 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The ~~185~~ 365 day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the ~~365~~ 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the ~~185-day~~ 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the ~~185-day~~ 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

(e) Time spent under short-term coverage counts as time spent under a preexisting condition limitation for purposes of group or individual health plans, other than short-term coverage, subsequently issued to that person, or to cover that person, by any health carrier, if the person maintains continuous coverage as defined in section 62L.02. Short-term coverage is a health plan and is qualifying coverage as defined in section 62L.02. Notwithstanding any other law to the contrary, a health carrier is not required under any circumstances to provide a person covered by short-term coverage the right to obtain coverage on a guaranteed issue basis under another health plan offered by the health carrier, as a result of the person's enrollment in short-term coverage.

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to policies issued on or after that date.

Sec. 8. Minnesota Statutes 2002, section 62D.095, subdivision 2, is amended to read:

Subd. 2. **CO-PAYMENTS.** (a) A health maintenance contract may impose a co-payment as authorized under Minnesota Rules, part 4685.0801, or under this section.

(b) A health maintenance organization may impose a flat fee co-payment on outpatient office visits not to exceed 40 percent of the median provider's charges for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801. A health maintenance organization may impose a flat fee co-payment on outpatient prescription drugs not to exceed 50 percent of the median provider's charges for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801.

(c) If a health maintenance contract is permitted to impose a co-payment for preexisting health status under sections 62D.01 to 62D.30, these provisions may vary with respect to length of enrollment in the health plan.

Sec. 9. Minnesota Statutes 2002, section 62D.095, is amended by adding a subdivision to read:

Subd. 6. **PUBLIC PROGRAMS.** This section does not apply to the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance program, the federal Medicare program, or the health plans provided through any of those programs.

Sec. 10. Minnesota Statutes 2002, section 62E.06, subdivision 1, is amended to read:

Subdivision 1. **NUMBER THREE PLAN.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $1,000,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $1,000,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;

(5) services of a home health agency if the services would qualify as reimbursable services under Medicare;

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(11) diagnostic x-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare, or any other governmental program except as otherwise provided by section 62A.04, subdivision 3, clause (4);

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to policies, contracts, and certificates issued or renewed on or after that date.

Sec. 11. Minnesota Statutes 2002, section 62J.17, subdivision 2, is amended to read:

Subd. 2. **DEFINITIONS.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

(b) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.

(e) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(f) "Major spending commitment" means an expenditure in excess of ~~$500,000~~ $1,000,000 for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(g) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(h) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

Sec. 12. Minnesota Statutes 2002, section 62J.23, is amended by adding a subdivision to read:

Subd. 5. **AUDITS OF EXEMPT PROVIDERS.** The commissioner may audit the referral patterns of providers that qualify for exceptions under the federal Stark Law, United States Code, title 42, section 1395nn. The commissioner has access to provider records according to section 144.99, subdivision 2. The commissioner shall report to the legislature any audit results that reveal a pattern of referrals by a provider for the furnishing of health services to an entity with which the provider has a direct or indirect financial relationship.

Sec. 13. **[62J.26] EVALUATION OF PROPOSED HEALTH COVERAGE MANDATES.**

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given unless the context otherwise requires:

(1) "commissioner" means the commissioner of commerce;

(2) "health plan" means a health plan as defined in section 62A.011, subdivision 3, but includes coverage listed in clauses (7) and (10) of that definition;

(3) "mandated health benefit proposal" means a proposal that would statutorily require a health plan to do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service; or

(iii) provide coverage for care delivered by a specific type of provider.

"Mandated health benefit proposal" does not include health benefit proposals amending the scope of practice of a licensed health care professional.

Subd. 2. **EVALUATION PROCESS AND CONTENT.** (a) The commissioner, in consultation with the commissioners of health and employee relations, must evaluate mandated health benefit proposals as provided under subdivision 3.

(b) The purpose of the evaluation is to provide the legislature with a complete and timely analysis of all ramifications of any mandated health benefit proposal. The evaluation must include, in addition to other relevant information, the following:

(1) scientific and medical information on the proposed health benefit, on the potential for harm or benefit to the patient, and on the comparative benefit or harm from alternative forms of treatment;

(2) public health, economic, and fiscal impacts of the proposed mandate on persons receiving health services in Minnesota, on the relative cost-effectiveness of the benefit, and on the health care system in general;

(3) the extent to which the service is generally utilized by a significant portion of the population;

(4) the extent to which insurance coverage for the proposed mandated benefit is already generally available;

(5) the extent to which the mandated coverage will increase or decrease the cost of the service; and

(6) the commissioner may consider actuarial analysis done by health insurers in determining the cost of the proposed mandated benefit.

(c) The commissioner must summarize the nature and quality of available information on these issues, and, if possible, must provide preliminary information to the public. The commissioner may conduct research on these issues or may determine that existing research is sufficient to meet the informational needs of the legislature. The commissioner may seek the assistance and advice of researchers, community leaders, or other persons or organizations with relevant expertise.

Subd. 3. **REQUESTS FOR EVALUATION.** (a) Whenever a legislative measure containing a mandated health benefit proposal is introduced as a bill or offered as an

amendment to a bill, or is likely to be introduced as a bill or offered as an amendment, a chair of any standing legislative committee that has jurisdiction over the subject matter of the proposal may request that the commissioner complete an evaluation of the proposal under this section, to inform any committee of floor action by either house of the legislature.

(b) The commissioner must conduct an evaluation described in subdivision 2 of each mandated health benefit proposal for which an evaluation is requested under paragraph (a), unless the commissioner determines under paragraph (c) or subdivision 4 that priorities and resources do not permit its evaluation.

(c) If requests for evaluation of multiple proposals are received, the commissioner must consult with the chairs of the standing legislative committees having jurisdiction over the subject matter of the mandated health benefit proposals to prioritize the requests and establish a reporting date for each proposal to be evaluated. The commissioner is not required to direct an unreasonable quantity of the commissioner's resources to these evaluations.

Subd. 4. **SOURCES OF FUNDING.** (a) The commissioner need not use any funds for purposes of this section other than as provided in this subdivision or as specified in an appropriation.

(b) The commissioner may seek and accept funding from sources other than the state to pay for evaluations under this section to supplement or replace state appropriations. Any money received under this paragraph must be deposited in the state treasury, credited to a separate account for this purpose in the special revenue fund, and is appropriated to the commissioner for purposes of this section.

(c) If a request for an evaluation under this section has been made, the commissioner may use for purposes of the evaluation:

(1) any funds appropriated to the commissioner specifically for purposes of this section; or

(2) funds available under paragraph (b), if use of the funds for evaluation of that mandated health benefit proposal is consistent with any restrictions imposed by the source of the funds.

(d) The commissioner must ensure that the source of the funding has no influence on the process or outcome of the evaluation.

Subd. 5. **REPORT TO LEGISLATURE.** The commissioner must submit a written report on the evaluation to the legislature no later than 180 days after the request. The report must be submitted in compliance with sections 3.195 and 3.197.

**EFFECTIVE DATE.** This section is effective January 1, 2004.

Sec. 14. Minnesota Statutes 2002, section 62J.52, subdivision 1, is amended to read:

Subdivision 1. **UNIFORM BILLING FORM HCFA 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form HCFA 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, ~~including infusion therapy,~~ freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Sec. 15. Minnesota Statutes 2002, section 62J.52, subdivision 2, is amended to read:

Subd. 2. **UNIFORM BILLING FORM HCFA 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form HCFA 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the HCFA 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form HCFA 1500 include physician services and supplies, durable medical equipment, noninstitutional ambu-

lance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

Sec. 16. Minnesota Statutes 2002, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **APPLICATION PROCESS.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota state colleges and universities system or members of the Minnesota private college council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in ~~paragraph~~ paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(c)~~ (d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

~~(d)~~ (e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 17. Minnesota Statutes 2002, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **DISTRIBUTION OF FUNDS.** (a) The commissioner shall annually distribute 90 percent of available medical education funds to all qualifying applicants based on ~~the following criteria~~ a distribution formula that reflects a summation of two factors:

(1) ~~total medical education funds available for distribution;~~ an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) ~~total number of eligible trainee FTEs in each clinical medical education program; and~~

~~(3) the statewide average cost per trainee as determined by the application information provided in the first year of the biennium, by type of trainee, in each clinical medical education program.~~ a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total

statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of total available medical education funds to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a). Applicants may also choose to distribute funds to clinical training sites with a valid Minnesota medical assistance identification number that host fewer than 0.5 eligible trainee FTE's for a clinical medical education program.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(c)~~ (d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the department of education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(d)~~ (e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(e) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under section 62J.694, subdivision 2a, paragraph (b), plus five percent interest to the University of Minnesota board of regents for the costs of the academic health center as specified under section 62J.694, subdivision 2a, paragraph (a).~~

Sec. 18. Minnesota Statutes 2002, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **REPORT.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) The reports must provide verification of the distribution of the funds and must include:

(1) the total number of eligible trainee FTEs in each clinical medical education program;

(2) the name of each funded program and, for each program, the dollar amount distributed to each training site;

(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;

(4) a statement by the sponsoring institution describing the distribution of funds allocated under subdivision 4, paragraph (b), including information on which clinical training sites received funding and the rationale used for determining funding priorities;

(5) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) By February 15 of each year, the commissioner, with advice from the advisory committee, shall provide an annual summary report to the legislature on the implementation of this section.

Sec. 19. Minnesota Statutes 2002, section 62J.692, subdivision 7, is amended to read:

Subd. 7. **TRANSFERS FROM THE COMMISSIONER OF HUMAN SERVICES.** (a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on a ~~distribution formula that reflects a summation of two factors:~~ the formula in subdivision 4, paragraph (a).

~~(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and~~

~~(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool created under this subdivision.~~

~~In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.~~

~~Public program revenue for the distribution formula shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue shall be ineligible for funds available under this paragraph.~~

(b) Fifty percent of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40. Of the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), 24 percent of the amount shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education. The remaining 26 percent of the amount transferred shall be distributed by the commissioner in accordance with subdivision 7a. If the federal approval is not obtained for the matching funds under section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount transferred under this paragraph shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40.

(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (3), shall be distributed by the commissioner upon receipt to the University of Minnesota board of regents for the purposes of clinical graduate medical education.

Sec. 20. Minnesota Statutes 2002, section 62J.694, is amended by adding a subdivision to read:

Subd. 5. **EFFECTIVE DATE.** This section is only in effect if there are funds available in the medical education endowment fund.

Sec. 21. Minnesota Statutes 2002, section 62L.05, subdivision 4, is amended to read:

Subd. 4. **BENEFITS.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3. Benefits under this subdivision may be provided through the managed care procedures practiced by health carriers:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12). The health care services required to be covered under this clause must also be covered if rendered in

a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;

(2) physician, chiropractor, and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic x-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to policies, contracts, and certificates issued or renewed on or after that date.

Sec. 22. Minnesota Statutes 2002, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **DESIGNATION.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; or

(5) ~~a rural hospital that has qualified for~~ a sole community hospital ~~financial assistance grant in the past three years under section 144.1484, subdivision 1~~. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Sec. 23. Minnesota Statutes 2002, section 62Q.19, subdivision 2, is amended to read:

Subd. 2. **APPLICATION.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in ~~paragraph~~ paragraphs (d) and (e), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, 2001, from:

(1) one applicant that is a nonprofit community health care facility, certified as a medical assistance provider effective April 1, 1998, that provides culturally competent health care to an underserved Southeast Asian immigrant and refugee population residing in the immediate neighborhood of the facility;

(2) one applicant that is a nonprofit home health care provider, certified as a Medicare and a medical assistance provider that provides culturally competent home health care services to a low-income culturally diverse population;

(3) up to five applicants that are nonprofit community mental health centers certified as medical assistance providers that provide mental health services to children with serious emotional disturbance and their families or to adults with serious and persistent mental illness; and

(4) one applicant that is a nonprofit provider certified as a medical assistance provider that provides mental health, child development, and family services to children with physical and mental health disorders and their families.

(e) The commissioner shall accept an application for designation as an essential community provider until June 30, 2003, from one applicant that is a nonprofit community clinic located in Hennepin county that provides health care to an underserved American Indian population and that is collaborating with other neighboring organizations on a community diabetes project and an immunization project.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

Sec. 24. **[62Q.675] HEARING AIDS; PERSONS 18 OR YOUNGER.**

A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to policies, contracts, and certificates issued or renewed on or after that date.

Sec. 25. Minnesota Statutes 2002, section 144.1222, is amended by adding a subdivision to read:

Subd. 1a. **FEES.** All plans and specifications for public swimming pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each spa pool, $500;

(2) projects valued at $250,000 or less, a minimum of $800 per pool plus:

(i) for each slide, an additional $400; and

(ii) for each spa pool, an additional $500;

(3) projects valued at $250,000 or more, 0.5 percent of documented estimated project cost to a maximum fee of $10,000;

(4) alterations to an existing pool without changing the size or configuration of the pool, $400;

(5) removal or replacement of pool disinfection equipment only, $75; and

(6) request for variance from the public pool and spa rules, $500.

Sec. 26. Minnesota Statutes 2002, section 144.125, is amended to read:

144.125 **TESTS OF INFANTS FOR ~~INBORN METABOLIC ERRORS~~ HERITABLE AND CONGENITAL DISORDERS.**

Subdivision 1. **DUTY TO PERFORM TESTING.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for ~~inborn errors of metabolism in accordance with~~ heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. ~~In determining which tests must be administered, the commissioner shall take into consideration the adequacy of laboratory methods to detect the inborn metabolic error, the ability to treat or prevent medical conditions caused by the inborn metabolic error, and the severity of the medical conditions caused by the inborn metabolic error.~~ Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge laboratory service fees so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with ~~inborn metabolic errors~~ heritable or congenital disorders. The laboratory service fee is $61 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

Subd. 2. **DETERMINATION OF TESTS TO BE ADMINISTERED.** The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of laboratory methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14 and sections 14.385 and 14.386 do not apply.

Subd. 3. **OBJECTION OF PARENTS TO TEST.** Persons with a duty to perform testing under subdivision 1 shall advise parents of infants (1) that the blood or tissue samples used to perform testing thereunder as well as the results of such testing may be retained by the department of health, (2) the benefit of retaining the blood or tissue sample, and (3) that the following options are available to them with respect to the testing:

(i) to decline to have the tests, or

(ii) to elect to have the tests but to require that all blood samples and records of test results be destroyed within 24 months of the testing. If the parents of an infant object in writing to testing for heritable and congenital disorders or elect to require that blood samples and test results be destroyed, the objection or election shall be recorded

on a form that is signed by a parent or legal guardian and made part of the infant's medical record. A written objection exempts an infant from the requirements of this section and section 144.128.

Sec. 27. **[144.1255] ADVISORY COMMITTEE ON HERITABLE AND CONGENITAL DISORDERS.**

Subdivision 1. **CREATION AND MEMBERSHIP.** (a) By July 1, 2003, the commissioner of health shall appoint an advisory committee to provide advice and recommendations to the commissioner concerning tests and treatments for heritable and congenital disorders found in newborn children. Membership of the committee shall include, but not be limited to, at least one member from each of the following representative groups:

(1) parents and other consumers;

(2) primary care providers;

(3) clinicians and researchers specializing in newborn diseases and disorders;

(4) genetic counselors;

(5) birth hospital representatives;

(6) newborn screening laboratory professionals;

(7) nutritionists; and

(8) other experts as needed representing related fields such as emerging technologies and health insurance.

(b) The terms and removal of members are governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses. Notwithstanding section 15.059, subdivision 5, the advisory committee does not expire.

Subd. 2. **FUNCTION AND OBJECTIVES.** The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and reliability of various tests for heritable and congenital disorders;

(2) collection of information on the availability and efficacy of treatments for heritable and congenital disorders;

(3) collection of information on the severity of medical conditions caused by heritable and congenital disorders;

(4) discussion and assessment of the benefits of performing tests for heritable or congenital disorders as compared to the costs, treatment limitations, or other potential disadvantages of requiring the tests;

(5) discussion and assessment of ethical considerations surrounding the testing, treatment, and handling of data and specimens generated by the testing requirements of sections 144.125 to 144.128; and

(6) providing advice and recommendations to the commissioner concerning tests and treatments for heritable and congenital disorders found in newborn children.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 28. Minnesota Statutes 2002, section 144.128, is amended to read:

144.128 ~~**TREATMENT FOR POSITIVE DIAGNOSIS, REGISTRY OF CASES**~~ **COMMISSIONER'S DUTIES.**

The commissioner shall:

(1) notify the physicians of newborns tested of the results of the tests performed;

~~(1)~~ (2) make ~~arrangements~~ referrals for the necessary treatment of diagnosed cases of ~~hemoglobinopathy, phenylketonuria, and other inborn errors of metabolism~~ heritable or congenital disorders when treatment is indicated ~~and the family is uninsured and, because of a lack of available income, is unable to pay the cost of the treatment~~;

~~(2)~~ (3) maintain a registry of the cases of ~~hemoglobinopathy, phenylketonuria, and other inborn errors of metabolism~~ heritable and congenital disorders detected by the screening program for the purpose of follow-up services; and

~~(3)~~ (4) adopt rules to carry out ~~section 144.126 and this section~~ sections 144.125 to 144.128.

Sec. 29. Minnesota Statutes 2002, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT; MEMBERSHIP.** The commissioner of health shall establish a 15-member rural health advisory committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathy licensed under chapter 147;

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

(9) a licensed health care professional from an occupation not otherwise represented on the committee;

(10) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

(11) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation. Notwithstanding section 15.059, the advisory committee does not expire.

Sec. 30. Minnesota Statutes 2002, section 144.1483, is amended to read:

144.1483 **RURAL HEALTH INITIATIVES.**

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education services office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) ~~administer the program of financial assistance established under section 144.1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;~~

~~(4)~~ develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

~~(5)~~ (4) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

~~(6)~~ (5) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care

services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

~~(7)~~ (6) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

~~(8)~~ (7) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

~~(9)~~ (8) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

~~(10)~~ (9) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council;

~~(11)~~ (10) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

~~(12)~~ (11) carry out other activities necessary to address rural health problems.

Sec. 31. Minnesota Statutes 2002, section 144.1488, subdivision 4, is amended to read:

Subd. 4. **ELIGIBLE HEALTH PROFESSIONALS.** (a) To be eligible to apply to the commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, must have a current and unrestricted Minnesota license to practice, and must be ready to begin full-time clinical practice upon signing a contract for obligated service.

(b) Eligible providers are those specified by the federal Bureau of ~~Primary Health Care~~ Health Professions in the policy information notice for the state's current federal grant application. A health professional selected for participation is not eligible for loan repayment until the health professional has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner.

Sec. 32. Minnesota Statutes 2002, section 144.1491, subdivision 1, is amended to read:

Subdivision 1. **PENALTIES FOR BREACH OF CONTRACT.** A program participant who fails to complete ~~two~~ the required years of obligated service shall repay the amount paid, as well as a financial penalty ~~based upon the length of the service obligation not fulfilled. If the participant has served at least one year, the financial penalty is the number of unserved months multiplied by $1,000. If the participant has served less than one year, the financial penalty is the total number of obligated months multiplied by $1,000~~ specified by the federal Bureau of Health Professions in the policy information notice for the state's current federal grant application. The commissioner shall report to the appropriate health-related licensing board a participant who fails to complete the service obligation and fails to repay the amount paid or fails to pay any financial penalty owed under this subdivision.

Sec. 33. **[144.1501] HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS PROGRAM.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the following definitions apply.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(i) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(j) "Physician assistant" means a person registered under chapter 147A.

(k) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(l) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 2. **CREATION OF ACCOUNT.** A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas or underserved urban communities, for midlevel practitioners agreeing to practice in designated rural areas, and for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions. Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Subd. 3. **ELIGIBILITY.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical resident or be enrolled in a midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Subd. 4. **LOAN FORGIVENESS.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits

of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area or facility type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Subd. 5. **PENALTY FOR NONFULFILLMENT.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Subd. 6. **RULES.** The commissioner may adopt rules to implement this section.

Sec. 34. Minnesota Statutes 2002, section 144.1502, subdivision 4, is amended to read:

Subd. 4. **LOAN FORGIVENESS.** The commissioner of health may accept ~~up to~~ 14 applicants ~~per~~ each year for participation in the loan forgiveness program, within

the limits of available funding. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for practice serving public program patients, as indicated by experience or training. The commissioner shall give preference to applicants who have attended a Minnesota dentistry educational institution and to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to ~~$10,000 per year of service, not to exceed $40,000~~ 15 percent of the average educational debt for indebted dental school graduates in the year closest to the applicant's selection for which information is available or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 3.

Sec. 35. Minnesota Statutes 2002, section 144.396, subdivision 1, is amended to read:

Subdivision 1. **PURPOSE.** The legislature finds that it is important to reduce the prevalence of tobacco use among the youth of this state. It is a goal of the state to reduce tobacco use among youth by ~~30~~ 25 percent by the year 2005, and to promote statewide and local tobacco use prevention activities to achieve this goal.

Sec. 36. Minnesota Statutes 2002, section 144.396, subdivision 5, is amended to read:

Subd. 5. **STATEWIDE TOBACCO PREVENTION GRANTS.** (a) To the extent funds are appropriated for the purposes of this subdivision, the commissioner of health shall award competitive grants to eligible applicants for projects and initiatives directed at the prevention of tobacco use. The project areas for grants include:

(1) statewide public education and information campaigns which include implementation at the local level; and

(2) coordinated special projects, including training and technical assistance, a resource clearinghouse, and contracts with ethnic and minority communities.

(b) Eligible applicants may include, but are not limited to, nonprofit organizations, colleges and universities, professional health associations, community health boards, and other health care organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented to target tobacco use among youth, and must take into account the need for a coordinated statewide tobacco prevention effort.

(c) The commissioner must give priority to applicants who demonstrate that the proposed project:

(1) is research based or based on proven effective strategies;

(2) is designed to coordinate with other activities and education messages related to other health initiatives;

(3) utilizes and enhances existing prevention activities and resources; or

(4) involves innovative approaches preventing tobacco use among youth.

Sec. 37. Minnesota Statutes 2002, section 144.396, subdivision 7, is amended to read:

Subd. 7. **LOCAL PUBLIC HEALTH PROMOTION AND PROTECTION.** The commissioner shall distribute ~~the~~ funds ~~available under section 144.395, subdivision 2, paragraph (c), clause (3)~~ appropriated for the purpose of local health promotion and protection activities to community health boards ~~for local health promotion and protection activities~~ for local health initiatives other than tobacco prevention aimed at high risk health behaviors among youth. The commissioner shall distribute these funds to the community health boards based on demographics and other need-based factors relating to health.

Sec. 38. Minnesota Statutes 2002, section 144.396, subdivision 10, is amended to read:

Subd. 10. **REPORT.** The commissioner of health shall submit ~~an annual~~ a biennial report to the chairs and members of the house health and human services finance committee and the senate health and family security budget division on the statewide and local projects and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, and evaluation data and outcome measures, if available. These reports are due by January 15 of ~~each year~~ the odd-numbered years, beginning in 2001.

Sec. 39. Minnesota Statutes 2002, section 144.396, subdivision 11, is amended to read:

Subd. 11. **AUDITS.** The legislative auditor ~~shall~~ may audit tobacco use prevention and local public health ~~endowment fund~~ expenditures to ensure that the money is spent for tobacco use prevention measures and public health initiatives.

Sec. 40. Minnesota Statutes 2002, section 144.396, subdivision 12, is amended to read:

Subd. 12. **~~ENDOWMENT FUND~~ FUNDS NOT TO SUPPLANT EXISTING FUNDING.** ~~Appropriations from the tobacco use prevention and local public health endowment fund~~ Funds appropriated to the statewide tobacco prevention grants, local tobacco prevention grants, or the local public health promotion and prevention must not be used as a substitute for traditional sources of funding tobacco use prevention

activities or public health initiatives. Any local unit of government receiving money under this section must ensure that existing local financial efforts remain in place.

Sec. 41. Minnesota Statutes 2002, section 144.414, subdivision 3, is amended to read:

Subd. 3. **HEALTH CARE FACILITIES AND CLINICS.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, or other health care-related facility, other than a nursing home, boarding care facility, or licensed residential facility, except as allowed in this subdivision.

(b) ~~Smoking by patients in a chemical dependency treatment program or mental health program may be allowed in a separated well-ventilated area pursuant to a policy established by the administrator of the program that identifies circumstances in which prohibiting smoking would interfere with the treatment of persons recovering from chemical dependency or mental illness.~~

~~(c)~~ Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

**EFFECTIVE DATE.** This section is effective January 1, 2004.

Sec. 42. **[144.5509] RADIATION THERAPY FACILITY CONSTRUCTION.**

(a) A radiation therapy facility may be constructed only by an entity owned, operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either alone or in cooperation with another entity.

(b) This section expires August 1, 2008.

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to construction commenced on or after that date.

Sec. 43. Minnesota Statutes 2002, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **RESTRICTED CONSTRUCTION OR MODIFICATION.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice county that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not

exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami county; ~~or~~

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail county with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver county serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare; or

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services.

Sec. 44. Minnesota Statutes 2002, section 144E.50, subdivision 5, is amended to read:

Subd. 5. **DISTRIBUTION.** Money from the fund shall be distributed according to this subdivision. ~~Ninety-three and one-third~~ Ninety-five percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the board. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations. The board shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions. If one or more of the regions does not contract for the full amount of its even share or if its proposal is unsatisfactory, then the board may reallocate the unused funds to the remaining regions on a pro rata basis. ~~Six and two-thirds~~ Five percent of the fund shall be used

by the board to support regionwide reporting systems and to provide other regional administration and technical assistance.

Sec. 45. Minnesota Statutes 2002, section 145.881, subdivision 1, is amended to read:

Subdivision 1. **COMPOSITION OF TASK FORCE.** The commissioner shall establish and appoint a maternal and child health advisory task force consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the state department of health. Section 15.059 governs the maternal and child health advisory task force. Notwithstanding section 15.059, the maternal and child health advisory task force expires June 30, 2007.

Sec. 46. Minnesota Statutes 2002, section 145A.10, subdivision 10, is amended to read:

Subd. 10. **STATE AND LOCAL ADVISORY COMMITTEES.** (a) A state community health advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may receive a per diem and must be reimbursed for travel and other necessary expenses while engaged in their official duties. Notwithstanding section 15.059, the state community health advisory committee does not expire.

(b) The city councils or county boards that have established or are members of a community health board must appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on matters relating to the development, maintenance, funding, and evaluation of community health services. The committee must consist of at least five members and must be generally representative of the population and health care providers of the community health service area. The committee must meet at least three times a year and at the call of the chair or a majority of the members. Members may receive a per diem and reimbursement for travel and other necessary expenses while engaged in their official duties.

(c) State and local advisory committees must adopt bylaws or operating procedures that specify the length of terms of membership, procedures for assuring that no more than half of these terms expire during the same year, and other matters relating to the conduct of committee business. Bylaws or operating procedures may allow one alternate to be appointed for each member of a state or local advisory committee. Alternates may be given full or partial powers and duties of members.

Sec. 47. Minnesota Statutes 2002, section 147A.08, is amended to read:

147A.08 **EXEMPTIONS.**

(a) This chapter does not apply to, control, prevent, or restrict the practice, service, or activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13), persons regulated under section 214.01, subdivision 2, or persons defined in section ~~144.1495~~ 144.1501, subdivision 1, paragraphs ~~(a) to (d)~~ (e), (g), and (h).

(b) Nothing in this chapter shall be construed to require registration of:

(1) a physician assistant student enrolled in a physician assistant or surgeon assistant educational program accredited by the Committee on Allied Health Education and Accreditation or by its successor agency approved by the board;

(2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or

(3) technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who do not identify themselves as a physician assistant.

Sec. 48. Minnesota Statutes 2002, section 148.5194, subdivision 1, is amended to read:

Subdivision 1. **FEE PRORATION.** The commissioner shall prorate the registration fee for clinical fellowship, temporary, and first time registrants according to the number of months that have elapsed between the date registration is issued and the date registration expires or must be renewed under section 148.5191, subdivision 4.

Sec. 49. Minnesota Statutes 2002, section 148.5194, subdivision 2, is amended to read:

Subd. 2. **BIENNIAL REGISTRATION FEE.** The fee for initial registration and biennial registration, clinical fellowship registration, temporary registration, or renewal is $200.

Sec. 50. Minnesota Statutes 2002, section 148.5194, subdivision 3, is amended to read:

Subd. 3. **BIENNIAL REGISTRATION FEE FOR DUAL REGISTRATION.** The fee for initial registration and biennial registration, clinical fellowship registration, temporary registration, or renewal is $200.

Sec. 51. Minnesota Statutes 2002, section 148.5194, is amended by adding a subdivision to read:

Subd. 6. **VERIFICATION OF CREDENTIAL.** The fee for written verification of credentialed status is $25.

Sec. 52. Minnesota Statutes 2002, section 148.6445, subdivision 7, is amended to read:

Subd. 7. ~~**CERTIFICATION**~~ **VERIFICATION TO OTHER STATES.** The fee for ~~certification~~ verification of licensure to other states is $25.

Sec. 53. **[148C.12] FEES.**

Subdivision 1. **APPLICATION FEE.** The application fee is $295.

Subd. 2. **BIENNIAL RENEWAL FEE.** The license renewal fee is $295. If the commissioner changes the renewal schedule and the expiration date is less than two years, the fee must be prorated.

Subd. 3. **TEMPORARY PERMIT FEE.** The initial fee for applicants under section 148C.04, subdivision 6, paragraph (a), is $100. The fee for annual renewal of a temporary permit is $100.

Subd. 4. **EXAMINATION FEE.** The examination fee for the written examination is $95 and for the oral examination is $200.

Subd. 5. **INACTIVE RENEWAL FEE.** The inactive renewal fee is $150.

Subd. 6. **LATE FEE.** The late fee is 25 percent of the biennial renewal fee, the inactive renewal fee, or the annual fee for renewal of temporary practice status.

Subd. 7. **FEE TO RENEW AFTER EXPIRATION OF LICENSE.** The fee for renewal of a license that has expired for less than two years is the total of the biennial renewal fee, the late fee, and a fee of $100 for review and approval of the continuing education report.

Subd. 8. **FEE FOR LICENSE VERIFICATIONS.** The fee for license verification to institutions and other jurisdictions is $25.

Subd. 9. **SURCHARGE FEE.** Notwithstanding section 16A.1285, subdivision 2, a surcharge of $99 shall be paid at the time of initial application for or renewal of an alcohol and drug counselor license until June 30, 2013.

Subd. 10. **NONREFUNDABLE FEES.** All fees are nonrefundable.

Sec. 54. Minnesota Statutes 2002, section 153A.17, is amended to read:

153A.17 **EXPENSES; FEES.**

The expenses for administering the certification requirements including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15 and the consumer information center under section 153A.18 must be paid from initial application and examination fees, renewal fees, penalties, and fines. All fees are nonrefundable. The certificate application fee is ~~$165 for audiologists registered under section 148.511 and $490 for all others~~ $350, the examination fee is ~~$200~~ $250 for the written portion and ~~$200~~ $250 for the practical portion each time one or the other is taken, and the trainee application fee is ~~$100~~ $200. ~~Notwithstanding the policy set~~

~~forth in section 16A.1285, subdivision 2, a surcharge of $165 for audiologists registered under section 148.511 and $330 for all others shall be paid at the time of application or renewal until June 30, 2003, to recover the commissioner's accumulated direct expenditures for administering the requirements of this chapter.~~ The penalty fee for late submission of a renewal application is $200. The fee for verification of certification to other jurisdictions or entities is $25. All fees, penalties, and fines received must be deposited in the state government special revenue fund. The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

Sec. 55. Minnesota Statutes 2002, section 239.761, subdivision 3, is amended to read:

Subd. 3. **GASOLINE.** (a) Gasoline that is not blended with ethanol must not be contaminated with water or other impurities and must comply with ASTM specification ~~D 4814-96~~ D4814-01. Gasoline that is not blended with ethanol must also comply with the volatility requirements in Code of Federal Regulations, title 40, part 80.

(b) After gasoline is sold, transferred, or otherwise removed from a refinery or terminal, a person responsible for the product:

(1) may blend the gasoline with agriculturally derived ethanol as provided in subdivision 4;

(2) shall not blend the gasoline with any oxygenate other than denatured, agriculturally derived ethanol;

(3) shall not blend the gasoline with other petroleum products that are not gasoline or denatured, agriculturally derived ethanol;

(4) shall not blend the gasoline with products commonly and commercially known as casinghead gasoline, absorption gasoline, condensation gasoline, drip gasoline, or natural gasoline; and

(5) may blend the gasoline with a detergent additive, an antiknock additive, or an additive designed to replace tetra-ethyl lead, that is registered by the EPA.

Sec. 56. Minnesota Statutes 2002, section 239.761, subdivision 4, is amended to read:

Subd. 4. **GASOLINE BLENDED WITH ETHANOL.** (a) Gasoline may be blended with up to ten percent, by volume, agriculturally derived, denatured ethanol that complies with the requirements of subdivision 5.

(b) A gasoline-ethanol blend must:

(1) comply with the volatility requirements in Code of Federal Regulations, title 40, part 80;

(2) comply with ASTM specification ~~D 4814-96~~ D4814-01, or the gasoline base stock from which a gasoline-ethanol blend was produced must comply with ASTM specification ~~D 4814-96~~ D4814-01; and

(3) not be blended with casinghead gasoline, absorption gasoline, condensation gasoline, drip gasoline, or natural gasoline after the gasoline-ethanol blend has been sold, transferred, or otherwise removed from a refinery or terminal.

Sec. 57. Minnesota Statutes 2002, section 239.761, subdivision 5, is amended to read:

Subd. 5. **DENATURED ETHANOL.** Denatured ethanol that is to be blended with gasoline must be agriculturally derived and must comply with ASTM specification ~~D 4806-95b~~ D4806-01. This includes the requirement that ethanol may be denatured only as specified in Code of Federal Regulations, title 27, parts 20 and 21.

Sec. 58. Minnesota Statutes 2002, section 239.761, subdivision 6, is amended to read:

Subd. 6. **GASOLINE BLENDED WITH NONETHANOL OXYGENATE.** (a) A person responsible for the product shall comply with the following requirements:

(1) after July 1, 2000, gasoline containing in excess of one-third of one percent, in total, of ~~the~~ nonethanol oxygenates listed in paragraph (b) ~~may~~ must not be sold or offered for sale at any time in this state; and

(2) after July 1, 2005, gasoline containing any of the nonethanol oxygenates listed in paragraph (b) ~~may~~ must not be sold or offered for sale in this state.

(b) The oxygenates prohibited under paragraph (a) are:

(1) methyl tertiary butyl ether, as defined in section 296A.01, subdivision 34;

(2) ethyl tertiary butyl ether, as defined in section 296A.01, subdivision 18; or

(3) tertiary amyl methyl ether.

(c) Gasoline that is blended with ~~an~~ a nonethanol oxygenate ~~, other than denatured ethanol,~~ must comply with ASTM specification ~~D 4814-96~~ D4814-01. Nonethanol oxygenates~~, other than denatured ethanol,~~ must not be blended into gasoline after the gasoline has been sold, transferred, or otherwise removed from a refinery or terminal.

Sec. 59. Minnesota Statutes 2002, section 239.761, subdivision 7, is amended to read:

Subd. 7. **HEATING FUEL OIL.** Heating fuel oil must comply with ASTM specification ~~D 396-96~~ D396-01.

Sec. 60. Minnesota Statutes 2002, section 239.761, subdivision 8, is amended to read:

Subd. 8. **DIESEL FUEL OIL.** Diesel fuel oil must comply with ASTM specification ~~D 975-96a~~ D975-01a.

Sec. 61. Minnesota Statutes 2002, section 239.761, subdivision 9, is amended to read:

Subd. 9. **KEROSENE.** Kerosene must comply with ASTM specification ~~D 3699-96a~~ D3699-01.

Sec. 62. Minnesota Statutes 2002, section 239.761, subdivision 10, is amended to read:

Subd. 10. **AVIATION GASOLINE.** Aviation gasoline must comply with ASTM specification ~~D 910-96~~ D910-00.

Sec. 63. Minnesota Statutes 2002, section 239.761, subdivision 11, is amended to read:

Subd. 11. **AVIATION TURBINE FUEL, JET FUEL.** Aviation turbine fuel and jet fuel must comply with ASTM specification ~~D 1655-96c~~ D1655-01.

Sec. 64. Minnesota Statutes 2002, section 239.761, subdivision 12, is amended to read:

Subd. 12. **GAS TURBINE FUEL OIL.** Fuel oil for use in nonaviation gas turbine engines must comply with ASTM specification ~~D 2880-96a~~ D2880-00.

Sec. 65. Minnesota Statutes 2002, section 239.761, subdivision 13, is amended to read:

Subd. 13. **E85.** A blend of ethanol and gasoline, containing at least 60 percent ethanol and not more than 85 percent ethanol, produced for use as a motor fuel in alternative fuel vehicles as defined in section 296A.01, subdivision 5, must comply with ASTM specification ~~D 5798-96~~ D5798-99.

Sec. 66. Minnesota Statutes 2002, section 239.792, is amended to read:

239.792 **GASOLINE OCTANE.**

Subdivision 1. **DISCLOSURE.** A manufacturer, hauler, blender, agent, jobber, consignment agent, importer, or distributor who sells, delivers, or distributes gasoline or gasoline-oxygenate blends, shall provide, at the time of delivery, a bill of lading or shipping manifest to the person who receives the gasoline. The bill or manifest must state the minimum octane of the gasoline delivered. The stated octane number must be the average of the "motor method" octane number and the "research method" octane number as determined by the test methods in ASTM specification ~~D 4814-96~~ D4814-01, or by a test method adopted by department rule.

Subd. 2. **DISPENSER LABELING.** A person responsible for the product shall clearly, conspicuously, and permanently label each gasoline dispenser that is used to sell gasoline or gasoline-oxygenate blends at retail or to dispense gasoline or gasoline-oxygenate blends into the fuel supply tanks of motor vehicles, with the minimum octane of the gasoline dispensed. The label must meet the following requirements:

(a) The octane number displayed on the label must represent the average of the "motor method" octane number and the "research method" octane number as

determined by the test methods in ASTM specification ~~D 4814-96~~ D4814-01, or by a test method adopted by department rule.

(b) The label must be at least 2-1/2 inches high and three inches wide, with a yellow background, black border, and black figures and letters.

(c) The number representing the octane of the gasoline must be at least one inch high.

(d) The label must include the words "minimum octane" and the term "(R+M)/2" or "(RON+MON)/2."

Sec. 67. **[246.0141] TOBACCO USE PROHIBITED.**

No patient, staff, guest, or visitor on the grounds or in a state regional treatment center, the Minnesota security hospital, the Minnesota sex offender program, or the Minnesota extended treatment options program may possess or use tobacco or a tobacco related device. For the purposes of this section, "tobacco" and "tobacco related device" have the meanings given in section 609.685, subdivision 1. This section does not prohibit the possession or use of tobacco or a tobacco related device by an adult as part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

**EFFECTIVE DATE.** This section is effective January 1, 2004.

Sec. 68. Minnesota Statutes 2002, section 295.55, subdivision 2, is amended to read:

Subd. 2. **ESTIMATED TAX; HOSPITALS; SURGICAL CENTERS.** (a) Each hospital or surgical center must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within 15 days after the end of the month.

(b) Estimated tax payments are not required of hospitals or surgical centers if: (1) the tax for the current calendar year is less than $500; or (2) the tax for the previous calendar year is less than $500, if the taxpayer had a tax liability and was doing business the entire year~~; or (3) if a hospital has been allowed a grant under section 144.1484, subdivision 2, for the year~~.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return whichever comes first. An underpayment of an estimated installment is the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) one-twelfth of the total tax for the previous calendar year if the taxpayer had a tax liability and was doing business the entire year.

Sec. 69. Minnesota Statutes 2002, section 296A.01, subdivision 2, is amended to read:

Subd. 2. **AGRICULTURAL ALCOHOL GASOLINE.** "Agricultural alcohol gasoline" means a gasoline-ethanol blend of up to ten percent agriculturally derived fermentation ethanol derived from agricultural products, such as potatoes, cereal, grains, cheese whey, sugar beets, forest products, or other renewable resources, that:

(1) meets the specifications in ASTM specification ~~D 4806-95b~~ D4806-01; and

(2) is denatured as specified in Code of Federal Regulations, title 27, parts 20 and 21.

Sec. 70. Minnesota Statutes 2002, section 296A.01, subdivision 7, is amended to read:

Subd. 7. **AVIATION GASOLINE.** "Aviation gasoline" means any gasoline that is capable of use for the purpose of producing or generating power for propelling internal combustion engine aircraft, that meets the specifications in ASTM specification ~~D 910-96~~ D910-00, and that either:

(1) is invoiced and billed by a producer, manufacturer, refiner, or blender to a distributor or dealer, by a distributor to a dealer or consumer, or by a dealer to consumer, as "aviation gasoline"; or

(2) whether or not invoiced and billed as provided in clause (1), is received, sold, stored, or withdrawn from storage by any person, to be used for the purpose of producing or generating power for propelling internal combustion engine aircraft.

Sec. 71. Minnesota Statutes 2002, section 296A.01, subdivision 8, is amended to read:

Subd. 8. **AVIATION TURBINE FUEL AND JET FUEL.** "Aviation turbine fuel" and "jet fuel" mean blends of hydrocarbons derived from crude petroleum, natural gasoline, and synthetic hydrocarbons, intended for use in aviation turbine engines, and that meet the specifications in ASTM specification ~~D 1655-96c~~ D1655-01.

Sec. 72. Minnesota Statutes 2002, section 296A.01, subdivision 14, is amended to read:

Subd. 14. **DIESEL FUEL OIL.** "Diesel fuel oil" means a petroleum distillate or blend of petroleum distillate and residual fuels, intended for use as a motor fuel in internal combustion diesel engines, that meets the specifications in ASTM specification ~~D 975-96a~~ D975-01A. Diesel fuel includes number 1 and number 2 fuel oils. K-1 kerosene is not diesel fuel unless it is blended with diesel fuel for use in motor vehicles.

Sec. 73. Minnesota Statutes 2002, section 296A.01, subdivision 19, is amended to read:

Subd. 19. **E85.** "E85" means a petroleum product that is a blend of agriculturally derived denatured ethanol and gasoline or natural gasoline that typically contains 85 percent ethanol by volume, but at a minimum must contain 60 percent ethanol by volume. For the purposes of this chapter, the energy content of E85 will be considered to be 82,000 BTUs per gallon. E85 produced for use as a motor fuel in alternative fuel

vehicles as defined in subdivision 5 must comply with ASTM specification ~~D 5798-96~~ D5798-99.

Sec. 74. Minnesota Statutes 2002, section 296A.01, subdivision 20, is amended to read:

Subd. 20. **ETHANOL, DENATURED.** "Ethanol, denatured" means ethanol that is to be blended with gasoline, has been agriculturally derived, and complies with ASTM specification ~~D 4806-95b~~ D4806-01. This includes the requirement that ethanol may be denatured only as specified in Code of Federal Regulations, title 27, parts 20 and 21.

Sec. 75. Minnesota Statutes 2002, section 296A.01, subdivision 22, is amended to read:

Subd. 22. **GAS TURBINE FUEL OIL.** "Gas turbine fuel oil" means fuel that contains mixtures of hydrocarbon oils free of inorganic acid and excessive amounts of solid or fibrous foreign matter, intended for use in nonaviation gas turbine engines, and that meets the specifications in ASTM specification ~~D 2880-96a~~ D2880-00.

Sec. 76. Minnesota Statutes 2002, section 296A.01, subdivision 23, is amended to read:

Subd. 23. **GASOLINE.** (a) "Gasoline" means:

(1) all products commonly or commercially known or sold as gasoline regardless of their classification or uses, except casinghead gasoline, absorption gasoline, condensation gasoline, drip gasoline, or natural gasoline that under the requirements of section 239.761, subdivision 3, must not be blended with gasoline that has been sold, transferred, or otherwise removed from a refinery or terminal; and

(2) any liquid prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, a fuel in spark-ignition, internal combustion engines, and that when tested by the weights and measures division meets the specifications in ASTM specification ~~D 4814-96~~ D4814-01.

(b) Gasoline that is not blended with ethanol must not be contaminated with water or other impurities and must comply with both ASTM specification ~~D 4814-96~~ D4814-01 and the volatility requirements in Code of Federal Regulations, title 40, part 80.

(c) After gasoline is sold, transferred, or otherwise removed from a refinery or terminal, a person responsible for the product:

(1) may blend the gasoline with agriculturally derived ethanol, as provided in subdivision 24;

(2) must not blend the gasoline with any oxygenate other than denatured, agriculturally derived ethanol;

(3) must not blend the gasoline with other petroleum products that are not gasoline or denatured, agriculturally derived ethanol;

(4) must not blend the gasoline with products commonly and commercially known as casinghead gasoline, absorption gasoline, condensation gasoline, drip gasoline, or natural gasoline; and

(5) may blend the gasoline with a detergent additive, an antiknock additive, or an additive designed to replace tetra-ethyl lead, that is registered by the EPA.

Sec. 77. Minnesota Statutes 2002, section 296A.01, subdivision 24, is amended to read:

Subd. 24. **GASOLINE BLENDED WITH NONETHANOL OXYGENATE.** "Gasoline blended with nonethanol oxygenate" means gasoline blended with ETBE, MTBE, or other alcohol or ether, except denatured ethanol, that is approved as an oxygenate by the EPA, and that complies with ASTM specification ~~D 4814-96~~ D4814-01. Oxygenates, other than denatured ethanol, must not be blended into gasoline after the gasoline has been sold, transferred, or otherwise removed from a refinery or terminal.

Sec. 78. Minnesota Statutes 2002, section 296A.01, subdivision 25, is amended to read:

Subd. 25. **GASOLINE BLENDED WITH ETHANOL.** "Gasoline blended with ethanol" means gasoline blended with up to ten percent, by volume, agriculturally derived, denatured ethanol. The blend must comply with the volatility requirements in Code of Federal Regulations, title 40, part 80. The blend must also comply with ASTM specification ~~D 4814-96~~ D4814-01, or the gasoline base stock from which a gasoline-ethanol blend was produced must comply with ASTM specification ~~D 4814-96~~ D4814-01; and the gasoline-ethanol blend must not be blended with casinghead gasoline, absorption gasoline, condensation gasoline, drip gasoline, or natural gasoline after the gasoline-ethanol blend has been sold, transferred, or otherwise removed from a refinery or terminal. The blend need not comply with ASTM specification ~~D 4814-96~~ D4814-01 if it is subjected to a standard distillation test. For a distillation test, a gasoline-ethanol blend is not required to comply with the temperature specification at the 50 percent liquid recovery point, if the gasoline from which the gasoline-ethanol blend was produced complies with all of the distillation specifications.

Sec. 79. Minnesota Statutes 2002, section 296A.01, subdivision 26, is amended to read:

Subd. 26. **HEATING FUEL OIL.** "Heating fuel oil" means a petroleum distillate, blend of petroleum distillates and residuals, or petroleum residual heating fuel that meets the specifications in ASTM specification ~~D 396-96~~ D396-01.

Sec. 80. Minnesota Statutes 2002, section 296A.01, subdivision 28, is amended to read:

Subd. 28. **KEROSENE.** "Kerosene" means a refined petroleum distillate consisting of a homogeneous mixture of hydrocarbons essentially free of water, inorganic acidic and basic compounds, and excessive amounts of particulate contaminants and that meets the specifications in ASTM specification ~~D 3699-96a~~ D3699-01.

Sec. 81. Minnesota Statutes 2002, section 296A.01, is amended by adding a subdivision to read:

Subd. 38a. **NONETHANOL OXYGENATE.** "Nonethanol oxygenate" means ETBE or MTBE, as defined in this section, or other alcohol or ether, except denatured ethanol, that is approved as an oxygenate by the EPA.

Sec. 82. Minnesota Statutes 2002, section 326.42, is amended to read:

326.42 **APPLICATIONS, FEES.**

Subdivision 1. **APPLICATION.** Applications for plumber's license shall be made to the state commissioner of health, with fee. Unless the applicant is entitled to a renewal, the applicant shall be licensed by the state commissioner of health only after passing a satisfactory examination by the examiners showing fitness. Examination fees for both journeyman and master plumbers shall be in an amount prescribed by the state commissioner of health pursuant to section 144.122. Upon being notified that of having successfully passed the examination for original license the applicant shall submit an application, with the license fee herein provided. License fees shall be in an amount prescribed by the state commissioner of health pursuant to section 144.122. Licenses shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.

Subd. 2. **FEES.** Plumbing system plans and specifications that are submitted to the commissioner for review shall be accompanied by the appropriate plan examination fees. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid prior to plan approval. The commissioner shall charge the following fees for plan reviews and audits of plumbing installations for public, commercial, and industrial buildings:

(1) systems with both water distribution and drain, waste, and vent systems and having:

(i) 25 or fewer drainage fixture units, $150;

(ii) 26 to 50 drainage fixture units, $250;

(iii) 51 to 150 drainage fixture units, $350;

(iv) 151 to 249 drainage fixture units, $500;

(v) 250 or more drainage fixture units, $3 per drainage fixture unit to a maximum of $4,000; and

(vi) interceptors, separators, or catch basins, $70 per interceptor, separator, or catch basin;

(2) building sewer service only, $150;

(3) building water service only, $150;

(4) building water distribution system only, no drainage system, $5 per supply fixture unit or $150, whichever is greater;

(5) storm drainage system, a minimum fee of $150 or:

(i) $50 per drain opening, up to a maximum of $500; and

(ii) $70 per interceptor, separator, or catch basin;

(6) manufactured home park or campground, 1 to 25 sites, $300;

(7) manufactured home park or campground, 26 to 50 sites, $350;

(8) manufactured home park or campground, 51 to 125 sites, $400;

(9) manufactured home park or campground, more than 125 sites, $500;

(10) accelerated review, double the regular fee, one-half to be refunded if no response from the commissioner within 15 business days; and

(11) revision to previously reviewed or incomplete plans:

(i) review of plans for which commissioner has issued two or more requests for additional information, per review, $100 or ten percent of the original fee, whichever is greater;

(ii) proposer-requested revision with no increase in project scope, $50 or ten percent of original fee, whichever is greater; and

(iii) proposer-requested revision with an increase in project scope, $50 plus the difference between the original project fee and the revised project fee.

Sec. 83. Minnesota Statutes 2002, section 471.59, subdivision 1, is amended to read:

Subdivision 1. **AGREEMENT.** Two or more governmental units, by agreement entered into through action of their governing bodies, may jointly or cooperatively exercise any power common to the contracting parties or any similar powers, including those which are the same except for the territorial limits within which they may be exercised. The agreement may provide for the exercise of such powers by one or more of the participating governmental units on behalf of the other participating units. The term "governmental unit" as used in this section includes every city, county, town, school district, other political subdivision of this or another state, another state, the University of Minnesota, nonprofit hospitals licensed under sections 144.50 to 144.56, and any agency of the state of Minnesota or the United States, and includes any instrumentality of a governmental unit. For the purpose of this section, an instrumentality of a governmental unit means an instrumentality having independent policy making and appropriating authority.

Sec. 84. 2003 S.F. No. 1019, section 2, if enacted, is amended to read:

Sec. 2. **[144.7063] DEFINITIONS.**

Subdivision 1. **SCOPE.** Unless the context clearly indicates otherwise, for the purposes of sections 144.706 to 144.7069, the terms defined in this section have the meanings given them.

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of health.

Subd. 3. **FACILITY.** "Facility" means a hospital licensed under sections 144.50 to 144.58.

Subd. 4. **SERIOUS DISABILITY.** "Serious disability" means (1) a physical or mental impairment that substantially limits one or more of the major life activities of an individual~~,~~ ~~(2)~~ or a loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or ~~(3)~~ (2) loss of a body part.

Subd. 5. **SURGERY.** "Surgery" means the treatment of disease, injury, or deformity by manual or operative methods. Surgery includes endoscopies and other invasive procedures.

Sec. 85. 2003 S.F. No. 1019, section 3, if enacted, is amended to read:

Sec. 3. **[144.7065] FACILITY REQUIREMENTS TO REPORT, ANALYZE, AND CORRECT.**

Subdivision 1. **REPORTS OF ADVERSE HEALTH CARE EVENTS REQUIRED.** Each facility shall report to the commissioner the occurrence of any of the adverse health care events described in subdivisions 2 to 7 as soon as is reasonably and practically possible, but no later than 15 working days after discovery of the event. The report shall be filed in a format specified by the commissioner and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. The commissioner may consult with experts and organizations familiar with patient safety when developing the format for reporting and in further defining events in order to be consistent with industry standards.

Subd. 2. **SURGICAL EVENTS.** Events reportable under this subdivision are:

(1) surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(2) surgery performed on the wrong patient;

(3) the wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause

do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(4) retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

(5) death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Subd. 3. **PRODUCT OR DEVICE EVENTS.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

(2) patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

(3) patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Subd. 4. **PATIENT PROTECTION EVENTS.** Events reportable under this subdivision are:

(1) an infant discharged to the wrong person;

(2) patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and

(3) patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Subd. 5. **CARE MANAGEMENT EVENTS.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

(2) patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

(3) maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

(4) patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;

(5) death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;

(6) stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission; and

(7) patient death or serious disability due to spinal manipulative therapy.

Subd. 6. **ENVIRONMENTAL EVENTS.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

(2) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(3) patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;

(4) patient death associated with a fall while being cared for in a facility; and

(5) patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

Subd. 7. **CRIMINAL EVENTS.** Events reportable under this subdivision are:

(1) any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(2) abduction of a patient of any age;

(3) sexual assault on a patient within or on the grounds of a facility; and

(4) death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

Subd. 8. **ROOT CAUSE ANALYSIS; CORRECTIVE ACTION PLAN.** Following the occurrence of an adverse health care event, the facility must conduct a root cause analysis of the event. Following the analysis, the facility must: (1)

implement a corrective action plan to implement the findings of the analysis or (2) report to the commissioner any reasons for not taking corrective action. If the root cause analysis and the implementation of a corrective action plan are complete at the time an event must be reported, the findings of the analysis and the corrective action plan must be included in the report of the event. The findings of the root cause analysis and a copy of the corrective action plan must otherwise be filed with the commissioner within 60 days of the event.

Subd. 9. **ELECTRONIC REPORTING.** The commissioner must design the reporting system so that a facility may file by electronic means the reports required under this section. The commissioner shall encourage a facility to use the electronic filing option when that option is feasible for the facility.

Subd. 10. **RELATION TO OTHER LAW.** (a) Adverse health events described in subdivisions 2 to 6 do not constitute "maltreatment" or "a physical injury that is not reasonably explained" under section 626.557 and are excluded from the reporting requirements of section 626.557, provided the facility makes a determination within 24 hours of the discovery of the event that this section is applicable and the facility files the reports required under this section in a timely fashion.

(b) A facility that has determined that an event described in subdivisions 2 to 6 has occurred must inform persons who are mandated reporters under section 626.5572, subdivision 16, of that determination. A mandated reporter otherwise required to report under section 626.557, subdivision 3, paragraph (e), is relieved of the duty to report an event that the facility determines under paragraph (a) to be reportable under subdivisions 2 to 6.

(c) The protections and immunities applicable to voluntary reports under section 626.557 are not affected by this section.

(d) Notwithstanding section 626.557, a lead agency under section 626.5572, subdivision 13, is not required to conduct an investigation of an event described in subdivisions 2 to 6.

Sec. 86. 2003 S.F. No. 1019, section 7, if enacted, is amended to read:

Sec. 7. **ADVERSE HEALTH CARE EVENTS REPORTING SYSTEM TRANSITION PERIOD.**

(a) Effective July 1, 2003, limited implementation of the Adverse Health Care Events Reporting Act shall begin, provided the commissioner of health has secured sufficient nonstate funds for this purpose. During this period, the commissioner must:

(1) solicit additional nonstate funds to support full implementation of the system;

(2) work with organizations and experts familiar with patient safety to review reporting categories in Minnesota Statutes, section 144.7065, make necessary clarifications, and develop educational materials; and

(3) monitor activities of the National Quality Forum and other patient safety organizations, other states, and the federal government in the area of patient safety.

(b) Effective July 1, 2003, facilities defined in Minnesota Statutes, section 144.7063, subdivision 3, shall report any adverse health care events, as defined in Minnesota Statutes, section 144.7065, to the incident reporting system maintained by the Minnesota Hospital Association. The association shall provide a summary report to the commissioner that identifies the types of events by category. The association shall consult with the commissioner regarding the data to be reported to the commissioner, storage of data received by the association but not reported to the commissioner, and eventual retrieval by the commissioner of stored data.

(c) The commissioner shall report to the legislature by January 15 of 2004 and 2005, with a list of the number of reported events by type and recommendations, if any, for reporting system modifications, including additional categories of events that should be reported.

(d) From July 1, 2003, until full implementation of the reporting system, the commissioner of health shall not make a final disposition as defined in Minnesota Statutes, section 626.5572, subdivision 8, for investigations conducted in licensed hospitals under the provisions of Minnesota Statutes, section 626.557. The commissioner's findings in these cases shall identify noncompliance with federal certification or state licensure rules or laws.

(e) Effective July 1, 2004, the reporting system shall be fully implemented, provided (1) the commissioner has secured sufficient funds from nonstate sources to operate the system during fiscal year 2005, and (2) the commissioner has notified facilities by April 1, 2004, of their duty to report.

~~(f) Effective July 1, 2005, the reporting system shall be operated with state appropriations.~~

Sec. 87. **AUTHORITY TO COLLECT CERTAIN FEES SUSPENDED.**

(a) The commissioner's authority to collect the certificate application fee from hearing instrument dispensers under Minnesota Statutes, section 153A.17, is suspended for certified hearing instrument dispensers renewing certification in fiscal year 2004.

(b) The commissioner's authority to collect the license renewal fee from occupational therapy practitioners under Minnesota Statutes, section 148.6445, subdivision 2, is suspended for fiscal years 2004 and 2005.

Sec. 88. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall delete the reference to "144.1495" in Minnesota Statutes, section 62Q.145, and insert "144.1501."

(b) For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 89. **REPEALER.**

(a) Minnesota Statutes 2002, sections 62J.15; 62J.152; 62J.451; 62J.452; 144.126; 144.1484; 144.1494; 144.1495; 144.1496; 144.1497; 144A.36; 144A.38; 148.5194, subdivision 3a; and 148.6445, subdivision 9, are repealed.

(b) Minnesota Rules, parts 4763.0100; 4763.0110; 4763.0125; 4763.0135; 4763.0140; 4763.0150; 4763.0160; 4763.0170; 4763.0180; 4763.0190; 4763.0205; 4763.0215; 4763.0220; 4763.0230; 4763.0240; 4763.0250; 4763.0260; 4763.0270; 4763.0285; 4763.0295; and 4763.0300, are repealed.

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## ARTICLE 8

## LOCAL PUBLIC HEALTH GRANTS

Section 1. Minnesota Statutes 2002, section 144E.11, subdivision 6, is amended to read:

Subd. 6. **REVIEW CRITERIA.** When reviewing an application for licensure, the board and administrative law judge shall consider the following factors:

(1) ~~the relationship of the proposed service or expansion in primary service area to the current community health plan as approved by the commissioner of health under section 145A.12, subdivision 4;~~

~~(2)~~ the recommendations or comments of the governing bodies of the counties, municipalities, community health boards as defined under section 145A.09, subdivision 2, and regional emergency medical services system designated under section 144E.50 in which the service would be provided;

~~(3)~~ (2) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;

~~(4)~~ (3) the estimated effect of the proposed service or expansion in primary service area on the public health; and

~~(5)~~ (4) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service or expansion in primary service area. The administrative law judge shall recommend that the board either grant or deny a license or recommend that a modified license be granted. The reasons for the recommendation shall be set forth in detail. The administrative law judge shall make the recommendations and reasons available to any individual requesting them.

Sec. 2. Minnesota Statutes 2002, section 145.88, is amended to read:

145.88 **PURPOSE.**

~~The legislature finds that it is in the public interest to assure:~~

~~(a) statewide planning and coordination of maternal and child health services through the acquisition and analysis of population-based health data, provision of technical support and training, and coordination of the various public and private maternal and child health efforts; and~~

~~(b) support for targeted maternal and child health services in communities with significant populations of high risk, low income families through a grants process.~~

Federal money received by the Minnesota department of health, pursuant to United States Code, title 42, sections 701 to 709, shall be expended to:

(1) assure access to quality maternal and child health services for mothers and children, especially those of low income and with limited availability to health services and those children at risk of physical, neurological, emotional, and developmental problems arising from chemical abuse by a mother during pregnancy;

(2) reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children;

(3) reduce the need for inpatient and long-term care services and to otherwise promote the health of mothers and children, especially by providing preventive and primary care services for low-income mothers and children and prenatal, delivery and postpartum care for low-income mothers;

(4) provide rehabilitative services for blind and disabled children under age 16 receiving benefits under title XVI of the Social Security Act; and

(5) provide and locate medical, surgical, corrective and other service for children who are crippled or who are suffering from conditions that lead to crippling.

Sec. 3. Minnesota Statutes 2002, section 145.881, subdivision 2, is amended to read:

Subd. 2. **DUTIES.** The advisory task force shall meet on a regular basis to perform the following duties:

(a) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(b) review and report on the type, frequency and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(c) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory task force considers essential to providing an effective maternal and child health care program to low income populations and high risk persons and fulfilling the purposes defined in section 145.88;

(d) ~~review staff recommendations of the department of health regarding maternal and child health grant awards before the awards are made;~~

~~(e)~~ make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

~~(f)~~ (e) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services: (1) prenatal, delivery and postpartum care, (2) comprehensive health care for children, especially from birth through five years of age, (3) adolescent health services, (4) family planning services, (5) preventive dental care, (6) special services for chronically ill and handicapped children and (7) any other services which promote the health of mothers and children; and

~~(g) make recommendations to the commissioner of health on the process to distribute, award and administer the maternal and child health block grant funds; and~~

~~(h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.~~

(f) establish, in consultation with the commissioner and the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), statewide outcomes that will improve the health status of mothers and children as required in section 145A.12, subdivision 7.

Sec. 4. Minnesota Statutes 2002, section 145.882, subdivision 1, is amended to read:

Subdivision 1. **FUNDING ~~LEVELS AND ADVISORY TASK FORCE~~ REVIEW.** Any decrease in the amount of federal funding to the state for the maternal and child health block grant must be apportioned to reflect a proportional decrease for each recipient. Any increase in the amount of federal funding to the state must be distributed under subdivisions 2~~,~~ and 3~~, and~~ 4.

~~The advisory task force shall review and recommend the proportion of maternal and child health block grant funds to be expended for indirect costs, direct services and special projects.~~

Sec. 5. Minnesota Statutes 2002, section 145.882, subdivision 2, is amended to read:

Subd. 2. **ALLOCATION TO THE COMMISSIONER OF HEALTH.** Beginning January 1, 1986, up to one-third of the total maternal and child health block grant money may be retained by the commissioner of health ~~for administrative and technical assistance services, projects of regional or statewide significance, direct services to children with handicaps, and other activities of the commissioner.~~ to:

(1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report;

(2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year;

(3) provide technical assistance to community health boards in meeting statewide outcomes under section 145A.12, subdivision 7;

(4) evaluate the impact of maternal and child health activities on the health status of mothers and children;

(5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and

(6) perform other maternal and child health activities listed in section 145.88 and as deemed necessary by the commissioner.

Sec. 6. Minnesota Statutes 2002, section 145.882, subdivision 3, is amended to read:

Subd. 3. **ALLOCATION TO COMMUNITY HEALTH ~~SERVICES AREAS~~ BOARDS.** (a) The maternal and child health block grant money remaining after distributions made under subdivision 2 must be allocated according to the formula in ~~subdivision 4 to community health services areas~~ section 145A.131, subdivision 2, for distribution ~~by~~ to community health boards. ~~as defined in section 145A.02, subdivision 5, to qualified programs that provide essential services within the community health services area as long as:~~

~~(1) the Minneapolis community health service area is allocated at least $1,626,215 per year;~~

~~(2) the St. Paul community health service area is allocated at least $822,931 per year; and~~

~~(3) all other community health service areas are allocated at least $30,000 per county per year or their 1988–1989 funding cycle award, whichever is less.~~

(b) ~~Notwithstanding paragraph (a), if the total amount of maternal and child health block grant funding decreases, the decrease must be apportioned to reflect a proportional decrease for each recipient, including recipients who would otherwise receive a guaranteed minimum allocation under paragraph (a).~~ A community health board that receives funding under this section shall provide at least a 50 percent match for funds received under United States Code, title 42, sections 701 to 709. Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other funds, donations, nonfederal grants, or state funds received under the local public health grant defined in section 145A.131, that are used for maternal and child health activities as described in section 145.882, subdivision 7.

Sec. 7. Minnesota Statutes 2002, section 145.882, is amended by adding a subdivision to read:

Subd. 5a. **NONPARTICIPATING COMMUNITY HEALTH BOARDS.** If a community health board decides not to participate in maternal and child health block grant activities under subdivision 3 or the commissioner determines under section 145A.131, subdivision 7, not to fund the community health board, the commissioner is responsible for directing maternal and child health block grant activities in that community health board's geographic area. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or to contract with other governmental units or nonprofit organizations.

Sec. 8. Minnesota Statutes 2002, section 145.882, subdivision 7, is amended to read:

Subd. 7. **USE OF BLOCK GRANT MONEY.** ~~(a)~~ Maternal and child health block grant money allocated to a community health board ~~or community health services area~~ under this section must be used for qualified programs for high risk and low-income individuals. Block grant money must be used for programs that:

(1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, including prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide family planning and preventive medical care for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to decrease the occurrence of inappropriate pregnancy and minimize the risk of complications associated with pregnancy and childbirth; ~~or~~

(5) specifically address the frequency and severity of childhood and adolescent health issues, including injuries in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity.; ~~However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses (1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3.~~

~~(b) Maternal and child health block grant money may be used for purposes other than the purposes listed in this subdivision only under the following conditions:~~

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

~~(1) the community health board or community health services area can demonstrate that existing programs fully address the needs of the highest risk target populations described in this subdivision; or~~

~~(2) the money is used to continue projects that received funding before creation of the maternal and child health block grant in 1981.~~

~~(c) Projects that received funding before creation of the maternal and child health block grant in 1981, must be allocated at least the amount of maternal and child health special project grant funds received in 1989, unless (1) the local board of health provides equivalent alternative funding for the project from another source; or (2) the local board of health demonstrates that the need for the specific services provided by the project has significantly decreased as a result of changes in the demographic characteristics of the population, or other factors that have a major impact on the demand for services. If the amount of federal funding to the state for the maternal and child health block grant is decreased, these projects must receive a proportional decrease as required in subdivision 1. Increases in allocation amounts to local boards of health under subdivision 4 may be used to increase funding levels for these projects.~~

(6) specifically address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visits under section 145A.17; or

(7) specifically address nutritional issues of women, infants, and young children through WIC clinic services.

Sec. 9. **[145.8821] ACCOUNTABILITY.**

(a) Coordinating with the statewide outcomes established under section 145A.12, subdivision 7, and with accountability measures outlined in section 145A.131, subdivision 7, each community health board that receives money under section 145.882, subdivision 3, shall select by February 1, 2005, and every five years thereafter, up to two statewide maternal and child health outcomes.

(b) For the period January 1, 2004, to December 31, 2005, each community health board must work toward the Healthy People 2010 goal to reduce the state's percentage of low birth weight infants.

(c) The commissioner shall monitor and evaluate whether each community health board has made sufficient progress toward the selected outcomes established in paragraph (b) and under section 145A.12, subdivision 7.

(d) Community health boards shall provide the commissioner with annual information necessary to evaluate progress toward selected statewide outcomes and to meet federal reporting requirements.

Sec. 10. Minnesota Statutes 2002, section 145.883, subdivision 1, is amended to read:

Subdivision 1. **SCOPE.** For purposes of sections 145.881 to ~~145.888~~ 145.883, the terms defined in this section shall have the meanings given them.

Sec. 11. Minnesota Statutes 2002, section 145.883, subdivision 9, is amended to read:

Subd. 9. **COMMUNITY HEALTH ~~SERVICES AREA~~ BOARD.** "Community health ~~services area~~ board" means ~~a city, county, or multicounty area that is organized as a community health board under section 145A.09 and for which a state subsidy is received under sections 145A.09 to 145A.13~~ a board of health established, operating, and eligible for a local public health grant under sections 145A.09 to 145A.131.

Sec. 12. Minnesota Statutes 2002, section 145A.02, subdivision 5, is amended to read:

Subd. 5. **COMMUNITY HEALTH BOARD.** "Community health board" means a board of health established, operating, and eligible for a ~~subsidy~~ local public health grant under sections 145A.09 to ~~145A.13~~ 145A.131.

Sec. 13. Minnesota Statutes 2002, section 145A.02, subdivision 6, is amended to read:

Subd. 6. **COMMUNITY HEALTH SERVICES.** "Community health services" means activities designed to protect and promote the health of the general population within a community health service area by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community. ~~Program categories of community health services include disease prevention and control, emergency medical care, environmental health, family health, health promotion, and home health care.~~

Sec. 14. Minnesota Statutes 2002, section 145A.02, subdivision 7, is amended to read:

Subd. 7. **COMMUNITY HEALTH SERVICE AREA.** "Community health service area" means a city, county, or multicounty area that is organized as a community health board under section 145A.09 and for which a ~~subsidy~~ local public health grant is received under sections 145A.09 to ~~145A.13~~ 145A.131.

Sec. 15. Minnesota Statutes 2002, section 145A.06, subdivision 1, is amended to read:

Subdivision 1. **GENERALLY.** In addition to other powers and duties provided by law, the commissioner has the powers listed in subdivisions 2 to 4 5.

Sec. 16. Minnesota Statutes 2002, section 145A.09, subdivision 2, is amended to read:

Subd. 2. **COMMUNITY HEALTH BOARD; ELIGIBILITY.** A board of health that meets the requirements of sections 145A.09 to ~~145A.13~~ 145A.131 is a community

health board and is eligible for a ~~community health subsidy~~ local public health grant under section ~~145A.13~~ 145A.131.

Sec. 17. Minnesota Statutes 2002, section 145A.09, subdivision 4, is amended to read:

Subd. 4. **CITIES.** A city that received a subsidy under section 145A.13 and that meets the requirements of sections 145A.09 to ~~145A.13~~ 145A.131 is eligible for a ~~community health subsidy~~ local public health grant under section ~~145A.13~~ 145A.131.

Sec. 18. Minnesota Statutes 2002, section 145A.09, subdivision 7, is amended to read:

Subd. 7. **WITHDRAWAL.** (a) A county or city that has established or joined a community health board may withdraw from the ~~subsidy~~ local public health grant program authorized by sections 145A.09 to ~~145A.13~~ 145A.131 by resolution of its governing body in accordance with section 145A.03, subdivision 3, and this subdivision.

(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

(c) The withdrawal of a county or city from a community health board does not affect the eligibility for the ~~community health subsidy~~ local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(d) ~~The amount of additional annual payment for calendar year 1985 made pursuant to Minnesota Statutes 1984, section 145.921, subdivision 4, must be subtracted from the subsidy for a county that, due to withdrawal from a community health board, ceases to meet the terms and conditions under which that additional annual payment was made~~ The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

Sec. 19. Minnesota Statutes 2002, section 145A.10, subdivision 2, is amended to read:

Subd. 2. **PREEMPTION.** (a) Not later than 365 days after the ~~approval of a community health plan by the commissioner~~ formation of a community health board, any other board of health within the community health service area for which the plan has been prepared must cease operation, except as authorized in a joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07, subdivision 2, or as otherwise allowed by this subdivision.

(b) This subdivision does not preempt or otherwise change the powers and duties of any city or county eligible for ~~subsidy~~ a local public health grant under section 145A.09.

(c) This subdivision does not preempt the authority to operate a community health services program of any city of the first or second class operating an existing program of community health services located within a county with a population of 300,000 or more persons until the city council takes action to allow the county to preempt the city's powers and duties.

Sec. 20. Minnesota Statutes 2002, section 145A.10, is amended by adding a subdivision to read:

Subd. 5a. **DUTIES.** (a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

(1) establish local public health priorities based on an assessment of community health needs and assets; and

(2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, within the limits of available funding. In determining the mechanisms to address local public health priorities and achieve statewide outcomes, the community health board shall seek public input or consider the recommendations of the community health advisory committee and the following essential public health services:

(i) monitor health status to identify community health problems;

(ii) diagnose and investigate problems and health hazards in the community;

(iii) inform, educate, and empower people about health issues;

(iv) mobilize community partnerships to identify and solve health problems;

(v) develop policies and plans that support individual and community health efforts;

(vi) enforce laws and regulations that protect health and ensure safety;

(vii) link people to needed personal health care services;

(viii) ensure a competent public health and personal health care workforce;

(ix) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and

(x) research for new insights and innovative solutions to health problems.

(b) By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant under section 145A.131 shall notify the commissioner in writing of the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, that the board will address and the local priorities established under paragraph (a) that the board will address.

(c) Each community health board receiving a local public health grant under section 145A.131 must submit an annual report to the commissioner documenting progress toward the achievement of statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, and the local public health priorities established under paragraph (a), using reporting standards and procedures established by the commissioner and in compliance with all applicable federal requirements. If a community health board has identified additional local priorities for use of the local public health grant since the last notification of outcomes and priorities under paragraph (b), the community health board shall notify the commissioner of the additional local public health priorities in the annual report.

Sec. 21. Minnesota Statutes 2002, section 145A.10, subdivision 10, is amended to read:

Subd. 10. **STATE AND LOCAL ADVISORY COMMITTEES.** (a) A state community health advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may ~~receive a per diem and must~~ be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) The city councils or county boards that have established or are members of a community health board ~~must~~ may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on ~~matters relating to the development, maintenance, funding, and evaluation of community health services. The committee must consist of at least five members and must be generally representative of the population and health care providers of the community health service area. The committee must meet at least three times a year and at the call of the chair or a majority of the members. Members may receive a per diem and reimbursement for travel and other necessary expenses while engaged in their official duties.~~

~~(c) State and local advisory committees must adopt bylaws or operating procedures that specify the length of terms of membership, procedures for assuring that no more than half of these terms expire during the same year, and other matters relating to the conduct of committee business. Bylaws or operating procedures may allow one alternate to be appointed for each member of a state or local advisory committee. Alternates may be given full or partial powers and duties of members~~ the duties under subdivision 5a.

Sec. 22. Minnesota Statutes 2002, section 145A.11, subdivision 2, is amended to read:

Subd. 2. **CONSIDERATION OF ~~COMMUNITY HEALTH PLAN~~ LOCAL PUBLIC HEALTH PRIORITIES AND STATEWIDE OUTCOMES IN TAX**

**LEVY.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet ~~the objectives of the community health plan for its area~~ local public health priorities established under section 145A.10, subdivision 5a, and statewide outcomes established under section 145A.12, subdivision 7.

Sec. 23. Minnesota Statutes 2002, section 145A.11, subdivision 4, is amended to read:

Subd. 4. **ORDINANCES RELATING TO COMMUNITY HEALTH SERVICES.** A city council or county board that has established or is a member of a community health board may by ordinance adopt and enforce minimum standards for services provided according to sections 145A.02 and 145A.10~~, subdivision 5~~. An ordinance must not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city organized under section 145A.09, subdivision 4.

Sec. 24. Minnesota Statutes 2002, section 145A.12, subdivision 1, is amended to read:

Subdivision 1. **ADMINISTRATIVE AND PROGRAM SUPPORT.** The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

(1) informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and

(2) administrative and program guidelines and standards, developed with the advice of the state community health advisory committee. ~~Adoption of these guidelines by a community health board is not a prerequisite for plan approval as prescribed in subdivision 4.~~

Sec. 25. Minnesota Statutes 2002, section 145A.12, subdivision 2, is amended to read:

Subd. 2. **PERSONNEL STANDARDS.** In accordance with chapter 14, and in consultation with the state community health advisory committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning ~~and in each program area defined in section 145A.02~~.

Sec. 26. Minnesota Statutes 2002, section 145A.12, is amended by adding a subdivision to read:

Subd. 7. **STATEWIDE OUTCOMES.** (a) The commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local

public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

(b) At least one statewide outcome must be established in each of the following public health areas:

(1) preventing diseases;

(2) protecting against environmental hazards;

(3) preventing injuries;

(4) promoting healthy behavior;

(5) responding to disasters; and

(6) ensuring access to health services.

(c) The commissioner shall use Minnesota's public health goals established under section 62J.212 and the essential public health services under section 145A.10, subdivision 5a, as a basis for the development of statewide outcomes.

(d) The statewide maternal and child health outcomes established under section 145.8821 shall be included as statewide outcomes under this section.

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), and the maternal and child health advisory task force established under section 145.881, shall develop statewide outcomes for the local public health grant established under section 145A.131, based on state and local assessment data regarding the health of Minnesota residents, the essential public health services under section 145A.10, and current Minnesota public health goals established under section 62J.212.

Sec. 27. Minnesota Statutes 2002, section 145A.13, is amended by adding a subdivision to read:

Subd. 4. **EXPIRATION.** This section expires January 1, 2004.

Sec. 28. **[145A.131] LOCAL PUBLIC HEALTH GRANT.**

Subdivision 1. **FUNDING FORMULA FOR COMMUNITY HEALTH BOARDS.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.09, subdivision 2, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants, TANF MN ENABL grants, TANF youth risk behavior grants, and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.09, subdivision 2, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty community health boards shall receive a local partnership base of up to $5,000 per year for each county included in the community health board.

(d) The state community health advisory committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections 145A.09 to 145A.131 to achieve locally identified priorities under section 145A.12, subdivision 7, by July 1, 2004, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. **LOCAL MATCH.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1, and subject to paragraphs (b) to (d).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.09 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **ACCOUNTABILITY.** (a) Community health boards accepting local public health grants must document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.

(b) In determining whether or not the community health board is documenting progress toward statewide outcomes, the commissioner shall consider the following factors:

(1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;

(2) the effort put forth by the community health board toward the selected statewide outcomes;

(3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;

(4) the amount of funding received by the community health board to address the statewide outcomes; and

(5) other factors as the commissioner may require, if the commissioner specifically identifies the additional factors in the commissioner's written notice of determination.

(c) If the commissioner determines that a community health board has not by the applicable deadline documented progress toward the selected statewide outcomes established under section 145.8821 or 145A.12, subdivision 7, the commissioner shall notify the community health board in writing and recommend specific actions that the community health board should take over the following 12 months to maintain eligibility for the local public health grant.

(d) During the 12 months following the written notification, the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in the written notification.

(e) If the community health board has not taken the specific actions recommended by the commissioner within 12 months following written notification, the commissioner may determine not to distribute funds to the community health board under section 145A.12, subdivision 2, for the next fiscal year.

(f) If the commissioner determines not to distribute funds for the next fiscal year, the commissioner must give the community health board written notice of this determination and allow the community health board to appeal the determination in writing.

(g) If the commissioner determines not to distribute funds for the next fiscal year to a community health board that has not documented progress toward the statewide outcomes and not taken the actions recommended by the commissioner, the commissioner may retain local public health grant funds that the community health board would have otherwise received and directly carry out essential local activities to meet the statewide outcomes, or contract with other units of government or community-based organizations to carry out essential local activities related to the statewide outcomes.

(h) If the community health board that does not document progress toward the statewide outcomes is a city, the commissioner shall distribute the local public health funds that would have been allocated to that city to the county in which the city is located, if that county is part of a community health board.

(i) The commissioner shall establish a reporting system by which community health boards will document their progress toward statewide outcomes. This system will be developed in consultation with the state community health services advisory committee established in section 145A.10, subdivision 10, paragraph (a), and the maternal and the child health advisory committee established in section 145.881.

Subd. 4. **RESPONSIBILITY OF COMMISSIONER TO ENSURE A STATEWIDE PUBLIC HEALTH SYSTEM.** If a county withdraws from a community

health board and operates as a board of health or if a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board using the formula described in subdivision 1 and assume responsibility for public health activities to meet the statewide outcomes in the geographic area served by the board of health or community health board. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located, if the county is part of a community health board.

Subd. 5. **LOCAL PUBLIC HEALTH PRIORITIES.** Community health boards may use their local public health grant to address local public health priorities identified under section 145A.10, subdivision 5a.

Sec. 29. Minnesota Statutes 2002, section 145A.14, subdivision 2, is amended to read:

Subd. 2. **INDIAN HEALTH GRANTS.** (a) The commissioner may make special grants to ~~community health boards to~~ establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians who reside off reservations.

(b) ~~To qualify for a grant under this subdivision the community health plan submitted by the community health board must contain a proposal for the delivery of the services and documentation that representatives of the Indian community affected by the plan were involved in its development.~~

~~(c)~~ Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

~~(d)~~ (c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Sec. 30. Minnesota Statutes 2002, section 145A.14, is amended by adding a subdivision to read:

Subd. 2a. **TRIBAL GOVERNMENTS.** (a) Of the funding available for local public health grants, $1,500,000 per year is available to tribal governments for:

(1) maternal and child health activities under section 145.882, subdivision 7;

(2) activities to reduce health disparities under section 145.928, subdivision 10; and

(3) emergency preparedness.

(b) The commissioner, in consultation with tribal governments, shall establish a formula for distributing the funds and developing the outcomes to be measured.

Sec. 31. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall delete "145A.13" and insert "145A.131" in Minnesota Statutes, sections 145A.03, subdivision 1; 145A.04, subdivision 4; 145A.10, subdivision 1; 256E.03, subdivision 2; 383B.221, subdivision 2; and 402.02, subdivision 2.

(b) For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 32. **REPEALER.**

(a) Minnesota Statutes 2002, sections 144.401; 145.882, subdivisions 4, 5, 6, and 8; 145.883, subdivisions 4 and 7; 145.884; 145.885; 145.886; 145.888; 145.889; 145.890; 145A.02, subdivisions 9, 10, 11, 12, 13, and 14; 145A.09, subdivision 6; 145A.10, subdivisions 5, 6, and 8; 145A.11, subdivision 3; 145A.12, subdivisions 3, 4, and 5; 145A.14, subdivisions 3 and 4; and 145A.17, subdivision 2, are repealed.

(b) Minnesota Rules, parts 4736.0010; 4736.0020; 4736.0030; 4736.0040; 4736.0050; 4736.0060; 4736.0070; 4736.0080; 4736.0090; 4736.0120; and 4736.0130, are repealed effective January 1, 2004.

(c) Minnesota Rules, parts 4705.0100; 4705.0200; 4705.0300; 4705.0400; 4705.0500; 4705.0600; 4705.0700; 4705.0800; 4705.0900; 4705.1000; 4705.1100; 4705.1200; 4705.1300; 4705.1400; 4705.1500; and 4705.1600, are repealed effective June 30, 2004.

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## ARTICLE 9

## CHILD CARE AND MISCELLANEOUS PROVISIONS

Section 1. Minnesota Statutes 2002, section 119B.011, subdivision 5, is amended to read:

Subd. 5. **CHILD CARE.** "Child care" means the care of a child by someone other than a parent ~~or~~, stepparent, legal guardian, eligible relative caregiver, or the spouses of any of the foregoing in or outside the child's own home for gain or otherwise, on a regular basis, for any part of a 24-hour day.

Sec. 2. Minnesota Statutes 2002, section 119B.011, subdivision 6, is amended to read:

Subd. 6. **CHILD CARE FUND.** "Child care fund" means a program under this chapter providing:

(1) financial assistance for child care to parents engaged in employment, job search, or education and training leading to employment~~, or an at-home infant care subsidy~~; and

(2) grants to develop, expand, and improve the access and availability of child care services statewide.

Sec. 3. Minnesota Statutes 2002, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **INCOME.** "Income" means earned or unearned income received by all family members, including public assistance cash benefits ~~and at-home infant care subsidy payments~~, unless specifically excluded and child support and maintenance distributed to the family under section 256.741, subdivision 15. The following are excluded from income: funds used to pay for health insurance premiums for family members, Supplemental Security Income, scholarships, work-study income, and grants that cover costs or reimbursement for tuition, fees, books, and educational supplies; student loans for tuition, fees, books, supplies, and living expenses; state and federal earned income tax credits; assistance specifically excluded as income by law; in-kind income such as food stamps, energy assistance, foster care assistance, medical assistance, child care assistance, and housing subsidies; earned income of full-time or part-time students up to the age of 19, who have not earned a high school diploma or GED high school equivalency diploma including earnings from summer employment; grant awards under the family subsidy program; nonrecurring lump sum income only to the extent that it is earmarked and used for the purpose for which it is paid; and any income assigned to the public authority according to section 256.741.

Sec. 4. Minnesota Statutes 2002, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **PROVIDER.** "Provider" means: (1) an individual or child care center or facility, either licensed or unlicensed, providing legal child care services as defined under section 245A.03; or (2) an individual or child care center or facility holding a valid child care license issued by another state or a tribe and providing child care services in the licensing state or in the area under the licensing tribe's jurisdiction. A legally unlicensed ~~registered~~ family child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

Sec. 5. Minnesota Statutes 2002, section 119B.011, is amended by adding a subdivision to read:

Subd. 19a. **REGISTRATION.** "Registration" means the process used by a county to determine whether the provider selected by a family applying for or receiving child care assistance to care for that family's children meets the requirements necessary for payment of child care assistance for care provided by that provider.

Sec. 6. Minnesota Statutes 2002, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **TRANSITION YEAR FAMILIES.** (a) "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, for at least three of the last six months before losing eligibility for MFIP or families participating in work first under chapter 256K who meet the requirements of section 256K.07. Transition year child care may be used to support employment or job search. Transition year child care is not available to families who have been disqualified from MFIP due to fraud.

(b) "Transition year extension year families" means families who have completed their transition year of child care assistance under this subdivision and who are eligible for, but on a waiting list for, services under section 119B.03. For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2), families participating in extended transition year shall not be considered transition year families. Transition year extension child care may be used to support employment or a job search that meets the requirements of section 119B.10 for the length of time necessary for families to be moved from the basic sliding fee waiting list into the basic sliding fee program.

Sec. 7. Minnesota Statutes 2002, section 119B.011, subdivision 21, is amended to read:

Subd. 21. **RECOUPMENT OF OVERPAYMENTS.** "Recoupment of overpayments" means the reduction of child care assistance payments to an eligible family or a child care provider in order to correct an overpayment ~~to the family even when the overpayment is due to agency error or other circumstances outside the responsibility or control of the family~~ of child care assistance.

Sec. 8. Minnesota Statutes 2002, section 119B.02, subdivision 1, is amended to read:

Subdivision 1. **CHILD CARE SERVICES.** The commissioner shall develop standards for county and human services boards to provide child care services to enable eligible families to participate in employment, training, or education programs. Within the limits of available appropriations, the commissioner shall distribute money to counties to reduce the costs of child care for eligible families. The commissioner shall adopt rules to govern the program in accordance with this section. The rules must establish a sliding schedule of fees for parents receiving child care services. The rules shall provide that funds received as a lump sum payment of child support arrearages shall not be counted as income to a family in the month received but shall be prorated over the 12 months following receipt and added to the family income during those months. ~~In the rules adopted under this section, county and human services boards shall be authorized to establish policies for payment of child care spaces for absent children, when the payment is required by the child's regular provider. The rules shall not set a maximum number of days for which absence payments can be made, but instead shall direct the county agency to set limits and pay for absences according to the prevailing market practice in the county. County policies for payment of absences shall be subject to the approval of the commissioner.~~ The commissioner shall maximize

the use of federal money under title I and title IV of Public Law Number 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and other programs that provide federal or state reimbursement for child care services for low-income families who are in education, training, job search, or other activities allowed under those programs. Money appropriated under this section must be coordinated with the programs that provide federal reimbursement for child care services to accomplish this purpose. Federal reimbursement obtained must be allocated to the county that spent money for child care that is federally reimbursable under programs that provide federal reimbursement for child care services. The counties shall use the federal money to expand child care services. The commissioner may adopt rules under chapter 14 to implement and coordinate federal program requirements.

Sec. 9. **[119B.025] DUTIES OF COUNTIES.**

Subdivision 1. **FACTORS WHICH MUST BE VERIFIED.** (a) The county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) social security number, if given;

(7) income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) If a family did not use the universal application to apply for child care assistance, the family must complete the universal application at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations.

(c) The commissioner shall develop a recertification form to redetermine eligibility that minimizes paperwork for the county and the participant.

Subd. 2. **SOCIAL SECURITY NUMBERS.** The county must request social security numbers from all applicants for child care assistance under this chapter. A

county may not deny child care assistance solely on the basis of failure of an applicant to report a social security number.

Sec. 10. Minnesota Statutes 2002, section 119B.03, subdivision 4, is amended to read:

Subd. 4. **FUNDING PRIORITY.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or work first transition year.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin transition year under section 119B.011, subdivision 20, and must be moved into basic sliding fee as soon as possible after they complete their transition year.

Sec. 11. Minnesota Statutes 2002, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **PORTABILITY POOL.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) To be eligible for portable basic sliding fee assistance, a family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify the new county of residence within ~~30~~ 60 days of moving and ~~apply for basic sliding fee assistance in~~ submit information to the new county of residence to verify eligibility for the basic sliding fee program.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue basic sliding fee assistance for the lesser of six months or until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

Sec. 12. Minnesota Statutes 2002, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **ELIGIBLE PARTICIPANTS.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under chapter 256K;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their job search support or employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J or 256K as required in their employment plan approved according to chapter 256J or 256K; ~~and~~

(6) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

(7) families who are participating in the transition year extension under section 119B.011, subdivision 20, paragraph (a).

Sec. 13. Minnesota Statutes 2002, section 119B.08, subdivision 3, is amended to read:

Subd. 3. **CHILD CARE FUND PLAN.** The county and designated administering agency shall submit a biennial child care fund plan to the commissioner ~~an annual child care fund plan in its biennial community social services plan~~. The commissioner shall establish the dates by which the county must submit the plans. The plan shall include:

~~(1) a narrative of the total program for child care services, including all policies and procedures that affect eligible families and are used to administer the child care funds;~~

~~(2) the methods used by the county to inform eligible families of the availability of child care assistance and related services;~~

~~(3) the provider rates paid for all children with special needs by provider type;~~

~~(4) the county prioritization policy for all eligible families under the basic sliding fee program; and~~

~~(5) other~~ a description of strategies to coordinate and maximize public and private community resources, including school districts, health care facilities, government agencies, neighborhood organizations, and other resources knowledgeable in early childhood development, in particular to coordinate child care assistance with existing community-based programs and service providers including child care resource and referral programs, early childhood family education, school readiness, Head Start, local interagency early intervention committees, special education services, early childhood screening, and other early childhood care and education services and programs to the extent possible, to foster collaboration among agencies and other community-based programs that provide flexible, family-focused services to families with young children and to facilitate transition into kindergarten. The county must describe a method by which to share information, responsibility, and accountability among service and program providers;

(2) a description of procedures and methods to be used to make copies of the proposed state plan reasonably available to the public, including members of the public particularly interested in child care policies such as parents, child care providers, culturally specific service organizations, child care resource and referral programs, interagency early intervention committees, potential collaborative partners and agencies involved in the provision of care and education to young children, and allowing sufficient time for public review and comment; and

(3) information as requested by the department to ensure compliance with the child care fund statutes and rules promulgated by the commissioner.

The commissioner shall notify counties within ~~60~~ 90 days of the date the plan is submitted whether the plan is approved or the corrections or information needed to approve the plan. The commissioner shall withhold a county's allocation until it has an approved plan. Plans not approved by the end of the second quarter after the plan is due may result in a 25 percent reduction in allocation. Plans not approved by the end of the third quarter after the plan is due may result in a 100 percent reduction in the allocation to the county. Counties are to maintain services despite any reduction in their allocation due to plans not being approved.

Sec. 14. Minnesota Statutes 2002, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **GENERAL ELIGIBILITY REQUIREMENTS FOR ALL APPLICANTS FOR CHILD CARE ASSISTANCE.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J or 256K;

(2) have household income below the eligibility levels for MFIP; or

(3) have household income ~~within a range established by the commissioner~~ less than or equal to 175 percent of the federal poverty guidelines, adjusted for family size, at program entry and less than 250 percent of the federal poverty guidelines, adjusted for family size, at program exit.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

Sec. 15. Minnesota Statutes 2002, section 119B.09, subdivision 2, is amended to read:

Subd. 2. **SLIDING FEE.** Child care services to families ~~with incomes in the commissioner's established range~~ must be made available on a sliding fee basis. ~~The upper limit of the range must be neither less than 70 percent nor more than 90 percent of the state median income for a family of four, adjusted for family size.~~

Sec. 16. Minnesota Statutes 2002, section 119B.09, subdivision 7, is amended to read:

Subd. 7. **DATE OF ELIGIBILITY FOR ASSISTANCE.** (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was signed; the beginning date of employment, education, or training; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, subpart 2a, or chapter 256J or 256K. ~~The date of eligibility for the basic sliding fee at-home infant child care program is the later of the date the infant is born or, in a county with a basic sliding fee waiting list, the date the family applies for at-home infant child care.~~

(b) ~~Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.061.~~ Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or work first participants in employment and training services is effective the date of commencement of the services or the date of MFIP or

work first eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

Sec. 17. Minnesota Statutes 2002, section 119B.09, is amended by adding a subdivision to read:

Subd. 9. **LICENSED AND LEGAL NONLICENSED FAMILY CHILD CARE PROVIDERS; ASSISTANCE.** Licensed and legal nonlicensed family child care providers are not eligible to receive child care assistance subsidies under this chapter for their own children or children in their custody.

Sec. 18. Minnesota Statutes 2002, section 119B.09, is amended by adding a subdivision to read:

Subd. 10. **PAYMENT OF FUNDS.** All federal, state, and local child care funds must be paid directly to the parent when a provider cares for children in the children's own home. In all other cases, all federal, state, and local child care funds must be paid directly to the child care provider, either licensed or legal nonlicensed, on behalf of the eligible family.

Sec. 19. Minnesota Statutes 2002, section 119B.11, subdivision 2a, is amended to read:

Subd. 2a. **RECOVERY OF OVERPAYMENTS.** (a) An amount of child care assistance paid to a recipient in excess of the payment due is recoverable by the county agency under paragraphs (b) and (c), even when the overpayment was caused by agency error or circumstances outside the responsibility and control of the family or provider.

(b) An overpayment must be recouped or recovered from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under child care assistance program requirements. If the family remains eligible for child care assistance, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part ~~3400.0140, subpart 19~~ 3400.0187, except that the overpayments must be calculated and collected on a service period basis. If the family no longer remains eligible for child care assistance, the county may choose to initiate efforts to recover overpayments from the family for overpayment less than $50. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the family. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A family with an outstanding debt under this subdivision is not eligible for child care assistance until: (1) the debt is paid in full; or (2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements.

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until: (1) the debt is paid in full; or (2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

Sec. 20. Minnesota Statutes 2002, section 119B.12, subdivision 2, is amended to read:

Subd. 2. **PARENT FEE.** A family must be assessed a parent fee for each service period. A family's ~~monthly~~ parent fee must be a fixed percentage of its annual gross income. Parent fees must apply to families eligible for child care assistance under sections 119B.03 and 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed percent is based on the relationship of the family's annual gross income to 100 percent of ~~state median income~~ the annual federal poverty guidelines. ~~Beginning January 1, 1998, parent fees must begin at 75 percent of the poverty level. The minimum parent fees for families between 75 percent and 100 percent of poverty level must be $5 per month.~~ Parent fees must ~~be established in rule and must~~ provide for graduated movement to full payment.

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

Sec. 21. **[119B.125] PROVIDER REQUIREMENTS.**

Subdivision 1. **AUTHORIZATION.** Except as provided in subdivision 5, a county must authorize the provider chosen by an applicant or a participant before the county can authorize payment for care provided by that provider. The commissioner must establish the requirements necessary for authorization of providers.

Subd. 2. **PERSONS WHO CANNOT BE AUTHORIZED.** (a) A person who meets any of the conditions under paragraphs (b) to (n) must not be authorized as a legal nonlicensed family child care provider. For purposes of this subdivision, a finding that a delinquency petition is proven in juvenile court must be considered a conviction in state district court.

(b) The person has been convicted of one of the following offenses or has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of one of the following offenses: sections 609.185 to 609.195, murder in the first, second, or third degree; 609.2661 to 609.2663, murder of an unborn child in the first, second, or third degree; 609.322, solicitation, inducement, or promotion of prostitution; 609.323, receiving profit from prostitution; 609.342 to 609.345, criminal sexual conduct in the first, second, third, or fourth degree; 609.352, solicitation of children to engage in sexual conduct; 609.365, incest; 609.377, felony malicious punishment of a child; 617.246, use of minors in sexual performance; 617.247, possession of pictorial representation of a minor; 609.2242 to 609.2243, felony domestic assault; a felony offense of spousal abuse; a felony offense of child abuse or neglect; a felony offense of a crime against children; or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes; or an offense in any other state or country where the elements are substantially similar to any of the offenses listed in this paragraph.

(c) Less than 15 years have passed since the discharge of the sentence imposed for the offense and the person has received a felony conviction for one of the following offenses, or the person has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of a felony conviction for one of the following offenses: sections 609.20 to 609.205, manslaughter in the first or second degree; 609.21, criminal vehicular homicide; 609.215, aiding suicide or aiding attempted suicide; 609.221 to 609.2231, assault in the first, second, third, or fourth degree; 609.224, repeat offenses of fifth degree assault; 609.228, great bodily harm caused by distribution of drugs; 609.2325, criminal abuse of a vulnerable adult; 609.2335, financial exploitation of a vulnerable adult; 609.235, use of drugs to injure or facilitate a crime; 609.24, simple robbery; 617.241, repeat offenses of obscene materials and performances; 609.245, aggravated robbery; 609.25, kidnapping; 609.255, false imprisonment; 609.2664 to 609.2665, manslaughter of an unborn child in the first or second degree; 609.267 to 609.2672, assault of an unborn child in the first, second, or third degree; 609.268, injury or death of an unborn child in the commission of a crime; 609.27, coercion; 609.275, attempt to coerce; 609.324, subdivision 1, other prohibited acts, minor engaged in prostitution; 609.3451, repeat offenses of criminal sexual conduct in the fifth degree; 609.378, neglect or endangerment of a child; 609.52, theft; 609.521, possession of shoplifting gear; 609.561 to

609.563, arson in the first, second, or third degree; 609.582, burglary in the first, second, third, or fourth degree; 609.625, aggravated forgery; 609.63, forgery; 609.631, check forgery, offering a forged check; 609.635, obtaining signature by false pretenses; 609.66, dangerous weapon; 609.665, setting a spring gun; 609.67, unlawfully owning, possessing, or operating a machine gun; 609.687, adulteration; 609.71, riot; 609.713, terrorist threats; 609.749, harassment, stalking; 260.221, grounds for termination of parental rights; 152.021 to 152.022, controlled substance crime in the first or second degree; 152.023, subdivision 1, clause (3) or (4), or 152.023, subdivision 2, clause (4), controlled substance crime in third degree; 152.024, subdivision 1, clause (2), (3), or (4), controlled substance crime in fourth degree; 617.23, repeat offenses of indecent exposure; an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes; or an offense in any other state or country where the elements are substantially similar to any of the offenses listed in this paragraph.

(d) Less than ten years have passed since the discharge of the sentence imposed for the offense and the person has received a gross misdemeanor conviction for one of the following offenses or the person has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of a gross misdemeanor conviction for one of the following offenses: sections 609.224, fifth degree assault; 609.2242 to 609.2243, domestic assault; 518B.01, subdivision 14, violation of an order for protection; 609.3451, fifth degree criminal sexual conduct; 609.746, repeat offenses of interference with privacy; 617.23, repeat offenses of indecent exposure; 617.241, obscene materials and performances; 617.243, indecent literature, distribution; 617.293, disseminating or displaying harmful material to minors; 609.71, riot; 609.66, dangerous weapons; 609.749, harassment, stalking; 609.224, subdivision 2, paragraph (c), fifth degree assault against a vulnerable adult by a caregiver; 609.23, mistreatment of persons confined; 609.231, mistreatment of residents or patients; 609.2325, criminal abuse of a vulnerable adult; 609.2335, financial exploitation of a vulnerable adult; 609.233, criminal neglect of a vulnerable adult; 609.234, failure to report maltreatment of a vulnerable adult; 609.72, subdivision 3, disorderly conduct against a vulnerable adult; 609.265, abduction; 609.378, neglect or endangerment of a child; 609.377, malicious punishment of a child; 609.324, subdivision 1a, other prohibited acts, minor engaged in prostitution; 609.33, disorderly house; 609.52, theft; 609.582, burglary in the first, second, third, or fourth degree; 609.631, check forgery, offering a forged check; 609.275, attempt to coerce; an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes; or an offense in any other state or country where the elements are substantially similar to any of the offenses listed in this paragraph.

(e) Less than seven years have passed since the discharge of the sentence imposed for the offense and the person has received a misdemeanor conviction for one of the following offenses or the person has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of a misdemeanor conviction for one of the following offenses: sections 609.224, fifth degree assault; 609.2242, domestic assault; 518B.01, violation of an order for protection; 609.3232, violation of an order for protection; 609.746, interference with

privacy; 609.79, obscene or harassing telephone calls; 609.795, letter, telegram, or package, opening, harassment; 617.23, indecent exposure; 609.2672, assault of an unborn child, third degree; 617.293, dissemination and display of harmful materials to minors; 609.66, dangerous weapons; 609.665, spring guns; an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes; or an offense in any other state or country where the elements are substantially similar to any of the offenses listed in this paragraph.

(f) The person has been identified by the county's child protection agency or by the statewide child protection database as the person allegedly responsible for physical or sexual abuse of a child within the last seven years.

(g) The person has been identified by the county's adult protection agency or by the statewide adult protection database as the person responsible for abuse or neglect of a vulnerable adult within the last seven years.

(h) The person has refused to give written consent for disclosure of criminal history records.

(i) The person has been denied a family child care license or has received a fine or a sanction as a licensed child care provider that has not been reversed on appeal.

(j) The person has a family child care licensing disqualification that has not been set aside.

(k) The person has admitted or a county has found that there is a preponderance of evidence that fraudulent information was given to the county for application purposes or was used in submitting bills for payment.

(l) The person has been convicted or there is a preponderance of evidence of the crime of theft by wrongfully obtaining public assistance.

(m) The person has a household member age 13 or older who has access to children during the hours that care is provided and who meets one of the conditions listed in paragraphs (b) to (l).

(n) The person has a household member ages ten to 12 who has access to children during the hours that care is provided; information or circumstances exist which provide the county with articulable suspicion that further pertinent information may exist showing the household member meets one of the conditions listed in paragraphs (b) to (l); and the household member actually meets one of the conditions listed in paragraphs (b) to (l).

Subd. 3. **AUTHORIZATION EXCEPTION.** When a county denies a person authorization as a legal nonlicensed family child care provider under subdivision 2, the county later may authorize that person as a provider if the following conditions are met:

(1) after receiving notice of the denial of the authorization, the person applies for and obtains a valid child care license issued under chapter 245A, issued by a tribe, or issued by another state;

(2) the person maintains the valid child care license; and

(3) the person is providing child care in the state of licensure or in the area under the jurisdiction of the licensing tribe.

Subd. 4. **UNSAFE CARE.** A county may deny authorization as a child care provider to any applicant or rescind authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3.

Subd. 5. **PROVISIONAL PAYMENT.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

Subd. 6. **RECORD KEEPING REQUIREMENT.** All providers must keep daily attendance records for children receiving child care assistance and must make those records available immediately to the county upon request. The daily attendance records must be retained for six years after the date of service. A county may deny authorization as a child care provider to any applicant or rescind authorization of any provider when the county knows or has reason to believe that the provider has not complied with the record keeping requirement in this subdivision.

Sec. 22. Minnesota Statutes 2002, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **SUBSIDY RESTRICTIONS.** The maximum rate paid for child care assistance under the child care fund may not exceed the 75th percentile rate for like-care arrangements in the county as surveyed by the commissioner. A rate which includes a provider bonus paid under subdivision 2 or a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision. The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and handicapped care. Not less than once every two years, the commissioner shall evaluate market practices for payment of absences and shall establish policies for payment of absent days that reflect current market practice.

When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family copayment fee.

Sec. 23. Minnesota Statutes 2002, section 119B.13, is amended by adding a subdivision to read:

Subd. 1b. **LEGAL NONLICENSED FAMILY CHILD CARE PROVIDER RATES.** (a) Legal nonlicensed family child care providers receiving reimbursement

under this chapter must be paid on an hourly basis for care provided to families receiving assistance.

(b) The maximum rate paid to legal nonlicensed family child care providers must be 80 percent of the county maximum hourly rate for licensed family child care providers. In counties where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by 0.80.

(c) A rate which includes a provider bonus paid under subdivision 2 or a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

Sec. 24. Minnesota Statutes 2002, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **PROVIDER PAYMENTS.** (a) Counties or the state shall make vendor payments to the child care provider or pay the parent directly for eligible child care expenses.

(b) If payments for child care assistance are made to providers, the provider shall bill the county for services provided within ten days of the end of the ~~month of~~ service period. If bills are submitted ~~in accordance with the provisions of this subdivision~~ within ten days of the end of the service period, a county or the state shall issue payment to the provider of child care under the child care fund within 30 days of receiving ~~an invoice~~ a bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(c) All bills must be submitted within 60 days of the last date of service on the bill. A county may pay a bill submitted more than 60 days after the last date of service if the provider shows good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. A county may not pay any bill submitted more than a year after the last date of service on the bill.

(d) A county may stop payment issued to a provider or may refuse to pay a bill submitted by a provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms; or

(2) a county finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms.

(e) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

Sec. 25. Minnesota Statutes 2002, section 119B.16, is amended by adding a subdivision to read:

Subd. 1a. **FAIR HEARING ALLOWED FOR PROVIDERS.** (a) This subdivision applies to providers caring for children receiving child care assistance.

(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.

Sec. 26. Minnesota Statutes 2002, section 119B.16, is amended by adding a subdivision to read:

Subd. 1b. **JOINT FAIR HEARINGS.** When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing. The referee assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve overpayment issues raised in the appeal.

Sec. 27. Minnesota Statutes 2002, section 119B.16, subdivision 2, is amended to read:

Subd. 2. **INFORMAL CONFERENCE.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants ~~and~~, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

Sec. 28. Minnesota Statutes 2002, section 119B.19, subdivision 7, is amended to read:

Subd. 7. **CHILD CARE RESOURCE AND REFERRAL PROGRAMS.** Within each region, a child care resource and referral program must:

(1) maintain one database of all existing child care resources and services and one database of family referrals;

(2) provide a child care referral service for families;

(3) develop resources to meet the child care service needs of families;

(4) increase the capacity to provide culturally responsive child care services;

(5) coordinate professional development opportunities for child care and school-age care providers;

(6) administer and award child care services grants;

(7) administer and provide loans for child development education and training; ~~and~~

(8) cooperate with the Minnesota Child Care Resource and Referral Network and its member programs to develop effective child care services and child care resources; and

(9) assist in fostering coordination, collaboration, and planning among child care programs and community programs such as school readiness, Head Start, early childhood family education, local interagency early intervention committees, early childhood screening, special education services, and other early childhood care and education services and programs that provide flexible, family-focused services to families with young children to the extent possible.

Sec. 29. Minnesota Statutes 2002, section 119B.21, subdivision 11, is amended to read:

Subd. 11. **STATEWIDE ADVISORY TASK FORCE.** The commissioner may convene a statewide advisory task force to advise the commissioner on statewide grants or other child care issues. The following groups must be represented: family child care providers, child care center programs, school-age care providers, parents who use child care services, health services, social services, Head Start, public schools, school-based early childhood programs, special education programs, employers, and other citizens with demonstrated interest in child care issues. Additional members may be appointed by the commissioner. The commissioner may compensate members for their travel, child care, and child care provider substitute expenses for attending task force meetings. The commissioner may also pay a stipend to parent representatives for participating in task force meetings.

Sec. 30. Minnesota Statutes 2002, section 119B.23, subdivision 3, is amended to read:

Subd. 3. **BIENNIAL PLAN.** The county board shall biennially develop a plan for the distribution of money for child care services as part of the ~~community social~~

~~services plan described in section 256E.09~~ child care fund plan under section 119B.08. All licensed child care programs shall be given written notice concerning the availability of money and the application process.

Sec. 31. Minnesota Statutes 2002, section 256.046, subdivision 1, is amended to read:

Subdivision 1. **HEARING AUTHORITY.** A local agency must initiate an administrative fraud disqualification hearing for individuals, including child care providers caring for children receiving child care assistance, accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, MFIP, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, medical care, or food stamp programs. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16, for the food stamp program and title 45, section 235.112, as of September 30, 1995, for the cash grant ~~and~~, medical care programs, and child care assistance under chapter 119B.

Sec. 32. Minnesota Statutes 2002, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **QUALIFYING OVERPAYMENT.** Any overpayment for assistance granted under ~~section 119B.05~~ chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361, and the AFDC program formerly codified under sections 256.72 to 256.871; chapters 256B, 256D, 256I, 256J, and 256K; and the food stamp program, except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

Sec. 33. Minnesota Statutes 2002, section 256.98, subdivision 8, is amended to read:

Subd. 8. **DISQUALIFICATION FROM PROGRAM.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program, the food stamp program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of three months, six months, and two years for the first, second, and third offenses respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to have wrongfully obtained child care assistance by a federal court, state court, or an administrative hearing determination or waiver under section 256.046, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions. The disqualification must be for a period of one year for the first offense and two years for the second offense. Any subsequent violation must result in permanent disqualification. The disqualification period must be imposed immediately after a determination is made under this paragraph. During the disqualification period, the provider is disqualified from receiving payment from any child care program under chapter 119B.

Sec. 34. **DIRECTION TO COMMISSIONER; PROVIDER RATES.**

The provider rates determined under Minnesota Statutes, section 119B.13, for fiscal year 2003 and implemented on July 1, 2002, are to be continued in effect through

June 30, 2005. The commissioner of human services is directed to evaluate the costs of child care in Minnesota, to examine the differences in the cost of child care in rural and metropolitan areas, and to make recommendations to the legislature for containing future cost increases in the child care program under Minnesota Statutes, chapter 119B, in a manner that complies with federal child care and development block grant requirements for promoting parental choice and permits the department to track the effect of rate changes on child care assistance program costs, the availability of different types of care throughout the state, the length of waiting lists, and the care options available to program participants. The commissioner shall also examine the allocation formula under Minnesota Statutes, section 119B.03, and make recommendations to the legislature in order to create a more equitable formula. The commissioner shall consider the impact any recommendations might have on work incentives for low and middle income families and possible changes to MFIP child care, basic sliding fee child care, and the dependent care tax credit. The commissioner shall make recommendations to the legislature by January 15, 2005.

The commissioner shall also study the relationship between child care assistance subsidies and tax credits or tax incentives related to child care expenses, and include this information in the January 15, 2005, report to the legislature under this section.

Sec. 35. **CHILD CARE WAITING LIST.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivision 6, the commissioner may manage the child care assistance waiting list under Minnesota Statutes, section 119B.03, subdivision 2, on a regional or statewide basis in order to ensure that families listed under higher priority categories, as determined by Minnesota Statutes, section 119B.03, subdivision 4, are served before families listed under lower priority categories.

Sec. 36. **CHILD CARE ASSISTANCE PARENT FEE SCHEDULE.**

Notwithstanding Minnesota Rules, part 3400.0100, subpart 4, the parent fee schedule is as follows:

| Income Range (as a percentage of the federal poverty guidelines) | Co-payment (as a percentage of adjusted gross income) |
|---|---|
| 0-74.99% | $ 0/month |
| 75.00-99.99% | $10/month |
| 100.00-104.99% | 3.85% |
| 105.00-109.99% | 3.85% |
| 110.00-114.99% | 3.85% |
| 115.00-119.99% | 3.85% |
| 120.00-124.99% | 4.29% |
| 125.00-139.99% | 4.29% |
| 140.00-144.99% | 4.73% |
| 145.00-149.99% | 4.73% |

| | |
|---|---|
| 150.00-154.99% | 4.73% |
| 155.00-159.99% | 5.65% |
| 160.00-164.99% | 5.65% |
| 165.00-169.99% | 6.56% |
| 170.00-174.99% | 7.00% |
| 175.00-179.99% | 7.44% |
| 180.00-184.99% | 8.31% |
| 185.00-189.99% | 8.75% |
| 190.00-194.99% | 9.19% |
| 195.00-199.99% | 10.06% |
| 200.00-209.99% | 12.25% |
| 210.00-224.99% | 16.10% |
| 225.00-229.99% | 17.15% |
| 230.00-234.99% | 19.25% |
| 235.00-239.99% | 19.78% |
| 240.00-244.99% | 21.35% |
| 245.00-249.99% | 22.00% |
| 250% | ineligible |

A family's monthly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

Sec. 37. **ELIGIBILITY FOR FAMILIES WITH HOUSEHOLD INCOME GREATER THAN 250 PERCENT OF THE FEDERAL POVERTY GUIDELINES.**

Families receiving child care assistance on July 1, 2003, who have household income greater than 250 percent of the federal poverty guidelines, adjusted for family size, are eligible to continue receiving child care assistance until the family's next eligibility redetermination.

Sec. 38. **REPEALER.**

(a) Minnesota Statutes 2002, sections 119B.061 and 119B.13, subdivision 2, are repealed.

(b) Laws 2000, chapter 489, article 1, section 36, and Laws 2001, First Special Session chapter 3, article 1, section 16, are repealed.

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## ARTICLE 10

## CHILD SUPPORT FEDERAL COMPLIANCE

Section 1. Minnesota Statutes 2002, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **CLASSIFICATIONS.** (a) The following government data of the department of public safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically handicapped persons;

(2) other data on holders of a disability certificate under section 169.345, except that data that are not medical data may be released to law enforcement agencies;

(3) social security numbers in driver's license and motor vehicle registration records, except that social security numbers must be provided to the department of revenue for purposes of tax administration ~~and~~, the department of labor and industry for purposes of workers' compensation administration and enforcement, and the department of natural resources for purposes of license application administration; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the social security number only as provided in clause (3) and must not sell or otherwise provide individual social security numbers or lists of social security numbers for any other purpose.

(b) The following government data of the department of public safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

Sec. 2. **[97A.482] LICENSE APPLICATIONS; COLLECTION OF SOCIAL SECURITY NUMBERS.**

(a) All applicants for individual noncommercial game and fish licenses under this chapter and chapters 97B and 97C must include the applicant's social security number on the license application. If an applicant does not have a social security number, the applicant must certify that the applicant does not have a social security number.

(b) The social security numbers collected by the commissioner on game and fish license applications are private data under section 13.49, subdivision 1, and must be provided by the commissioner to the commissioner of human services for child support enforcement purposes. Title IV-D of the Social Security Act, United States Code, title 42, section 666(a)(13), requires the collection of social security numbers on game and fish license applications for child support enforcement purposes.

Sec. 3. Minnesota Statutes 2002, section 171.06, subdivision 3, is amended to read:

Subd. 3. **CONTENTS OF APPLICATION; OTHER INFORMATION.** (a) An application must:

(1) state the full name, date of birth, sex, and residence address of the applicant;

(2) as may be required by the commissioner, contain a description of the applicant and any other facts pertaining to the applicant, the applicant's driving privileges, and the applicant's ability to operate a motor vehicle with safety;

(3) ~~for a class C, class B, or class A driver's license,~~ state:

(i) the applicant's social security number ~~or, for a class D driver's license, have a space for the applicant's social security number and state that providing the number is optional, or otherwise convey that the applicant is not required to enter the social security number;~~ or

(ii) if the applicant does not have a social security number and is applying for a Minnesota identification card, instruction permit, or class D provisional or driver's license, that the applicant certifies that the applicant does not have a social security number;

(4) contain a space where the applicant may indicate a desire to make an anatomical gift according to paragraph (b); and

(5) contain a notification to the applicant of the availability of a living will/health care directive designation on the license under section 171.07, subdivision 7.

(b) If the applicant does not indicate a desire to make an anatomical gift when the application is made, the applicant must be offered a donor document in accordance with section 171.07, subdivision 5. The application must contain statements sufficient to comply with the requirements of the Uniform Anatomical Gift Act (1987), sections 525.921 to 525.9224, so that execution of the application or donor document will make the anatomical gift as provided in section 171.07, subdivision 5, for those indicating a desire to make an anatomical gift. The application must be accompanied by information describing Minnesota laws regarding anatomical gifts and the need for and benefits of anatomical gifts, and the legal implications of making an anatomical gift, including the law governing revocation of anatomical gifts. The commissioner shall distribute a notice that must accompany all applications for and renewals of a driver's license or Minnesota identification card. The notice must be prepared in conjunction with a Minnesota organ procurement organization that is certified by the federal Department of Health and Human Services and must include:

(1) a statement that provides a fair and reasonable description of the organ donation process, the care of the donor body after death, and the importance of informing family members of the donation decision; and

(2) a telephone number in a certified Minnesota organ procurement organization that may be called with respect to questions regarding anatomical gifts.

(c) The application must be accompanied also by information containing relevant facts relating to:

(1) the effect of alcohol on driving ability;

(2) the effect of mixing alcohol with drugs;

(3) the laws of Minnesota relating to operation of a motor vehicle while under the influence of alcohol or a controlled substance; and

(4) the levels of alcohol-related fatalities and accidents in Minnesota and of arrests for alcohol-related violations.

Sec. 4. Minnesota Statutes 2002, section 171.07, is amended by adding a subdivision to read:

Subd. 14. **USE OF SOCIAL SECURITY NUMBER.** An applicant's social security number must not be displayed, encrypted, or encoded on the driver's license or Minnesota identification card or included in a magnetic strip or bar code used to store data on the license or Minnesota identification card. The social security number must not be used as a Minnesota driver's license or identification number.

Sec. 5. Minnesota Statutes 2002, section 518.551, subdivision 12, is amended to read:

Subd. 12. **OCCUPATIONAL LICENSE SUSPENSION.** (a) Upon motion of an obligee, if the court finds that the obligor is or may be licensed by a licensing board listed in section 214.01 or other state, county, or municipal agency or board that issues an occupational license and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518.553 that is approved by the court, a child support magistrate, or the public authority, the court shall direct the licensing board or other licensing agency to suspend the license under section 214.101. The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518.553. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518.553 after the 90 days expires, the court's order becomes effective. If the obligor is a licensed attorney, the court shall report the matter to the lawyers professional responsibility board for appropriate action in accordance with the rules of professional conduct. The remedy under this subdivision is in addition to any other enforcement remedy available to the court.

(b) If a public authority responsible for child support enforcement finds that the obligor is or may be licensed by a licensing board listed in section 214.01 or other state, county, or municipal agency or board that issues an occupational license and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518.553 that is approved by the court, a child support magistrate, or the public authority, the court or the public authority shall direct the licensing board

or other licensing agency to suspend the license under section 214.101. If the obligor is a licensed attorney, the public authority may report the matter to the lawyers professional responsibility board for appropriate action in accordance with the rules of professional conduct. The remedy under this subdivision is in addition to any other enforcement remedy available to the public authority.

(c) At least 90 days before notifying a licensing authority or the lawyers professional responsibility board under paragraph (b), the public authority shall mail a written notice to the license holder addressed to the license holder's last known address that the public authority intends to seek license suspension under this subdivision and that the license holder must request a hearing within 30 days in order to contest the suspension. If the license holder makes a written request for a hearing within 30 days of the date of the notice, a court hearing or a hearing under section 484.702 must be held. Notwithstanding any law to the contrary, the license holder must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the license holder. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement pursuant to section 518.553 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the licensing board or other licensing agency to suspend the obligor's license under paragraph (b), or shall report the matter to the lawyers professional responsibility board.

(d) The public authority or the court shall notify the lawyers professional responsibility board for appropriate action in accordance with the rules of professional responsibility conduct or order the licensing board or licensing agency to suspend the license if the judge finds that:

(1) the person is licensed by a licensing board or other state agency that issues an occupational license;

(2) the person has not made full payment of arrearages found to be due by the public authority; and

(3) the person has not executed or is not in compliance with a payment plan approved by the court, a child support magistrate, or the public authority.

(e) Within 15 days of the date on which the obligor either makes full payment of arrearages found to be due by the court or public authority or executes and initiates good faith compliance with a written payment plan approved by the court, a child support magistrate, or the public authority, the court, a child support magistrate, or the public authority responsible for child support enforcement shall notify the licensing board or licensing agency or the lawyers professional responsibility board that the obligor is no longer ineligible for license issuance, reinstatement, or renewal under this subdivision.

(f) In addition to the criteria established under this section for the suspension of an obligor's occupational license, a court, a child support magistrate, or the public

authority may direct the licensing board or other licensing agency to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

(g) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. ~~Notice to the obligor of an intent to suspend under this paragraph must be served by first class mail at the obligor's last known address and must include a notice of hearing. The notice must be served upon the obligor not less than ten days before the date of the hearing.~~ Prior to suspending a license for noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's occupational license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the licensing board or other licensing agency to suspend the obligor's license under paragraph (b), and, if the obligor is a licensed attorney, must report the matter to the lawyers professional responsibility board. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail to the obligor's last known address. If the obligor appears at the hearing and the ~~judge~~ court determines that the obligor has failed to comply with an approved written payment agreement, the ~~judge shall~~ court or public authority must notify the occupational licensing board or other licensing agency to suspend the obligor's license under paragraph ~~(c)~~ (b) and, if the obligor is a licensed attorney, must report the matter to the lawyers professional responsibility board. If the obligor fails to appear at the hearing, the ~~public authority may~~ court or public authority must notify the occupational ~~or~~ licensing board or other licensing agency to suspend the obligor's license under paragraph ~~(c)~~ (b), and if the obligor is a licensed attorney, must report the matter to the lawyers professional responsibility board.

Sec. 6. Minnesota Statutes 2002, section 518.551, subdivision 13, is amended to read:

Subd. 13. **DRIVER'S LICENSE SUSPENSION.** (a) Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in

court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518.553 that is approved by the court, a child support magistrate, or the public authority, the court shall order the commissioner of public safety to suspend the obligor's driver's license. The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518.553. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518.553 after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this subdivision is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

(b) If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement pursuant to section 518.553 that is approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license. The remedy under this subdivision is in addition to any other enforcement remedy available to the public authority.

(c) At least 90 days prior to notifying the commissioner of public safety according to paragraph (b), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice must include information that apprises the obligor of the requirement to develop a written payment agreement that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement regarding child support, maintenance, and any arrearages in order to avoid license suspension. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement pursuant to section 518.553 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph (b).

(d) At a hearing requested by the obligor under paragraph (c), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement pursuant to section 518.553 that is approved by the court, a child support magistrate, or the public authority.

(e) An obligor whose driver's license or operating privileges are suspended may:

(1) provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements pursuant to section 518.553;

(2) bring a motion for reinstatement of the driver's license. At the hearing, if the court or child support magistrate orders reinstatement of the driver's license, the court or child support magistrate must establish a written payment agreement pursuant to section 518.553; or

(3) seek a limited license under section 171.30. A limited license issued to an obligor under section 171.30 expires 90 days after the date it is issued.

Within 15 days of the receipt of that proof or a court order, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

(f) On January 15, 1997, and every two years after that, the commissioner of human services shall submit a report to the legislature that identifies the following information relevant to the implementation of this section:

(1) the number of child support obligors notified of an intent to suspend a driver's license;

(2) the amount collected in payments from the child support obligors notified of an intent to suspend a driver's license;

(3) the number of cases paid in full and payment agreements executed in response to notification of an intent to suspend a driver's license;

(4) the number of cases in which there has been notification and no payments or payment agreements;

(5) the number of driver's licenses suspended;

(6) the cost of implementation and operation of the requirements of this section; and

(7) the number of limited licenses issued and number of cases in which payment agreements are executed and cases are paid in full following issuance of a limited license.

(g) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

(h) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. ~~Notice to the obligor of an intent to suspend under this paragraph must be served by first class mail at the obligor's last known address and must include a notice of hearing. The notice must be served upon the obligor not less than ten days before the date of the hearing.~~ Prior to suspending a license for noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's driver's license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the department of public safety to suspend the obligor's license under paragraph (b). If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail at the obligor's last known address. If the obligor appears at the hearing and the ~~judge~~ court determines that the obligor has failed to comply with an approved written payment agreement, the ~~judge~~ court or public authority shall notify the department of public safety to suspend the obligor's license under paragraph ~~(c)~~ (b). If the obligor fails to appear at the hearing, the ~~public authority may~~ court or public authority must notify the department of public safety to suspend the obligor's license under paragraph ~~(c)~~ (b).

Sec. 7. Laws 1997, chapter 245, article 2, section 11, is amended to read:

Sec. 11. **FEDERAL FUNDS FOR VISITATION AND ACCESS.**

The commissioner of human services may accept on behalf of the state any federal funding received under Public Law Number 104-193 for access and visitation programs, and ~~shall transfer these funds to the state court administrator for the cooperation for the children pilot project and the parent education program under Minnesota Statutes, section 518.571~~ must administer the funds for the activities allowed under federal law. The commissioner may distribute the funds on a competitive basis and must monitor, evaluate, and report on the access and visitation programs in accordance with any applicable regulations.

Sec. 8. **EFFECTIVE DATE.**

Sections 1 to 4 are effective August 1, 2003.

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## ARTICLE 11

## COMMUNITY SERVICES ACT

Section 1. **[256M.01] CITATION.**

Sections 256M.01 to 256M.80 may be cited as the "Children and Community Services Act." This act establishes a fund to address the needs of children, adolescents, and adults within each county in accordance with a service plan entered into by the board of county commissioners of each county and the commissioner. The service plan shall specify the outcomes to be achieved, the general strategies to be employed, and the respective state and county roles. The service plan shall be reviewed and updated every two years, or sooner if both the state and the county deem it necessary.

Sec. 2. **[256M.10] DEFINITIONS.**

Subdivision 1. **SCOPE.** For the purposes of sections 256M.01 to 256M.80, the terms defined in this section have the meanings given them.

Subd. 2. **CHILDREN AND COMMUNITY SERVICES.** (a) "Children and community services" means services provided or arranged for by county boards for children, adolescents and other individuals in transition from childhood to adulthood, and adults who experience dependency, abuse, neglect, poverty, disability, chronic health conditions, or other factors, including ethnicity and race, that may result in poor outcomes or disparities, as well as services for family members to support those individuals. These services may be provided by professionals or nonprofessionals, including the person's natural supports in the community.

(b) Children and community services do not include services under the public assistance programs known as the Minnesota family investment program, Minnesota supplemental aid, medical assistance, general assistance, general assistance medical care, MinnesotaCare, or community health services.

Subd. 3. **COMMISSIONER.** "Commissioner" means the commissioner of human services.

Subd. 4. **COUNTY BOARD.** "County board" means the board of county commissioners in each county.

Subd. 5. **FORMER CHILDREN'S SERVICES AND COMMUNITY SERVICE GRANTS.** "Former children's services and community service grants" means allocations for the following grants:

(1) community social service grants under sections 252.24, 256E.06, and 256E.14;

(2) family preservation grants under section 256F.05, subdivision 3;

(3) concurrent permanency planning grants under section 260C.213, subdivision 5;

(4) social service block grants (Title XX) under section 256E.07; and

(5) children's mental health grants under sections 245.4886 and 260.152.

Subd. 6. **HUMAN SERVICES BOARD.** "Human services board" means a board established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

Sec. 3. **[256M.20] DUTIES OF COMMISSIONER OF HUMAN SERVICES.**

Subdivision 1. **GENERAL SUPERVISION.** Each year the commissioner shall allocate funds to each county with an approved service plan according to section 256M.40 and service plans under section 256M.30. The funds shall be used to address the needs of children, adolescents, and adults. The commissioner, in consultation with counties, shall provide technical assistance and evaluate county performance in achieving outcomes.

Subd. 2. **ADDITIONAL DUTIES.** The commissioner shall:

(1) provide necessary information and assistance to each county for establishing baselines and desired improvements on mental health, safety, permanency, and well-being for children and adolescents;

(2) provide training, technical assistance, and other supports to each county board to assist in needs assessment, planning, implementation, and monitoring of outcomes and service quality;

(3) use data collection, evaluation of service outcomes, and the review and approval of county service plans to supervise county performance in the delivery of children and community services;

(4) specify requirements for reports, including fiscal reports to account for funds distributed;

(5) request waivers from federal programs as necessary to implement this act; and

(6) have authority under sections 14.055 and 14.056 to grant a variance to existing state rules as needed to eliminate barriers to achieving desired outcomes.

Subd. 3. **SANCTIONS.** The commissioner shall establish and maintain a monitoring program designed to reduce the possibility of noncompliance with federal laws and federal regulations that may result in federal fiscal sanctions. If a county is not complying with federal law or federal regulation and the noncompliance may result in federal fiscal sanctions, the commissioner may withhold a portion of the county's share of state and federal funds for that program. The amount withheld must be equal

to the percentage difference between the level of compliance maintained by the county and the level of compliance required by the federal regulations, multiplied by the county's share of state and federal funds for the program. The state and federal funds may be withheld until the county is found to be in compliance with all federal laws or federal regulations applicable to the program. If a county remains out of compliance for more than six consecutive months, the commissioner may reallocate the withheld funds to counties that are in compliance with the federal regulations.

Subd. 4. **CORRECTIVE ACTION PROCEDURE.** The commissioner must comply with the following procedures when reducing county funds under subdivision 3.

(a) The commissioner shall notify the county, by certified mail, of the statute, rule, federal law, or federal regulation with which the county has not complied.

(b) The commissioner shall give the county 30 days to demonstrate to the commissioner that the county is in compliance with the statute, rule, federal law, or federal regulation cited in the notice or to develop a corrective action plan to address the problem. Upon request from the county, the commissioner shall provide technical assistance to the county in developing a corrective action plan. The county shall have 30 days from the date the technical assistance is provided to develop the corrective action plan.

(c) The commissioner shall take no further action if the county demonstrates compliance with the statute, rule, federal law, or federal regulation cited in the notice.

(d) The commissioner shall review and approve or disapprove the corrective action plan within 30 days after the commissioner receives the corrective action plan.

(e) If the commissioner approves the corrective action plan submitted by the county, the county has 90 days after the date of approval to implement the corrective action plan.

(f) If the county fails to demonstrate compliance or fails to implement the corrective action plan approved by the commissioner, the commissioner may reduce the county's share of state or federal funds according to subdivision 3.

Sec. 4. **[256M.30] SERVICE PLAN.**

Subdivision 1. **SERVICE PLAN SUBMITTED TO COMMISSIONER.** Effective January 1, 2004, and each two-year period thereafter, each county must have a biennial service plan approved by the commissioner in order to receive funds. Counties may submit multicounty or regional service plans.

Subd. 2. **CONTENTS.** The service plan shall be completed in a form prescribed by the commissioner. The plan must include:

(1) a statement of the needs of the children, adolescents, and adults who experience the conditions defined in section 256M.10, subdivision 2, paragraph (a), and strengths and resources available in the community to address those needs;

(2) strategies the county will pursue to achieve the performance targets. Strategies must include specification of how funds under this section and other community resources will be used to achieve desired performance targets;

(3) a description of the county's process to solicit public input and a summary of that input;

(4) beginning with the service plans submitted for the period from January 1, 2006, through December 21, 2007, performance targets on statewide indicators for each county to measure outcomes of children's mental health, and child safety, permanency, and well-being. The commissioner shall consult with counties and other stakeholders to develop these indicators and collect baseline data to inform the establishment of individual county performance targets for the 2006-2007 biennium and subsequent plans; and

(5) a budget for services to be provided with funds under this section. The county must budget at least 40 percent of funds appropriated under sections 256M.01 to 256M.80 for services to ensure the mental health, safety, permanency, and well-being of children from low-income families. The commissioner may reduce the portion of child and community services funds that must be budgeted by a county for services to children in low-income families if:

(i) the incidence of children in low-income families within the county's population is significantly below the statewide median; or

(ii) the county has successfully achieved past performance targets for children's mental health, and child safety, permanency, and well-being and its proposed service plan is judged by the commissioner to provide an adequate level of service to the population with less funding.

Subd. 3. **CONTINUITY OF SERVICES.** In developing the plan required under this section, a county shall endeavor, within the limits of funds available, to consider the continuing need for services and programs for children and persons with disabilities that were funded by the former children's services and community service grants.

Subd. 4. **INFORMATION.** The commissioner shall provide each county with information and technical assistance needed to complete the service plan, including: information on children's mental health, and child safety, permanency, and well-being in the county; comparisons with other counties; baseline performance on outcome measures; and promising program practices.

Subd. 5. **TIMELINES.** The preliminary service plan must be submitted to the commissioner by October 15, 2003, and October 15 of every two years thereafter.

Subd. 6. **PUBLIC COMMENT.** The county board must determine how citizens in the county will participate in the development of the service plan and provide opportunities for such participation. The county must allow a period of no less than 30

days prior to the submission of the plan to the commissioner to solicit comments from the public on the contents of the plan.

Subd. 7. **COMMISSIONER'S RESPONSIBILITIES.** The commissioner must, within 60 days of receiving each county service plan, inform the county if the service plan has been approved. If the service plan is not approved, the commissioner must inform the county of any revisions needed for approval.

Sec. 5. **[256M.40] STATE CHILDREN AND COMMUNITY SERVICES GRANT ALLOCATION.**

Subdivision 1. **FORMULA.** The commissioner shall allocate state funds appropriated for children and community services grants to each county board on a calendar year basis in an amount determined according to the formula in paragraphs (a) to (c).

(a) For July 1, 2003, through December 31, 2003, the commissioner shall allocate funds to each county equal to that county's allocation for the grants under section 256M.10, subdivision 5, for calendar year 2003 less payments made on or before June 30, 2003.

(b) For calendar year 2004 and 2005, the commissioner shall allocate available funds to each county in proportion to that county's share of the calendar year 2003 allocations for the grants under section 256M.10, subdivision 5.

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

Subd. 2. **PROJECT OF REGIONAL SIGNIFICANCE; STUDY.** The commissioner shall study whether and how to dedicate a portion of the allocated funds for projects of regional significance. The study shall include an analysis of the amount of annual funding to be dedicated for projects of regional significance and what efforts these projects must support. The commissioner shall submit a report to the chairs of the house and senate committees with jurisdiction over children and community services grants by January 15, 2005. The commissioner of finance, in preparing the proposed biennial budget for fiscal years 2006 and 2007, is instructed to include $25 million each year in funding for projects of regional significance under this chapter.

Subd. 3. **PAYMENTS.** Calendar year allocations under subdivision 1 shall be paid to counties on or before July 10 of each year.

Sec. 6. **[256M.50] FEDERAL CHILDREN AND COMMUNITY SERVICES GRANT ALLOCATION.**

In federal fiscal year 2004 and subsequent years, money for social services received from the federal government to reimburse counties for social service expenditures according to Title XX of the Social Security Act shall be allocated to each county according to section 256M.40, except for funds allocated for administrative purposes and migrant day care.

Sec. 7. **[256M.60] DUTIES OF COUNTY BOARDS.**

Subdivision 1. **RESPONSIBILITIES.** The county board of each county shall be responsible for administration and funding of children and community services as defined in section 256M.10, subdivision 1. Each county board shall singly or in combination with other county boards use funds available to the county under this act to carry out these responsibilities. The county board shall coordinate and facilitate the effective use of formal and informal helping systems to best support and nurture children, adolescents, and adults within the county who experience dependency, abuse, neglect, poverty, disability, chronic health conditions, or other factors, including ethnicity and race, that may result in poor outcomes or disparities, as well as services for family members to support such individuals. This includes assisting individuals to function at the highest level of ability while maintaining family and community relationships to the greatest extent possible.

Subd. 2. **DAY TRAINING AND HABILITATION SERVICES; ALTERNATIVE HABILITATION SERVICES.** To the extent provided in the county service plan under section 256M.30, the county board of each county shall be responsible for providing day training and habilitation services or alternative habilitation services during the day for persons with developmental disabilities to the extent this is required by the person's individualized service plan.

Subd. 3. **REPORTS.** The county board shall provide necessary reports and data as required by the commissioner.

Subd. 4. **CONTRACTS FOR SERVICES.** The county board may contract with a human services board, a multicounty board established by a joint powers agreement, other political subdivisions, a children's mental health collaborative, a family services collaborative, or private organizations in discharging its duties.

Subd. 5. **EXEMPTION FROM LIABILITY.** The state of Minnesota, the county boards, or the agencies acting on behalf of the county boards in the implementation and administration of children and community services shall not be liable for damages, injuries, or liabilities sustained through the purchase of services by the individual, the individual's family, or the authorized representative under this section.

Subd. 6. **FEES FOR SERVICES.** The county board may establish a schedule of fees based upon clients' ability to pay to be charged to recipients of children and community services. Payment, in whole or in part, for services may be accepted from any person except that no fee may be charged to persons or families whose adjusted gross household income is below the federal poverty level. When services are provided to any person, including a recipient of aids administered by the federal, state, or county government, payment of any charges due may be billed to and accepted from a public assistance agency or from any public or private corporation.

Sec. 8. **[256M.70] FISCAL LIMITATIONS.**

Subdivision 1. **DEMONSTRATION OF REASONABLE EFFORT.** The county shall make reasonable efforts to comply with all children and community

services requirements. For the purposes of this section, a county is making reasonable efforts if the county has made efforts to comply with requirements within the limits of available funding, including efforts to identify and apply for commonly available state and federal funding for services.

Subd. 2. **IDENTIFICATION OF SERVICES TO BE PROVIDED.** If a county has made reasonable efforts to provide services according to the service plan under section 256M.30, but funds appropriated for purposes of sections 256M.01 to 256M.80 are insufficient, then the county may limit services that do not meet the following criteria while giving the highest funding priority to clauses (1), (2), and (3):

(1) services needed to protect individuals from maltreatment, abuse, and neglect;

(2) emergency and crisis services needed to protect clients from physical, emotional, or psychological harm;

(3) services that maintain a person in the person's home or least restrictive setting;

(4) assessment of persons applying for services and referral to appropriate services when necessary;

(5) public guardianship services;

(6) case management for persons with developmental disabilities, children with serious emotional disturbances, and adults with serious and persistent mental illness; and

(7) fulfilling licensing responsibilities delegated to the county by the commissioner under section 245A.16.

Subd. 3. **DENIAL, REDUCTION, OR TERMINATION OF SERVICES DUE TO FISCAL LIMITATIONS.** Before a county denies, reduces, or terminates services to an individual due to fiscal limitations, the county must meet the requirements in this section. The county must notify the individual and the individual's guardian in writing of the reason for the denial, reduction, or termination of services and must inform the individual and the individual's guardian in writing that the county will, upon request, meet to discuss alternatives before services are terminated or reduced.

Sec. 9. **[256M.80] PROGRAM EVALUATION.**

Subdivision 1. **COUNTY EVALUATION.** Each county shall submit to the commissioner data from the past calendar year on the outcomes and performance indicators in the service plan. The commissioner shall prescribe standard methods to be used by the counties in providing the data. The data shall be submitted no later than March 1 of each year, beginning with March 1, 2005.

Subd. 2. **STATEWIDE EVALUATION.** Six months after the end of the first full calendar year and annually thereafter, the commissioner shall prepare a report on the counties' progress in improving the outcomes of children, adolescents, and adults related to mental health, safety, permanency, and well-being. This report shall be disseminated throughout the state.

Sec. 10. **[256M.90] GRANTS AND PURCHASE OF SERVICE CONTRACTS.**

Subdivision 1. **AUTHORITY.** The local agency may purchase community social services by grant or purchase of service contract from agencies or individuals approved as vendors.

Subd. 2. **DUTIES OF LOCAL AGENCY.** The local agency must:

(1) use a written grant or purchase of service contract when purchasing community social services. Every grant and purchase of service contract must be completed, signed, and approved by all parties to the agreement, including the county board, unless the county board has designated the local agency to sign on its behalf. No service shall be provided before the effective date of the grant or purchase of service contract;

(2) determine a client's eligibility for purchased services, or delegate the responsibility for making the preliminary determination to the approved vendor under the terms of the grant or purchase of service contract;

(3) ensure the development of an individual social service plan based on the client's needs;

(4) monitor purchased services and evaluate grants and contracts on the basis of client outcomes; and

(5) purchase only from approved vendors.

Subd. 3. **LOCAL AGENCY CRITERIA.** When the local agency chooses to purchase community social services from a vendor that is not subject to state licensing laws or department rules, the local agency must establish written criteria for vendor approval to ensure the health, safety, and well being of clients.

Subd. 4. **CASE RECORDS AND REPORTING REQUIREMENTS.** Case records and data reporting requirements for grants and purchased services are the same as case record and data reporting requirements for direct services.

Subd. 5. **FILES.** The local agency must keep an administrative file for each grant and contract.

Subd. 6. **CONTRACTING WITHIN AND ACROSS COUNTY LINES; LEAD COUNTY CONTRACTS.** Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts.

(a) Once a local agency and an approved vendor execute a contract that meets the requirements of this subdivision, the contract governs all other purchases of service from the vendor by all other local agencies for the term of the contract. The local agency that negotiated and entered into the contract becomes the lead county for the contract.

(b) When the local agency in the county where a vendor is located wants to purchase services from that vendor and the vendor has no contract with the local agency or any other county, the local agency must negotiate and execute a contract with the vendor.

(c) When a local agency in one county wants to purchase services from a vendor located in another county, it must notify the local agency in the county where the vendor is located. Within 30 days of being notified, the local agency in the vendor's county must:

(1) if it has a contract with the vendor, send a copy to the inquiring agency;

(2) if there is a contract with the vendor for which another local agency is the lead county, identify the lead county to the inquiring agency; or

(3) if no local agency has a contract with the vendor, inform the inquiring agency whether it will negotiate a contract and become the lead county. If the agency where the vendor is located will not negotiate a contract with the vendor because of concerns related to clients' health and safety, the agency must share those concerns with the inquiring agency.

(d) If the local agency in the county where the vendor is located declines to negotiate a contract with the vendor or fails to respond within 30 days of receiving the notification under paragraph (c), the inquiring agency is authorized to negotiate a contract and must notify the local agency that declined or failed to respond.

(e) When the inquiring county under paragraph (d) becomes the lead county for a contract and the contract expires and needs to be renegotiated, that county must again follow the requirements under paragraph (c) and notify the local agency where the vendor is located. The local agency where the vendor is located has the option of becoming the lead county for the new contract. If the local agency does not exercise the option, paragraph (d) applies.

(f) This subdivision does not affect the requirement to seek county concurrence under section 256B.092, subdivision 8a, when the services are to be purchased for a person with mental retardation or a related condition or under section 245.4711, subdivision 3, when the services to be purchased are for an adult with serious and persistent mental illness.

Subd. 7. **CONTRACTS WITH COMMUNITY MENTAL HEALTH BOARDS.** A local agency within the geographic area served by a community mental health board authorized by sections 245.61 to 245.69, may contract directly with the community mental health board. However, if a local agency outside of the geographic area served by a community mental health board wishes to purchase services from the board, the local agency must follow the requirements under subdivision 6.

Subd. 8. **PLACEMENT AGREEMENTS.** A placement agreement must be used for residential services. Placement agreements are valid when signed by authorized representatives of the facility and the county of financial responsibility. If the county

of financial responsibility and the county where the approved vendor is located are not the same, the county of financial responsibility must, if requested, mail a copy of the placement agreement to the county where the approved vendor is providing the service and to the lead county within ten calendar days after the date on which the placement agreement is signed. The placement agreement must specify that the service will be provided in accordance with the individual service plan as required and must specify the unit cost, the date of placement, and the date for the review of the placement. A placement agreement may also be used for nonresidential services.

Sec. 11. **REVISOR'S INSTRUCTION.**

For sections in Minnesota Statutes and Minnesota Rules affected by the repealed sections in this article, the revisor shall 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.

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2002, sections 245.478; 245.4886; 245.4888; 245.496; 254A.17; 256E.01; 256E.02; 256E.03; 256E.04; 256E.05; 256E.06; 256E.07; 256E.08; 256E.081; 256E.09; 256E.10; 256E.11; 256E.115; 256E.13; 256E.14; 256E.15; 256F.01; 256F.02; 256F.03; 256F.04; 256F.05; 256F.06; 256F.07; 256F.08; 256F.11; 256F.12; 256F.14; 257.075; 257.81; 260.152; and 626.562, are repealed.

(b) Minnesota Rules, parts 9550.0010; 9550.0020; 9550.0030; 9550.0040; 9550.0050; 9550.0060; 9550.0070; 9550.0080; 9550.0090; 9550.0091; 9550.0092; and 9550.0093, are repealed.

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## ARTICLE 12

## HEALTH CARE

Section 1. Minnesota Statutes 2002, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **FEDERAL FINANCIAL PARTICIPATION.** (a) The commissioner of human services shall seek to maximize federal financial participation in payments for medical education and research costs. If the commissioner of human services determines that federal financial participation is available for the medical education and research, the commissioner of health shall transfer to the commissioner of human services the amount of state funds necessary to maximize the federal funds available. The amount transferred to the commissioner of human services, plus the amount of federal financial participation, shall be distributed to medical assistance providers in accordance with the distribution methodology described in subdivision 4.

(b) For the purposes of paragraph (a), the commissioner shall use physician clinic rates where possible to maximize federal financial participation.

Sec. 2. Minnesota Statutes 2002, section 256.01, subdivision 2, is amended to read:

Subd. 2. **SPECIFIC POWERS.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

(1) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(a) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(b) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(c) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(d) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(e) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(f) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(g) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(2) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

(4) Administer and supervise all noninstitutional service to handicapped persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise handicapped. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(5) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(7) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(8) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as mentally retarded. For children under the guardianship of the commissioner whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(9) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(10) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(11) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(a) The secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity.

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

(13) According to federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(14) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(a) One-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits

issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due.

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

(15) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(16) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(17) Have the authority to establish and enforce the following county reporting requirements:

(a) The commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced.

(b) The county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner.

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

(e) The final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period.

(f) The commissioner may not delay payments, withhold funds, or require repayment under paragraph (c) or (e) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under paragraph (c) or (e), the county board may appeal the action according to sections 14.57 to 14.69.

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

(18) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV-E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV-E foster care maintenance claim for that period.

(19) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(20) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the

beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the ~~basic~~ rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8(c)(1). ~~This basic rebate shall be applied to single-source and multiple-source drugs.~~ The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(22) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(23) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

(24) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this

purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(25) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(26) Incorporate cost reimbursement claims from First Call Minnesota and Greater Twin Cities United Way into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota and Greater Twin Cities United Way according to normal department payment schedules.

(27) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

Sec. 3. Minnesota Statutes 2002, section 256.046, subdivision 1, is amended to read:

Subdivision 1. **HEARING AUTHORITY.** A local agency must initiate an administrative fraud disqualification hearing for individuals accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, MFIP, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, ~~medical care,~~ ~~or~~ food stamp programs, general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16, for the food stamp program and title 45, section 235.112, as of September 30, 1995, for the cash grant and medical care programs.

Sec. 4. **[256.954] PRESCRIPTION DRUG DISCOUNT PROGRAM.**

Subdivision 1. **ESTABLISHMENT; ADMINISTRATION.** The commissioner of human services shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. **COMMISSIONER'S AUTHORITY.** The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all

manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. **DEFINITIONS.** For the purpose of this section, the following terms have the meanings given them:

(a) "Commissioner" means the commissioner of human services.

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 461.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. **ELIGIBLE PERSONS.** To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in medical assistance, general assistance medical care, MinnesotaCare, or the prescription drug program under section 256.955;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or under a pharmacy benefit program offered by a pharmaceutical manufacturer;

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et. seq., as amended; and

(5) have a gross household income that does not exceed 250 percent of the federal poverty guidelines.

Subd. 5. **APPLICATION PROCEDURE.** (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Eligibility begins the month after approval.

(b) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. **PARTICIPATING PHARMACY.** According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any administrative fee and switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. **NOTIFICATION OF REBATE AMOUNT.** The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. **PROVISION OF REBATE.** To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. **PAYMENT TO PHARMACIES.** The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8

to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals, minus the amount of the administrative fee established by the commissioner under subdivision 10.

Subd. 10. **ADMINISTRATIVE FEE; SWITCH FEE.** (a) The commissioner shall establish a reasonable administrative fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. **DEDICATED FUND; CREATION; USE OF FUND.** (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner of human services to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section, to reimburse the commissioner of human services for costs related to enrollment, processing claims, distributing rebates, and for other reasonable administrative costs related to administration of the prescription drug discount program, and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Subd. 12. **EXPIRATION.** This section expires upon the effective date of an expanded prescription drug benefit under Medicare.

**EFFECTIVE DATE.** This section is effective July 1, 2005.

Sec. 5. Minnesota Statutes 2002, section 256.955, subdivision 2a, is amended to read:

Subd. 2a. **ELIGIBILITY.** An individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is at least 65 years of age or older; and

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3~~,~~ or 3a, ~~or 3b, clause (1),~~ or is eligible under section 256B.057, subdivision 3~~,~~ or 3a, ~~or 3b, clause (1),~~ and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5.

Sec. 6. Minnesota Statutes 2002, section 256.955, subdivision 3, is amended to read:

Subd. 3. **PRESCRIPTION DRUG COVERAGE.** Coverage under the program shall be limited to those prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivision 13; ~~and~~

(2) are provided by manufacturers that have fully executed senior drug rebate agreements with the commissioner and comply with such agreements; and

(3) for a specific enrollee, are not covered under an assistance program offered by a pharmaceutical manufacturer, as determined by the board on aging under section 256.975, subdivision 9, except that this shall not apply to qualified individuals under this section who are also eligible for medical assistance with a spenddown as described in subdivision 2a, clause (2), and subdivision 2b, clause (2).

**EFFECTIVE DATE.** This section is effective 90 days after implementation by the board of aging of the prescription drug assistance program under section 256.975, subdivision 9.

Sec. 7. Minnesota Statutes 2002, section 256.955, is amended by adding a subdivision to read:

Subd. 4a. **REFERRALS TO PRESCRIPTION DRUG ASSISTANCE PROGRAM.** County social service agencies, in coordination with the commissioner and the Minnesota board on aging, shall refer individuals applying to the prescription drug program, or enrolled in the prescription drug program, to the prescription drug assistance program for all required prescription drugs that the board on aging determines, under section 256.975, subdivision 9, are covered under an assistance program offered by a pharmaceutical manufacturer. Applicants and enrollees referred to the prescription drug assistance program remain eligible for coverage under the prescription drug program of all prescription drugs covered under subdivision 3. The board on aging shall phase-in participation of enrollees, over a period of 90 days, after implementation of the program under section 256.975, subdivision 9. This subdivision does not apply to individuals who are also eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5.

**EFFECTIVE DATE.** This section is effective 90 days after implementation by the board of aging of the prescription drug assistance program under section 256.975, subdivision 9.

Sec. 8. Minnesota Statutes 2002, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **OPERATING PAYMENT RATES.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish

operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, and January 1, 2005. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 9. Minnesota Statutes 2002, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **PAYMENTS.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and

established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.

Sec. 10. Minnesota Statutes 2002, section 256.969, is amended by adding a subdivision to read:

Subd. 8b. **ADMISSIONS FOR PERSONS WHO APPLY DURING HOSPITALIZATION.** For admissions for individuals under section 256D.03, subdivision 3, paragraph (a), clause (2), that occur before the date of eligibility, payment for the days that the patient is eligible shall be established according to the methods of subdivision 14.

**EFFECTIVE DATE.** This section is effective October 1, 2003.

Sec. 11. Minnesota Statutes 2002, section 256.975, is amended by adding a subdivision to read:

Subd. 9. **PRESCRIPTION DRUG ASSISTANCE.** (a) The Minnesota board on aging shall establish and administer a prescription drug assistance program to assist individuals in accessing programs offered by pharmaceutical manufacturers that provide free or discounted prescription drugs or provide coverage for prescription drugs. The board shall use computer software programs to:

(1) list eligibility requirements for pharmaceutical assistance programs offered by manufacturers;

(2) list drugs that are included in a supplemental rebate contract between the commissioner and a pharmaceutical manufacturer under section 256.01, subdivision 2, clause (23); and

(3) link individuals with the pharmaceutical assistance programs most appropriate for the individual. The board shall make information on the prescription drug assistance program available to interested individuals and health care providers and shall coordinate the program with the statewide information and assistance service provided through the Senior LinkAge Line under subdivision 7.

(b) The board shall work with the commissioner and county social service agencies to coordinate the enrollment of individuals who are referred to the

prescription drug assistance program from the prescription drug program, as required under section 256.955, subdivision 4a.

Sec. 12. Minnesota Statutes 2002, section 256.98, subdivision 3, is amended to read:

Subd. 3. **AMOUNT OF ASSISTANCE INCORRECTLY PAID.** The amount of the assistance incorrectly paid under this section is:

(a) the difference between the amount of assistance actually received on the basis of misrepresented or concealed facts and the amount to which the recipient would have been entitled had the specific concealment or misrepresentation not occurred. Unless required by law, rule, or regulation, earned income disregards shall not be applied to earnings not reported by the recipient; or

(b) equal to all payments for health care services, including capitation payments made to a health plan, made on behalf of a person enrolled in MinnesotaCare, medical assistance, or general assistance medical care, for which the person was not entitled due to the concealment or misrepresentation of facts.

Sec. 13. Minnesota Statutes 2002, section 256.98, subdivision 4, is amended to read:

Subd. 4. **RECOVERY OF ASSISTANCE.** The amount of assistance determined to have been incorrectly paid is recoverable from:

(1) the recipient or the recipient's estate by the county or the state as a debt due the county or the state or both; and

(2) any person found to have taken independent action to establish eligibility for, conspired with, or aided and abetted, any recipient of public assistance found to have been incorrectly paid.

The obligations established under this subdivision shall be joint and several and shall extend to all cases involving client error as well as cases involving wrongfully obtained assistance.

MinnesotaCare participants who have been found to have wrongfully obtained assistance as described in subdivision 1, but who otherwise remain eligible for the program, may agree to have their MinnesotaCare premiums increased by an amount equal to ten percent of their premiums or $10 per month, whichever is greater, until the debt is satisfied.

Sec. 14. Minnesota Statutes 2002, section 256.98, subdivision 8, is amended to read:

Subd. 8. **DISQUALIFICATION FROM PROGRAM.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in

the Minnesota family investment program, the food stamp program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of three months, six months, and two years for the first, second, and third offenses respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

(c) Any person found to be guilty of wrongfully obtaining general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare, except for children through age 18, by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, is disqualified from that program. The period of disqualification is one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. The

period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved.

Sec. 15. Minnesota Statutes 2002, section 256B.055, is amended by adding a subdivision to read:

Subd. 13. **RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES.** Beginning October 1, 2003, persons who would be eligible for medical assistance under this chapter but for residing in a facility that is determined by the commissioner or the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases are eligible for medical assistance without federal financial participation, except that coverage shall not include payment for a nursing facility determined to be an institution for mental diseases.

Sec. 16. Minnesota Statutes 2002, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **INCOME AND ASSETS GENERALLY.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and social security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law ~~Number~~ 104-193, shall be used, except that effective ~~July 1, 2002, the $90 and $30 and one-third earned income disregards shall not apply and the disregard specified in subdivision 1c shall apply~~ October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 17. Minnesota Statutes 2002, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. **FAMILIES WITH CHILDREN INCOME METHODOLOGY.** (a)(1) For children ages one to five whose eligibility is determined under section

256B.057, subdivision 2, 21 percent of countable earned income shall be disregarded for up to four months. This clause expires July 1, 2003.

(2) For applications processed within one calendar month prior to the date clause (1) expires, eligibility shall be determined by applying the income standards and methodologies in effect prior to the date of the expiration for any months in the six-month budget period before the expiration date and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: $90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

**EFFECTIVE DATE.** The amendments to paragraphs (b) and (c) are effective July 1, 2003.

Sec. 18. Minnesota Statutes 2002, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **ASSET LIMITATIONS FOR FAMILIES AND CHILDREN.** A household of two or more persons must not own more than ~~$30,000~~ $20,000 in total net assets, and a household of one person must not own more than ~~$15,000~~ $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law ~~Number~~ 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; and

(7) assets owned by children are not considered.

Sec. 19. Minnesota Statutes 2002, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **PREGNANT WOMEN AND INFANTS.** (a)(1) An infant less than one year of age ~~or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse,~~ is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 200 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law ~~Number~~ 104-193, except for the earned income disregard and employment deductions.

(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b)(1) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law ~~Number~~ 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age. This clause expires July 1, 2003.

(2) For applications processed within one calendar month prior to the date clause (1) expires, eligibility shall be determined by applying the income standards and methodologies in effect prior to the date of the expiration for any months in the six-month budget period before the expiration date and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(c) Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.

~~(b)~~ (d) An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

**EFFECTIVE DATE.** This section is effective February 1, 2004, or upon federal approval, whichever is later, except where a different date is specified in the text.

Sec. 20. Minnesota Statutes 2002, section 256B.057, subdivision 2, is amended to read:

Subd. 2. **CHILDREN.** (a) Except as specified in subdivision 1b, effective ~~July 1, 2002~~ October 1, 2003, a child one through 18 years of age in a family whose countable income is no greater than ~~170~~ 150 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance.

(b) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

Sec. 21. Minnesota Statutes 2002, section 256B.057, subdivision 3b, is amended to read:

Subd. 3b. **QUALIFYING INDIVIDUALS.** Beginning July 1, 1998, ~~to the extent of the federal allocation to Minnesota~~ contingent upon federal funding, a person who would otherwise be eligible as a qualified Medicare beneficiary under subdivision 3, except that the person's income is in excess of the limit, is eligible as a qualifying individual according to the following criteria:

(1) if the person's income is greater than 120 percent, but less than 135 percent of the official federal poverty guidelines for the applicable family size, the person is eligible for medical assistance reimbursement of Medicare Part B premiums; or

(2) if the person's income is equal to or greater than 135 percent but less than 175 percent of the official federal poverty guidelines for the applicable family size, the person is eligible for medical assistance reimbursement of that portion of the Medicare Part B premium attributable to an increase in Part B expenditures which resulted from the shift of home care services from Medicare Part A to Medicare Part B under Public Law ~~Number~~ 105-33, section 4732, the Balanced Budget Act of 1997.

The commissioner shall limit enrollment of qualifying individuals under this subdivision according to the requirements of Public Law ~~Number~~ 105-33, section 4732.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 22. Minnesota Statutes 2002, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **EMPLOYED PERSONS WITH DISABILITIES.** (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) effective November 1, 2003, pays a premium~~, if required,~~ and other obligations under paragraph ~~(c)~~ (d).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, social security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(d)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (1).

(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount.

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

~~(d)~~ (e) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

~~(e)~~ (f) Any required premium shall be determined at application and redetermined ~~annually at recertification~~ at the enrollee's six-month income review or when a change in income or ~~family~~ household size ~~occurs~~ is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

~~(f)~~ (g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

~~(g)~~ (h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

**EFFECTIVE DATE.** This section is effective November 1, 2003, except that the amendments to Minnesota Statutes 2002, section 256B.057, subdivision 9, paragraphs (f) and (h), are effective July 1, 2003.

Sec. 23. Minnesota Statutes 2002, section 256B.057, subdivision 10, is amended to read:

Subd. 10. **CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.** (a) Medical assistance may be paid for a person who:

(1) has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program, and program funds have been used to pay for the person's screening;

(2) according to the person's treating health professional, needs treatment, including diagnostic services necessary to determine the extent and proper course of treatment, for breast or cervical cancer, including precancerous conditions and early stage cancer;

(3) meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program;

(4) is under age 65;

(5) is not otherwise eligible for medical assistance under United States Code, title 42, section 1396(a)(10)(A)(i); and

(6) is not otherwise covered under creditable coverage, as defined under United States Code, title 42, section ~~300gg(e)~~ 1396a(aa).

(b) Medical assistance provided for an eligible person under this subdivision shall be limited to services provided during the period that the person receives treatment for breast or cervical cancer.

(c) A person meeting the criteria in paragraph (a) is eligible for medical assistance without meeting the eligibility criteria relating to income and assets in section 256B.056, subdivisions 1a to 5b.

Sec. 24. Minnesota Statutes 2002, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **PROHIBITED TRANSFERS.** (a) For transfers of assets made on or before August 10, 1993, if a person or the person's spouse has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for

the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity described in this paragraph purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota department of commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(f) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with mental retardation, and home and community-based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 25. Minnesota Statutes 2002, section 256B.0595, is amended by adding a subdivision to read:

Subd. 1b. **PROHIBITED TRANSFERS.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, if the transfer occurred within 72 months before the person applies for medical assistance, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, may not give away, sell, dispose of, or reduce ownership or control of any income, asset, or interest therein for less than fair market value for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the

institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for medical assistance services, any transfer of such income or assets for less than fair market value within 72 months before or any time after a person applies for medical assistance may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility, and the person is ineligible for medical assistance services for the period of time determined under subdivision 2b, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose or unless the transfer is permitted under subdivision 3b or 4b.

(b) This section applies to transfers to trusts. The commissioner shall determine valid trust purposes under this section. Assets placed into a trust that is not for a valid purpose shall always be considered available for the purposes of medical assistance eligibility, regardless of when the trust is established.

(c) This section applies to transfers of income or assets for less than fair market value, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized written agreement that was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any income, asset, or interest therein that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or the person's spouse while alive, based on estimated life expectancy, using the life expectancy tables employed by the supplemental security income program, or based on a shorter life expectancy if the annuitant had a medical condition that would shorten the annuitant's life expectancy and that was diagnosed before funds were placed into the annuity. The agency may request and receive a physician's statement to determine if the annuitant had a diagnosed medical condition that would shorten the annuitant's life expectancy. If so, the agency shall determine the expected value of the benefits based upon the physician's statement instead of using a life expectancy table. This section applies to an annuity described in this paragraph purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota department of commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(f) Transfers under this section shall affect determinations of eligibility for all medical assistance services or long-term care services, whichever receives federal approval.

**EFFECTIVE DATE.** (a) This section is effective July 1, 2003, to the extent permitted by federal law. If any provision of this section is prohibited by federal law, the provision shall become effective when federal law is changed to permit its application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 2003, any provision of this section is not effective because of prohibitions in federal law, the commissioner of human services shall apply to the federal government by August 1, 2003, for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. In applying for federal approval to extend the lookback period, the commissioner shall seek the longest lookback period the federal government will approve, not to exceed 72 months.

Sec. 26. Minnesota Statutes 2002, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. **PERIOD OF INELIGIBILITY.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated

value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin ~~in~~ on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was not reported to the local agency ~~at the time of application~~, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $200, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

**EFFECTIVE DATE.** Paragraph (b) of this section is effective July 1, 2003.

Sec. 27. Minnesota Statutes 2002, section 256B.0595, is amended by adding a subdivision to read:

Subd. 2b. **PERIOD OF INELIGIBILITY.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers, including transfers to trusts, involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not

apply to transfers made prior to July 1, 2003. For any uncompensated transfer occurring within 72 months prior to the date of application, at any time after application, or while eligible, the number of months of cumulative ineligibility for medical assistance services shall be the total uncompensated value of the assets and income transferred divided by the statewide average per-person nursing facility payment made by the state in effect at the time a penalty for a transfer is determined. The amount used to calculate the average per-person nursing facility payment shall be adjusted each July 1 to reflect average payments for the previous calendar year. For applicants, the period of ineligibility begins with the month in which the person applied for medical assistance and satisfied all other requirements for eligibility, or the first month the local agency becomes aware of the transfer and can give proper notice, if later. For recipients, the period of ineligibility begins in the first month after the month the agency becomes aware of the transfer and can give proper notice, except that penalty periods for transfers made during a period of ineligibility as determined under this section shall begin in the month following the existing period of ineligibility. If the transfer was not reported to the local agency, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility or for the uncompensated amount of the transfer that was not recovered from the transferor through the implementation of a penalty period under this subdivision, whichever is less. Recovery shall include the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256B. The total uncompensated value is the fair market value of the income or asset at the time it was given away, sold, or disposed of, less the amount of compensation received. No cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(b) If a calculation of a penalty period results in a partial month, payments for medical assistance services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $200, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

(c) Ineligibility under this section shall apply to medical assistance services or long-term care services, whichever receives federal approval.

**EFFECTIVE DATE.** (a) This section is effective July 1, 2003, to the extent permitted by federal law. If any provision of this section is prohibited by federal law,

the provision shall become effective when federal law is changed to permit its application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 2003, any provision of this section is not effective because of prohibitions in federal law, the commissioner of human services shall apply to the federal government by August 1, 2003, for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. In applying for federal approval to extend the lookback period, the commissioner shall seek the longest lookback period the federal government will approve, not to exceed 72 months.

Sec. 28. Minnesota Statutes 2002, section 256B.0595, is amended by adding a subdivision to read:

Subd. 3b. **HOMESTEAD EXCEPTION TO TRANSFER PROHIBITION.** (a) This subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person is not ineligible for medical assistance services due to a transfer of assets for less than fair market value as described in subdivision 1b, if the asset transferred was a homestead, and:

(1) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(2) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual and there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (2), a cause of action exists against the person to whom the homestead was transferred for that portion of medical assistance services granted within 72 months of the date the transferor applied

for medical assistance and satisfied all other requirements for eligibility or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256B.

**EFFECTIVE DATE.** (a) This section is effective July 1, 2003, to the extent permitted by federal law. If any provision of this section is prohibited by federal law, the provision shall become effective when federal law is changed to permit its application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 2003, any provision of this section is not effective because of prohibitions in federal law, the commissioner of human services shall apply to the federal government by August 1, 2003, for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. In applying for federal approval to extend the lookback period, the commissioner shall seek the longest lookback period the federal government will approve, not to exceed 72 months.

Sec. 29. Minnesota Statutes 2002, section 256B.0595, is amended by adding a subdivision to read:

Subd. 4b. **OTHER EXCEPTIONS TO TRANSFER PROHIBITION.** This subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person or a person's spouse who made a transfer prohibited by subdivision 1b is not ineligible for medical assistance services if one of the following conditions applies:

(1) the assets or income were transferred to the individual's spouse or to another for the sole benefit of the spouse, except that after eligibility is established and the assets have been divided between the spouses as part of the asset allowance under section 256B.059, no further transfers between spouses may be made;

(2) the institutionalized spouse, prior to being institutionalized, transferred assets or income to a spouse, provided that the spouse to whom the assets or income were transferred does not then transfer those assets or income to another person for less than fair market value. At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059;

(3) the assets or income were transferred to a trust for the sole benefit of the individual's child who is blind or permanently and totally disabled as determined in the

supplemental security income program and the trust reverts to the state upon the disabled child's death to the extent the medical assistance has paid for services for the grantor or beneficiary of the trust. This clause applies to a trust established after the commissioner publishes a notice in the State Register that the commissioner has been authorized to implement this clause due to a change in federal law or the approval of a federal waiver;

(4) a satisfactory showing is made that the individual intended to dispose of the assets or income either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for medical assistance services would cause undue hardship and grants a waiver of a penalty resulting from a transfer for less than fair market value because there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter.

**EFFECTIVE DATE.** (a) This section is effective July 1, 2003, to the extent permitted by federal law. If any provision of this section is prohibited by federal law, the provision shall become effective when federal law is changed to permit its application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 2003, any provision of this section is not effective because of prohibitions in federal law, the commissioner of human services shall apply to the federal government by August 1, 2003, for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. In applying for federal approval to extend the lookback period, the commissioner shall seek the longest lookback period the federal government will approve, not to exceed 72 months.

Sec. 30. **[256B.0596] MENTAL HEALTH CASE MANAGEMENT.**

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week.

Sec. 31. Minnesota Statutes 2002, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **CITIZENSHIP REQUIREMENTS.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law ~~Number~~ 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law ~~Number~~ 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law ~~Number~~ 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of chapter 256B are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(i) refugees admitted to the United States according to United States Code, title 8, section 1157;

(ii) persons granted asylum according to United States Code, title 8, section 1158;

(iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(iv) veterans of the United States Armed Forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(v) persons on active duty in the United States Armed Forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully residing in the United States and who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of chapter 256B are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of chapter 256B, if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care.

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i) Pregnant noncitizens who are undocumented or nonimmigrants, who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance payment without federal financial participation for care and services through the period of pregnancy, and 60 days postpartum, except for labor and delivery.

(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

(k) ~~The commissioner shall submit to the legislature by December 31, 1998, a report on the number of recipients and cost of coverage of care and services made according to paragraphs (i) and (j).~~ Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under chapter 256B or general assistance medical care under section 256D.03 are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this clause shall not be required to participate in prepaid medical assistance.

**EFFECTIVE DATE.** This section is effective July 1, 2003, except where a different date is specified in the text.

Sec. 32. Minnesota Statutes 2002, section 256B.061, is amended to read:

256B.061 **ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.**

~~(a)~~ If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for

such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

~~(b) On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:~~

~~(1) whose gross income is less than 90 percent of the applicable income standard;~~

~~(2) whose total liquid assets are less than 90 percent of the asset limit;~~

~~(3) does not reside in a long-term care facility; and~~

~~(4) meets all other eligibility requirements.~~

~~The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.~~

**EFFECTIVE DATE.** This section is effective July 1, 2003, or upon federal approval, whichever is later.

Sec. 33. Minnesota Statutes 2002, section 256B.0625, subdivision 5a, is amended to read:

Subd. 5a. **INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS.** ~~(a)~~ **COVERAGE.** Medical assistance covers home-based intensive early intervention behavior therapy for children with autism spectrum disorders, effective July 1, 2007. Children with autism spectrum disorder, and their custodial parents or foster parents, may access other covered services to treat autism spectrum disorder, and are not required to receive intensive early intervention behavior therapy services under this subdivision. Intensive early intervention behavior therapy does not include coverage for services to treat developmental disorders of language, early onset psychosis, Rett's disorder, selective mutism, social anxiety disorder, stereotypic movement disorder, dementia, obsessive compulsive disorder, schizoid personality disorder, avoidant personality disorder, or reactive attachment disorder. If a child with autism spectrum disorder is diagnosed to have one or more of these conditions, intensive early intervention behavior therapy includes coverage only for services necessary to treat the autism spectrum disorder.

~~(b)~~ Subd. 5b. **PURPOSE OF INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES (IEIBTS).** The purpose of IEIBTS is to improve the child's behavioral functioning, to prevent development of challenging behaviors, to eliminate autistic behaviors, to reduce the risk of out-of-home placement, and to establish independent typical functioning in language and social behavior. The procedures used to accomplish these goals are based upon research in applied behavior analysis.

~~(c)~~ Subd. 5c. **ELIGIBLE CHILDREN.** A child is eligible to initiate IEIBTS if, the child meets the additional eligibility criteria in paragraph (d) and in a diagnostic assessment by a mental health professional who is not under the employ of the service provider, the child:

(1) is found to have an autism spectrum disorder;

(2) has a current IQ of either untestable, or at least 30;

(3) if nonverbal, initiated behavior therapy by 42 months of age;

(4) if verbal, initiated behavior therapy by 48 months of age; or

(5) if having an IQ of at least 50, initiated behavior therapy by 84 months of age.

To continue after six-month individualized treatment plan (ITP) reviews, at least one of the child's custodial parents or foster parents must participate in an average of at least five hours of documented behavior therapy per week for six months, and consistently implement behavior therapy recommendations 24 hours a day. To continue after six-month individualized treatment plan (ITP) reviews, the child must show documented progress toward mastery of six-month benchmark behavior objectives. The maximum number of months during which services may be billed is 54, or up to the month of August in the first year in which the child completes first grade, whichever comes last. If significant progress towards treatment goals has not been achieved after 24 months of treatment, treatment must be discontinued.

~~(d)~~ Subd. 5d. **ADDITIONAL ELIGIBILITY CRITERIA.** A child is eligible to initiate IEIBTS if:

(1) in medical and diagnostic assessments by medical and mental health professionals, it is determined that the child does not have severe or profound mental retardation;

(2) an accurate assessment of the child's hearing has been performed, including audiometry if the brain stem auditory evokes response;

(3) a blood lead test has been performed prior to initiation of treatment; and

(4) an EEG or neurologic evaluation is done, prior to initiation of treatment, if the child has a history of staring spells or developmental regression.

~~(e)~~ Subd. 5e. **COVERED SERVICES.** The focus of IEIBTS must be to treat the principal diagnostic features of the autism spectrum disorder. All IEIBTS must be delivered by a team of practitioners under the consistent supervision of a single clinical supervisor. A mental health professional must develop the ITP for IEIBTS. The ITP must include six-month benchmark behavior objectives. All behavior therapy must be based upon research in applied behavior analysis, with an emphasis upon positive reinforcement of carefully task-analyzed skills for optimum rates of progress. All behavior therapy must be consistently applied and generalized throughout the 24-hour day and seven-day week by all of the child's regular care providers. When placing the child in school activities, a majority of the peers must have no mental health diagnosis,

and the child must have sufficient social skills to succeed with 80 percent of the school activities. Reactive consequences, such as redirection, correction, positive practice, or time-out, must be used only when necessary to improve the child's success when proactive procedures alone have not been effective. IEIBTS must be delivered by a team of behavior therapy practitioners who are employed under the direction of the same agency. The team may deliver up to 200 billable hours per year of direct clinical supervisor services, up to 700 billable hours per year of senior behavior therapist services, and up to 1,800 billable hours per year of direct behavior therapist services. A one-hour clinical review meeting for the child, parents, and staff must be scheduled 50 weeks a year, at which behavior therapy is reviewed and planned. At least one-quarter of the annual clinical supervisor billable hours shall consist of on-site clinical meeting time. At least one-half of the annual senior behavior therapist billable hours shall consist of direct services to the child or parents. All of the behavioral therapist billable hours shall consist of direct on-site services to the child or parents. None of the senior behavior therapist billable hours or behavior therapist billable hours shall consist of clinical meeting time. If there is any regression of the autistic spectrum disorder after 12 months of therapy, a neurologic consultation must be performed.

~~(f)~~ Subd. 5f. **PROVIDER QUALIFICATIONS.** The provider agency must be capable of delivering consistent applied behavior analysis (ABA) based behavior therapy in the home. The site director of the agency must be a mental health professional and a board certified behavior analyst certified by the behavior analyst certification board. Each clinical supervisor must be a certified associate behavior analyst certified by the behavior analyst certification board or have equivalent experience in applied behavior analysis.

~~(g)~~ Subd. 5g. **SUPERVISION REQUIREMENTS.** (1) Each behavior therapist practitioner must be continuously supervised while in the home until the practitioner has mastered competencies for independent practice. Each behavior therapist must have mastered three credits of academic content and practice in an applied behavior analysis sequence at an accredited university before providing more than 12 months of therapy. A college degree or minimum hours of experience are not required. Each behavior therapist must continue training through weekly direct observation by the senior behavior therapist, through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in applied behavior analysis.

(2) Each senior behavior therapist practitioner must have mastered the senior behavior therapy competencies, completed one year of practice as a behavior therapist, and six months of co-therapy training with another senior behavior therapist or have an equivalent amount of experience in applied behavior analysis. Each senior behavior therapist must have mastered 12 credits of academic content and practice in an applied behavior analysis sequence at an accredited university before providing more than 12 months of senior behavior therapy. Each senior behavior therapist must continue training through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in applied behavior analysis.

(3) Each clinical supervisor practitioner must have mastered the clinical supervisor and family consultation competencies, completed two years of practice as a senior behavior therapist and one year of co-therapy training with another clinical supervisor, or equivalent experience in applied behavior analysis. Each clinical supervisor must continue training through annual training in applied behavior analysis.

~~(h)~~ Subd. 5h. **PLACE OF SERVICE.** IEIBTS are provided primarily in the child's home and community. Services may be provided in the child's natural school or preschool classroom, home of a relative, natural recreational setting, or day care.

~~(i)~~ Subd. 5i. **PRIOR AUTHORIZATION REQUIREMENTS.** Prior authorization shall be required for services provided after 200 hours of clinical supervisor, 700 hours of senior behavior therapist, or 1,800 hours of behavior therapist services per year.

~~(j)~~ Subd. 5j. **PAYMENT RATES.** The following payment rates apply:

(1) for an IEIBTS clinical supervisor practitioner under supervision of a mental health professional, the lower of the submitted charge or $67 per hour unit;

(2) for an IEIBTS senior behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $37 per hour unit; or

(3) for an IEIBTS behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $27 per hour unit.

An IEIBTS practitioner may receive payment for travel time which exceeds 50 minutes one-way. The maximum payment allowed will be $0.51 per minute for up to a maximum of 300 hours per year.

For any week during which the above charges are made to medical assistance, payments for the following services are excluded: supervising mental health professional hours and personal care attendant, home-based mental health, family-community support, or mental health behavioral aide hours.

~~(k)~~ Subd. 5k. **REPORT.** The commissioner shall collect evidence of the effectiveness of intensive early intervention behavior therapy services and present a report to the legislature by July 1, ~~2006~~ 2010.

Sec. 34. Minnesota Statutes 2002, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **DENTAL SERVICES.** (a) Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

(b) Coverage of dental services for adults age 21 and over who are not pregnant is subject to a $500 annual benefit limit and covered services are limited to:

(1) diagnostic and preventative services;

(2) basic restorative services; and

(3) emergency services.

Emergency services, dentures, and extractions related to dentures are not included in the $500 annual benefit limit.

Sec. 35. Minnesota Statutes 2002, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

Subd. 13c. **FORMULARY COMMITTEE.** The commissioner, after receiving recommendations from professional medical associations and professional ~~pharmacist~~ pharmacy associations, and consumer groups shall designate a formulary committee to ~~advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative~~ carry out duties as described in

subdivisions 13 to 13g. The formulary committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the formulary committee shall not be employed by the department of human services. Committee members shall serve three-year terms and ~~shall serve without compensation. Members~~ may be reappointed ~~once~~ by the commissioner. The formulary committee shall meet at least quarterly. The commissioner may require more frequent formulary committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Subd. 13d. **DRUG FORMULARY.** ~~(b)~~ The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents.

The formulary shall not include:

~~(i)~~ (1) drugs or products for which there is no federal funding;

~~(ii)~~ (2) over-the-counter drugs, except ~~for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14~~ as provided in subdivision 13;

~~(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese~~ (3) drugs used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

~~(iv)~~ (4) drugs for which medical value has not been established; and

~~(v)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

~~The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.~~

Subd. 13e. **PAYMENT RATES.** ~~(c)~~ (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~nine~~ 11.5 percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the ~~nine~~ 11.5 percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. ~~The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332.~~ Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, ~~unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2~~ or on the maximum allowable cost established by the commissioner.

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

(d) ~~For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:~~

~~(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";~~

~~(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and~~

~~(3) are sold or marketed in Minnesota.~~

~~"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.~~

~~(e)~~ The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, the average wholesale price minus five percent, or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraphs (a) to (c).

Subd. 13f. **PRIOR AUTHORIZATION.** (a) The formulary committee shall review and recommend drugs which require prior authorization. ~~The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria and on cost before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:~~

~~(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;~~

~~(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days;~~

~~(3) the drug formulary committee must consider data from the state Medicaid program if such data is available; and~~

~~(4) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and on program costs, and information regarding whether the drug is subject to clinical abuse or misuse.~~

~~Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. If prior authorization of a drug is required by the commissioner, the commissioner must provide a 30-day notice period before imple-~~

~~menting the prior authorization. If a prior authorization request is denied by the department, the recipient may appeal the denial in accordance with section 256.045. If an appeal is filed, the drug must be provided without prior authorization until a decision is made on the appeal.~~

~~(f) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).~~

~~(g) Prior authorization shall not be required or utilized for any antipsychotic drug prescribed for the treatment of mental illness where there is no generically equivalent drug available unless the commissioner determines that prior authorization is necessary for patient safety. This paragraph applies to any supplemental drug rebate program established or administered by the commissioner.~~ The formulary committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the formulary committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the formulary committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the formulary committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner.

~~(h)~~ (d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available ~~unless the commissioner determines that prior authorization is necessary for patient safety. This paragraph applies to~~ if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner. This paragraph expires July 1, ~~2003~~ 2005.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

Subd. 13g. **PREFERRED DRUG LIST.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor or one or more states for the purpose of participating in a multistate preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the formulary committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization, unless the drug manufacturer signs a supplemental rebate contract.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 36. Minnesota Statutes 2002, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **TRANSPORTATION COSTS.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by ~~nonambulatory~~ eligible persons in obtaining emergency or nonemer-

gency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. ~~For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.~~

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the ~~provider receives and maintains a current physician's order by the recipient's attending physician certifying that the~~ recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. ~~The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair-accessible van or stretcher-accessible vehicle and for those who do not need a wheelchair-accessible van or stretcher-accessible vehicle. The average of these two rates per trip must not exceed $15 for the base rate and $1.40 per mile. Special transportation provided to nonambulatory persons who do not need a wheelchair-accessible van or stretcher-accessible vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair-accessible van or stretcher-accessible vehicle.~~ Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the most direct route available. The maximum medical assistance reimbursement rates for special transportation services are:

(1) $18 for the base rate and $1.40 per mile for services to eligible persons who need a wheelchair-accessible van;

(2) $12 for the base rate and $1.35 per mile for services to eligible persons who do not need a wheelchair-accessible van; and

(3) $36 for the base rate and $1.40 per mile, and an attendant rate of $9 per trip, for services to eligible persons who need a stretcher-accessible vehicle.

Sec. 37. **[256B.0631] MEDICAL ASSISTANCE CO-PAYMENTS.**

Subdivision 1. **CO-PAYMENTS.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or

established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital-based emergency room; and

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Recipients of medical assistance are responsible for all co-payments in this subdivision.

Subd. 2. **EXCEPTIONS.** Co-payments shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the mentally retarded;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. **COLLECTION.** The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in subdivision 4.

Subd. 4. **UNCOLLECTED DEBT.** If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

Sec. 38. Minnesota Statutes 2002, section 256B.0635, subdivision 1, is amended to read:

Subdivision 1. **INCREASED EMPLOYMENT.** (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law ~~Number~~ 100-485.

(b) Beginning July 1, 2002, contingent upon federal funding, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, in at least three of six months preceding the month in which the person became ineligible under that section if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law ~~Number~~ 100-485.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 39. Minnesota Statutes 2002, section 256B.0635, subdivision 2, is amended to read:

Subd. 2. **INCREASED CHILD OR SPOUSAL SUPPORT.** (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP or medical assistance, if the

ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

(b) Beginning July 1, 2002, contingent upon federal funding, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, in at least three of the six months preceding the month in which the person became ineligible under that section if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 40. Minnesota Statutes 2002, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **POLICY, APPLICABILITY, PURPOSE, AND CONSTRUCTION; DEFINITION.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the total cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remaindermen or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D, but does not include the alternative care program for nonmedical assistance recipients under section 256B.0913, subdivision 4.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to estates of decedents who die on or after that date.

Sec. 41. Minnesota Statutes 2002, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **ESTATES SUBJECT TO CLAIMS.** If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the

person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over 55 years of age, and received services under this chapter~~, excluding alternative care~~;

(b) the person resided in a medical institution for six months or longer, received services under this chapter ~~excluding alternative care~~, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

(c) the person received general assistance medical care services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

**EFFECTIVE DATE.** The amendments in this section relating to the alternative care program are effective July 1, 2003, and apply to the estates of decedents who die on or after that date. The remaining amendments in this section are effective August 1, 2003, and apply to the estates of decedents who die on and after that date.

Sec. 42. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1c. **NOTICE OF POTENTIAL CLAIM.** (a) A state agency with a claim or potential claim under this section may file a notice of potential claim under this subdivision anytime before or within one year after a medical assistance recipient dies. The claimant shall be the state agency. A notice filed prior to the recipient's death shall not take effect and shall not be effective as notice until the recipient dies. A notice filed after a recipient dies shall be effective from the time of filing.

(b) The notice of claim shall be filed or recorded in the real estate records in the office of the county recorder or registrar of titles for each county in which any part of the property is located. The recorder shall accept the notice for recording or filing. The registrar of titles shall accept the notice for filing if the recipient has a recorded interest in the property. The registrar of titles shall not carry forward to a new certificate of title any notice filed more than one year from the date of the recipient's death.

(c) The notice must be dated, state the name of the claimant, the medical assistance recipient's name and social security number if filed before their death and their date of death if filed after they die, the name and date of death of any predeceased spouse of the medical assistance recipient for whom a claim may exist, a statement that the claimant may have a claim arising under this section, generally identify the recipient's interest in the property, contain a legal description for the property and whether it is abstract or registered property, a statement of when the notice becomes effective and the effect of the notice, be signed by an authorized representative of the state agency, and may include such other contents as the state agency may deem appropriate.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 43. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1d. **EFFECT OF NOTICE.** From the time it takes effect, the notice shall be notice to remaindermen, joint tenants, or to anyone else owning or acquiring an interest in or encumbrance against the property described in the notice that the medical assistance recipient's life estate, joint tenancy, or other interests in the real estate described in the notice:

(1) shall, in the case of life estate and joint tenancy interests, continue to exist for purposes of this section, and be subject to liens and claims as provided in this section;

(2) shall be subject to a lien in favor of the claimant effective upon the death of the recipient and dealt with as provided in this section;

(3) may be included in the recipient's estate, as defined in this section; and

(4) may be subject to administration and all other provisions of chapter 524 and may be sold, assigned, transferred, or encumbered free and clear of their interest or encumbrance to satisfy claims under this section.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 44. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1e. **FULL OR PARTIAL RELEASE OF NOTICE.** (a) The claimant may fully or partially release the notice and the lien arising out of the notice of record in the

real estate records where the notice is filed or recorded at any time. The claimant may give a full or partial release to extinguish any life estates or joint tenancy interests which are or may be continued under this section or whose existence or nonexistence may create a cloud on the title to real property at any time whether or not a notice has been filed. The recorder or registrar of titles shall accept the release for recording or filing. If the release is a partial release, it must include a legal description of the property being released.

(b) At any time, the claimant may, at the claimant's discretion, wholly or partially release, subordinate, modify, or amend the recorded notice and the lien arising out of the notice.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 45. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1f. **AGENCY LIEN.** (a) The notice shall constitute a lien in favor of the department of human services against the recipient's interests in the real estate it describes for a period of 20 years from the date of filing or the date of the recipient's death, whichever is later. Notwithstanding any law or rule to the contrary, a recipient's life estate and joint tenancy interests shall not end upon the recipient's death but shall continue according to subdivisions 1h, 1i, and 1j. The amount of the lien shall be equal to the total amount of the claims that could be presented in the recipient's estate under this section.

(b) If no estate has been opened for the deceased recipient, any holder of an interest in the property may apply to the lien holder for a statement of the amount of the lien or for a full or partial release of the lien. The application shall include the applicant's name, current mailing address, current home and work telephone numbers, and a description of their interest in the property, a legal description of the recipient's interest in the property, and the deceased recipient's name, date of birth, and social security number. The lien holder shall send the applicant by certified mail, return receipt requested, a written statement showing the amount of the lien, whether the lien holder is willing to release the lien and under what conditions, and inform them of the right to a hearing under section 256.045. The lien holder shall have the discretion to compromise and settle the lien upon any terms and conditions the lien holder deems appropriate.

(c) Any holder of an interest in property subject to the lien has a right to request a hearing under section 256.045 to determine the validity, extent, or amount of the lien. The request must be in writing, and must include the names, current addresses, and home and business telephone numbers for all other parties holding an interest in the property. A request for a hearing by any holder of an interest in the property shall be deemed to be a request for a hearing by all parties owning interests in the property. Notice of the hearing shall be given to the lien holder, the party filing the appeal, and

all of the other holders of interests in the property at the addresses listed in the appeal by certified mail, return receipt requested, or by ordinary mail. Any owner of an interest in the property to whom notice of the hearing is mailed shall be deemed to have waived any and all claims or defenses in respect to the lien unless they appear and assert any claims or defenses at the hearing.

(d) If the claim the lien secures could be filed under subdivision 1h, the lien holder may collect, compromise, settle, or release the lien upon any terms and conditions it deems appropriate. If the claim the lien secures could be filed under subdivision 1i or 1j, the lien may be adjusted or enforced to the same extent had it been filed under subdivisions 1i and 1j, and the provisions of subdivisions 1i, clause (f), and 1j, clause (d), shall apply to voluntary payment, settlement, or satisfaction of the lien.

(e) If no probate proceedings have been commenced for the recipient as of the date the lien holder executes a release of the lien on a recipient's life estate or joint tenancy interest, created for purposes of this section, the release shall terminate the life estate or joint tenancy interest created under this section as of the date it is recorded or filed to the extent of the release. If the claimant executes a release for purposes of extinguishing a life estate or a joint tenancy interest created under this section to remove a cloud on title to real property, the release shall have the effect of extinguishing any life estate or joint tenancy interests in the property it describes which may have been continued by reason of this section retroactive to the date of death of the deceased life tenant or joint tenant except as provided for in section 514.981, subdivision 6.

(f) If the deceased recipient's estate is probated, a claim shall be filed under this section. The amount of the lien shall be limited to the amount of the claim as finally allowed. If the claim the lien secures is filed under subdivision 1h, the lien may be released in full after any allowance of the claim becomes final or according to any agreement to settle and satisfy the claim. The release shall release the lien but shall not extinguish or terminate the interest being released. If the claim the lien secures is filed under subdivision 1i or 1j, the lien shall be released after the lien under subdivision 1i or 1j is filed or recorded, or settled according to any agreement to settle and satisfy the claim. The release shall not extinguish or terminate the interest being released. If the claim is finally disallowed in full, the claimant shall release the claimant's lien at the claimant's expense.

**EFFECTIVE DATE.** This section takes effect on August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 46. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1g. **ESTATE PROPERTY.** Notwithstanding any law or rule to the contrary, if a claim is presented under this section, interests or the proceeds of interests in real property a decedent owned as a life tenant or a joint tenant with a right of survivorship shall be part of the decedent's estate, subject to administration, and shall be dealt with as provided in this section.

**EFFECTIVE DATE.** This section takes effect on August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 47. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1h. **ESTATES OF SPECIFIC PERSONS RECEIVING MEDICAL ASSISTANCE.** (a) For purposes of this section, paragraphs (b) to (k) apply if a person received medical assistance for which a claim may be filed under this section and died single, or the surviving spouse of the couple and was not survived by any of the persons described in subdivisions 3 and 4.

(b) For purposes of this section, the person's estate consists of: (1) their probate estate; (2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death; (3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent they become part of the probate estate under section 524.6-307; and (4) all of the person's interests in joint accounts, multiple party accounts, and pay on death accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent they become part of the probate estate under section 524.6-207. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section shall be a creditor under section 524.6-307.

(c) Notwithstanding any law or rule to the contrary, the person's life estate or joint tenancy interest in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon the person's death and shall continue as provided in this subdivision. The life estate in the person's estate shall be that portion of the interest in the real property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in real property in the estate shall be equal to the fractional interest the person would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the person died.

(d) The court upon its own motion, or upon motion by the personal representative or any interested party, may enter an order directing the remaindermen or surviving joint tenants and their spouses, if any, to sign all documents, take all actions, and otherwise fully cooperate with the personal representative and the court to liquidate the decedent's life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of those interests to the personal representative and provide for any legal and equitable sanctions as the court deems appropriate to enforce and carry out the order, including an award of reasonable attorney fees.

(e) The personal representative may make, execute, and deliver any conveyances or other documents necessary to convey the decedent's life estate or joint tenancy

interest in the estate that are necessary to liquidate and reduce to cash the decedent's interest or for any other purposes.

(f) Subject to administration, all costs, including reasonable attorney fees, directly and immediately related to liquidating the decedent's life estate or joint tenancy interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation allocable to the decedent's interest and the net proceeds shall be turned over to the personal representative and applied to payment of the claim presented under this section.

(g) The personal representative shall bring a motion in the district court in which the estate is being probated to compel the remaindermen or surviving joint tenants to account for and deliver to the personal representative all or any part of the proceeds of any sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the decedent's life estate or joint tenancy interest in the decedent's estate, and do everything necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of the sale or other disposition over to the personal representative. The court may grant any legal or equitable relief including, but not limited to, ordering a partition of real estate under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy interest available to the estate for payment of a claim under this section.

(h) Subject to administration, the personal representative shall use all of the cash or proceeds of interests to pay an allowable claim under this section. The remaindermen or surviving joint tenants and their spouses, if any, may enter into a written agreement with the personal representative or the claimant to settle and satisfy obligations imposed at any time before or after a claim is filed.

(i) The personal representative may, at their discretion, provide any or all of the other owners, remaindermen, or surviving joint tenants with an affidavit terminating the decedent's estate's interest in real property the decedent owned as a life tenant or as a joint tenant with others, if the personal representative determines in good faith that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section, or if the personal representative has filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as presented, or if there is a written agreement under paragraph (h), or if the claim, as allowed, has been paid in full or to the full extent of the assets the estate has available to pay it. The affidavit may be recorded in the office of the county recorder or filed in the office of the registrar of titles for the county in which the real property is located. Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a joint tenant with others. The affidavit shall: (1) be signed by the personal representative; (2) identify the decedent and the interest being terminated; (3) give recording information sufficient to identify the instrument that created the interest in real property being terminated; (4) legally describe the affected real property; (5) state that the personal representative has determined that neither the decedent nor any of the decedent's predeceased spouses

received any medical assistance for which a claim could be filed under this section; (6) state that the decedent's estate has other assets sufficient to pay the claim, as presented, or that there is a written agreement between the personal representative and the claimant and the other owners or remaindermen or other joint tenants to satisfy the obligations imposed under this subdivision; and (7) state that the affidavit is being given to terminate the estate's interest under this subdivision, and any other contents as may be appropriate.

The recorder or registrar of titles shall accept the affidavit for recording or filing. The affidavit shall be effective as provided in this section and shall constitute notice even if it does not include recording information sufficient to identify the instrument creating the interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

(j) The holder of a lien arising under subdivision 1c shall release the lien at the holder's expense against an interest terminated under paragraph (h) to the extent of the termination.

(k) If a lien arising under subdivision 1c is not released under paragraph (j), prior to closing the estate, the personal representative shall deed the interest subject to the lien to the remaindermen or surviving joint tenants as their interests may appear. Upon recording or filing, the deed shall work a merger of the recipient's life estate or joint tenancy interest, subject to the lien, into the remainder interest or interest the decedent and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest at the time of the decedent's death.

**EFFECTIVE DATE.** This section takes effect on August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 48. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1i. **ESTATES OF PERSONS RECEIVING MEDICAL ASSISTANCE AND SURVIVED BY OTHERS.** (a) For purposes of this subdivision, the person's estate consists of the person's probate estate and all of the person's interests in real property the person owned as a life tenant or a joint tenant at the time of the person's death.

(b) Notwithstanding any law or rule to the contrary, this subdivision applies if a person received medical assistance for which a claim could be filed under this section but for the fact the person was survived by a spouse or by a person listed in subdivision 3, or if subdivision 4 applies to a claim arising under this section.

(c) The person's life estate or joint tenancy interests in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon death and shall continue as provided in this subdivision. The life estate in the estate shall be the portion of the interest in the property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date

of the person's death. The joint tenancy interest in the estate shall be equal to the fractional interest the medical assistance recipient would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the medical assistance recipient died.

(d) The county agency shall file a claim in the estate under this section on behalf of the claimant who shall be the commissioner of human services, notwithstanding that the decedent is survived by a spouse or a person listed in subdivision 3. The claim, as allowed, shall not be paid by the estate and shall be disposed of as provided in this paragraph. The personal representative or the court shall make, execute, and deliver a lien in favor of the claimant on the decedent's interest in real property in the estate in the amount of the allowed claim on forms provided by the commissioner to the county agency filing the lien. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

(e) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles for each county in which any of the real property is located. The recorder or registrar of titles shall accept the lien for filing or recording. All recording or filing fees shall be paid by the department of human services. The recorder or registrar of titles shall mail the recorded lien to the department of human services. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. Upon recording or filing of a lien against a life estate or a joint tenancy interest, the interest subject to the lien shall merge into the remainder interest or the interest the recipient and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.

(f) The department shall make no adjustment or recovery under the lien until after the decedent's spouse, if any, has died, and only at a time when the decedent has no surviving child described in subdivision 3. The estate, any owner of an interest in the property which is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. Such payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient, and neither the process of settling the claim, the payment of the claim, or the acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

(g) The lien under this subdivision may be enforced or foreclosed in the manner provided by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien is paid, satisfied, or otherwise discharged, the state or county agency shall prepare and file a release of lien at its own expense. No action to foreclose the lien shall be commenced unless the lien holder has first given 30 days' prior written notice to pay the lien to the owners and parties in

possession of the property subject to the lien. The notice shall: (1) include the name, address, and telephone number of the lien holder; (2) describe the lien; (3) give the amount of the lien; (4) inform the owner or party in possession that payment of the lien in full must be made to the lien holder within 30 days after service of the notice or the lien holder may begin proceedings to foreclose the lien; and (5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service of the notice shall be complete upon mailing or publication.

**EFFECTIVE DATE.** This section takes effect August 1, 2003, and applies to estates of decedents who die on or after that date.

Sec. 49. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1j. **CLAIMS IN ESTATES OF DECEDENTS SURVIVED BY OTHER SURVIVORS.** For purposes of this subdivision, the provisions in subdivision 1i, paragraphs (a) to (c) apply.

(a) If payment of a claim filed under this section is limited as provided in subdivision 4, and if the estate does not have other assets sufficient to pay the claim in full, as allowed, the personal representative or the court shall make, execute, and deliver a lien on the property in the estate that is exempt from the claim under subdivision 4 in favor of the commissioner of human services on forms provided by the commissioner to the county agency filing the claim. If the estate pays a claim filed under this section in full from other assets of the estate, no lien shall be filed against the property described in subdivision 4.

(b) The lien shall be in an amount equal to the unpaid balance of the allowed claim under this section remaining after the estate has applied all other available assets of the estate to pay the claim. The property exempt under subdivision 4 shall not be sold, assigned, transferred, conveyed, encumbered, or distributed until after the personal representative has determined the estate has other assets sufficient to pay the allowed claim in full, or until after the lien has been filed or recorded. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

(c) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles in each county in which any of the real property is located. The department shall pay the filing fees. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. The recorder or registrar of titles shall accept the lien for filing or recording.

(d) The commissioner shall make no adjustment or recovery under the lien until none of the persons listed in subdivision 4 are residing on the property or until the

property is sold or transferred. The estate or any owner of an interest in the property that is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. The payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient and neither the process of settling the claim, the payment of the claim, or acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

(e) A lien under this subdivision may be enforced or foreclosed in the manner provided for by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien has been paid, satisfied, or otherwise discharged, the claimant shall prepare and file a release of lien at the claimant's expense. No action to foreclose the lien shall be commenced unless the lien holder has first given 30 days prior written notice to pay the lien to the record owners of the property and the parties in possession of the property subject to the lien. The notice shall: (1) include the name, address, and telephone number of the lien holder; (2) describe the lien; (3) give the amount of the lien; (4) inform the owner or party in possession that payment of the lien in full must be made to the lien holder within 30 days after service of the notice or the lien holder may begin proceedings to foreclose the lien; and (5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service shall be complete upon mailing or publication.

(f) Upon filing or recording of a lien against a life estate or joint tenancy interest under this subdivision, the interest subject to the lien shall merge into the remainder interest or the interest the decedent and others owned jointly, effective on the date of recording and filing. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.

(g)(1) An affidavit may be provided by a personal representative, at their discretion, stating the personal representative has determined in good faith that a decedent survived by a spouse or a person listed in subdivision 3, or by a person listed in subdivision 4, or the decedent's predeceased spouse did not receive any medical assistance giving rise to a claim under this section, or that the real property described in subdivision 4 is not needed to pay in full a claim arising under this section.

(2) The affidavit shall: (i) describe the property and the interest being extinguished; (ii) name the decedent and give the date of death; (iii) state the facts listed in clause (1); (iv) state that the affidavit is being filed to terminate the life estate or joint tenancy interest created under this subdivision; (v) be signed by the personal representative; and (vi) contain any other information that the affiant deems appropriate.

(3) Except as provided in section 514.981, subdivision 6, when the affidavit is filed or recorded, the life estate or joint tenancy interest in real property that the

affidavit describes shall be terminated effective as of the date of filing or recording. The termination shall be final and may not be set aside for any reason.

**EFFECTIVE DATE.** This section takes effect on August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 50. Minnesota Statutes 2002, section 256B.15, is amended by adding a subdivision to read:

Subd. 1k. **FILING.** Any notice, lien, release, or other document filed under subdivisions 1c to 1l, and any lien, release of lien, or other documents relating to a lien filed under subdivisions 1h, 1i, and 1j must be filed or recorded in the office of the county recorder or registrar of titles, as appropriate, in the county where the affected real property is located. Notwithstanding section 386.77, the state or county agency shall pay any applicable filing fee. An attestation, certification, or acknowledgment is not required as a condition of filing. If the property described in the filing is registered property, the registrar of titles shall record the filing on the certificate of title for each parcel of property described in the filing. If the property described in the filing is abstract property, the recorder shall file and index the property in the county's grantor-grantee indexes and any tract indexes the county maintains for each parcel of property described in the filing. The recorder or registrar of titles shall return the filed document to the party filing it at no cost. If the party making the filing provides a duplicate copy of the filing, the recorder or registrar of titles shall show the recording or filing data on the copy and return it to the party at no extra cost.

**EFFECTIVE DATE.** This section takes effect on August 1, 2003, and applies to the estates of decedents who die on or after that date.

Sec. 51. Minnesota Statutes 2002, section 256B.15, subdivision 3, is amended to read:

Subd. 3. **SURVIVING SPOUSE, MINOR, BLIND, OR DISABLED CHILDREN.** If a decedent ~~who~~ is survived by a spouse, or was single~~,~~ or ~~who was~~ the surviving spouse of a married couple~~,~~ and is survived by a child who is under age 21 or blind or permanently and totally disabled according to the supplemental security income program criteria, ~~no~~ a claim shall be filed against the estate according to this section.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to decedents who die on or after that date.

Sec. 52. Minnesota Statutes 2002, section 256B.15, subdivision 4, is amended to read:

Subd. 4. **OTHER SURVIVORS.** If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate in an amount not to exceed the value of the nonhomestead property included in the estate and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid

balance of the claim to the claimant as provided under this section:

(a) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

(b) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to decedents who die on or after that date.

Sec. 53. Minnesota Statutes 2002, section 256B.195, subdivision 3, is amended to read:

Subd. 3. **PAYMENTS TO CERTAIN SAFETY NET PROVIDERS.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated after noon on the 15th of each month:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

(1) if the payments under subdivision 5 are approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments; or

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

Sec. 54. Minnesota Statutes 2002, section 256B.195, subdivision 5, is amended to read:

Subd. 5. **INCLUSION OF FAIRVIEW UNIVERSITY MEDICAL CENTER.** (a) Upon federal approval of the ~~inclusion of Fairview University Medical Center in~~

~~the nonstate government category~~ payments in paragraph (b), the commissioner shall establish an intergovernmental transfer with the University of Minnesota in an amount determined by the commissioner based on the ~~increase in the~~ amount of Medicare upper payment limit ~~due solely to the inclusion of Fairview University Medical Center as a nonstate government hospital and limited~~ available for nongovernment hospitals adjusted by hospital-specific charge limits and the amount available under the hospital-specific disproportionate share limit.

(b) Effective July 1, 2003, the commissioner shall increase payments for medical assistance admissions at Fairview University Medical Center by 71 percent of the transfer plus any federal matching payments on that amount, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care. ~~From this payment, Fairview University Medical Center shall pay to the University of Minnesota the cost of the transfer, on the same day the payment is received. Eighteen percent of the transfer plus any federal matching payments shall be used as specified in subdivision 3, paragraph (b), clause (1). Payments under section 256.969, subdivision 26, may be increased above the 90 percent level specified in that subdivision within the limits of additional funding available under this subdivision. Eleven percent of the transfer shall be used to increase the grants under section 145.9268~~ Twenty-nine percent of the transfer plus federal matching funds available as a result of the transfers in subdivision 5 shall be paid to the largest ten percent of hospitals in the nongovernment hospital category as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments. The commissioner shall determine which hospitals are in the nongovernment hospital category.

Sec. 55. Minnesota Statutes 2002, section 256B.32, subdivision 1, is amended to read:

Subdivision 1. **FACILITY FEE PAYMENT.** (a) The commissioner shall establish a facility fee payment mechanism that will pay a facility fee to all enrolled outpatient hospitals for each emergency room or outpatient clinic visit provided on or after July 1, 1989. This payment mechanism may not result in an overall increase in outpatient payment rates. This section does not apply to federally mandated maximum payment limits, department approved program packages, or services billed using a nonoutpatient hospital provider number.

(b) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 56. Minnesota Statutes 2002, section 256B.69, subdivision 2, is amended to read:

Subd. 2. **DEFINITIONS.** For the purposes of this section, the following terms have the meanings given.

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692. Notwithstanding the above, Itasca county may continue to participate as a demonstration provider until July 1, 2004.

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

~~(e) This paragraph supersedes paragraph (c) as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06. Notwithstanding sections 256B.055, 256B.056, and 256B.06, an individual who becomes ineligible for the program because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible to receive medical assistance coverage through the last day of the month following the month in which the enrollee became ineligible for the medical assistance program.~~

**EFFECTIVE DATE.** This section is effective July 1, 2003, or upon federal approval, whichever is later.

Sec. 57. Minnesota Statutes 2002, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have

continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20; ~~and~~

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in an individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 58. Minnesota Statutes 2002, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **PROSPECTIVE PER CAPITA PAYMENT.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the

commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older. Payments for elderly waiver services shall be made no earlier than the month following the month in which services were received.

Sec. 59. Minnesota Statutes 2002, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **MANAGED CARE CONTRACTS.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

**EFFECTIVE DATE.** This section is effective for services rendered on or after July 1, 2003, except that the amendment to paragraph (c) is effective for services rendered on or after January 1, 2004.

Sec. 60. Minnesota Statutes 2002, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **MEDICAL EDUCATION AND RESEARCH FUND.** (a) Except as provided in paragraph (c), the commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, the following:

(1) an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments as specified in this clause. Until January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments and after the regional rate adjustments under section 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, ~~2001, $2,537,000~~ 2003, $2,157,000 from the capitation rates paid under this section plus any federal matching funds on this amount;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund.

(c) Effective July 1, 2003, the amount reduced from the prepaid general assistance medical care payments under paragraph (a), clause (1), shall be transferred to the general fund.

Sec. 61. Minnesota Statutes 2002, section 256B.69, is amended by adding a subdivision to read:

Subd. 5h. **PAYMENT REDUCTION.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, and payments to demonstration projects for persons with disabilities.

Sec. 62. Minnesota Statutes 2002, section 256B.69, subdivision 6a, is amended to read:

Subd. 6a. **NURSING HOME SERVICES.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, up to ~~90~~ 180 days of nursing facility services as defined in section 256B.0625, subdivision 2, which are provided in a nursing facility certified by the Minnesota department of health for services provided and eligible for payment under Medicaid, shall be covered under the prepaid medical assistance program for individuals who are not residing in a nursing facility at the time of enrollment in the prepaid medical assistance program. The commissioner may develop a schedule to phase in implementation of the 180-day provision.

(b) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, nursing facility services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

Sec. 63. Minnesota Statutes 2002, section 256B.69, subdivision 6b, is amended to read:

Subd. 6b. **HOME AND COMMUNITY-BASED WAIVER SERVICES.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services.

Sec. 64. Minnesota Statutes 2002, section 256B.69, is amended by adding a subdivision to read:

Subd. 6d. **PRESCRIPTION DRUGS.** Effective January 1, 2004, the commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 65. Minnesota Statutes 2002, section 256B.69, subdivision 8, is amended to read:

Subd. 8. **PREADMISSION SCREENING WAIVER.** Except as applicable to the project's operation, the provisions of section 256B.0911 are waived for the purposes of this section for recipients enrolled with demonstration providers or in the prepaid medical assistance program for seniors.

Sec. 66. Minnesota Statutes 2002, section 256B.75, is amended to read:

256B.75 **HOSPITAL OUTPATIENT REIMBURSEMENT.**

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 67. Minnesota Statutes 2002, section 256B.76, is amended to read:

256B.76 **PHYSICIAN AND DENTAL REIMBURSEMENT.**

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new provid-

ers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may, within the limits of available appropriation, increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical

access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates:

(1) a Medicare-certified comprehensive outpatient rehabilitation facility; and

(2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(e) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

(f) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor.

Sec. 68. Minnesota Statutes 2002, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.** (a) General assistance medical care may be paid for any person who is not eligible for

medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c)~~;~~, and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06~~, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing~~; or

(2)~~(i)~~ who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in ~~chapter 256B~~ section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; ~~and~~ or

(ii) who has gross countable income ~~not in excess~~ above 75 percent of ~~the assistance standards established in section 256B.056, subdivision 5c, paragraph (b), or whose excess income is spent down to that standard using a six-month budget period. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall follow the AFDC income disregard and deductions in effect under the July 16, 1996, AFDC state plan. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed;~~

~~(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases; or~~

~~(4) who is ineligible for medical assistance under chapter 256B or general assistance medical care under any other provision of this section, and is receiving care and rehabilitation services from a nonprofit center established to serve victims of torture. These individuals are eligible for general assistance medical care only for the period during which they are receiving services from the center. During this period of eligibility, individuals eligible under this clause shall not be required to participate in prepaid general assistance medical care~~ the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month

budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) ~~Beginning January 1, 2000,~~ General assistance medical care may not be paid for applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are~~:~~

~~(i)~~ adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines~~;~~ ~~or.~~

~~(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256L.04, subdivision 7, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare. Earned income is deemed available to family members as defined in section 256D.02, subdivision 8.~~

(c) For ~~services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month~~ applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e).

(d) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and social security number, signed and dated, to the county agency or the department of human services. If the applicant is unable to provide ~~an initial application~~ a name, address, social security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on ~~the person's~~ an applicant's behalf to ~~complete~~ the establish the date of an initial Minnesota health care program application by providing the county agency or department of human services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary. ~~On the basis of information~~

~~provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:~~

~~(1) has gross income less than 90 percent of the applicable income standard;~~

~~(2) has liquid assets that total within $300 of the asset standard;~~

~~(3) does not reside in a long-term care facility; and~~

~~(4) meets all other eligibility requirements.~~

~~The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.~~

(e) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(f) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(g) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance. ~~General assistance medical care is limited to payment of emergency services only for applicants or recipients as described in paragraph (b), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256L.06 and 256L.07.~~

(h) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar

year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(i) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193, sections 421 and 422, and subsequently set out in federal rules.

(j)~~(1)~~ ~~An~~ Undocumented ~~noncitizen or a nonimmigrant is~~ noncitizens and nonimmigrants are ineligible for general assistance medical care ~~other than emergency services,~~ except an individual eligible under paragraph (a), clause (4), remains eligible through September 30, 2003. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

~~(2) This paragraph does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96-422, section 501(e)(1) or (2)(a), or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, or effective October 1, 1998, to an individual eligible for general assistance medical care under paragraph (a), clause (4), who cooperates with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.~~

(k) ~~For purposes of paragraphs (g) and (j), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.~~

~~(l)~~ Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(l) Effective July 1, 2003, general assistance medical care emergency services end.

**EFFECTIVE DATE.** (a) The amendments to paragraph (a), clauses (1) to (4), and paragraphs (b), (c), and (h), are effective October 1, 2003. For applications processed within one calendar month prior to the effective date, eligibility will be determined by applying the income standards and methodologies in effect prior to the

effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month will be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b) The amendments to paragraphs (d), (g), (j), and (k), are effective July 1, 2003.

Sec. 69. Minnesota Statutes 2002, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **GENERAL ASSISTANCE MEDICAL CARE; SERVICES.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause ~~(3)~~ (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) ~~Except as provided in paragraph (c), for a recipient who is eligible under subdivision 3, paragraph (a), clause (1) or (2), general assistance medical care covers the services listed in paragraph (a) with the exception of special transportation services.~~

~~(c)~~ Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

~~(d)~~ (c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the

opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. ~~Notwithstanding the provisions of subdivision 3, an individual who becomes ineligible for general assistance medical care because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible for general assistance medical care coverage through the last day of the month in which the enrollee became ineligible for general assistance medical care.~~

~~(e) There shall be no copayment required of any recipient of benefits for any services provided under this subdivision.~~

~~A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.~~

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, mental health professional, advanced practice nurse, physical therapist, occupational therapist, speech therapist, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on basic restorative dental services.

(e) Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

~~(f)~~ (g) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(g)~~ (h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(h)~~ (i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(i)~~ (j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

**EFFECTIVE DATE.** This section is effective October 1, 2003, except that paragraph (c) is effective July 1, 2003.

Sec. 70. Minnesota Statutes 2002, section 256G.05, subdivision 2, is amended to read:

Subd. 2. **NON-MINNESOTA RESIDENTS.** State residence is not required for receiving emergency assistance in the Minnesota supplemental aid program. The receipt of emergency assistance must not be used as a factor in determining county or state residence. ~~Non-Minnesota residents are not eligible for emergency general assistance medical care, except emergency hospital services, and professional services incident to the hospital services, for the treatment of acute trauma resulting from an accident occurring in Minnesota. To be eligible under this subdivision a non-Minnesota resident must verify that they are not eligible for coverage under any other health care program, including coverage from a program in their state of residence.~~

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 71. Minnesota Statutes 2002, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **COVERED HEALTH SERVICES.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than ~~preventive services~~ services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. ~~Effective July 1, 1998, adult dental care for nonpreventive services with the exception of orthodontic services is available to persons who qualify under section 256L.04, subdivisions 1 to 7, with family gross income equal to or less than 175 percent of the federal poverty guidelines.~~ Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

**EFFECTIVE DATE.** This section is effective October 1, 2003.

Sec. 72. **[256L.035] LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.**

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay, outpatient hospital services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year and the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive physician visit.

For purposes of this subdivision, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary.

Enrollees are responsible for all co-payments in this subdivision.

(b) The November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007, shall assume an adjustment in the aggregate cap on the services identified in paragraph (a), clause (3), in $1,000 increments up to a maximum of $10,000, but not less than $2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. The aggregate cap shall be adjusted according to the forecast.

(c) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (d).

(d) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

**EFFECTIVE DATE.** This section is effective October 1, 2003.

Sec. 73. Minnesota Statutes 2002, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **FAMILIES WITH CHILDREN.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children ~~and dependent siblings~~, if the children ~~and their dependent siblings~~ are eligible. Children ~~and dependent siblings~~ may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.

**EFFECTIVE DATE.** This section is effective October 1, 2003, unless the statutory language specifies a different effective date.

Sec. 74. Minnesota Statutes 2002, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **CITIZENSHIP REQUIREMENTS.** Eligibility for MinnesotaCare is limited to citizens of the United States, qualified noncitizens, and other persons residing lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

Subd. 10a. **SPONSOR'S INCOME AND RESOURCES DEEMED AVAILABLE; DOCUMENTATION.** When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a, shall be deemed to include their sponsors' income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law ~~Number~~ 104-193, sections 421 and 422, and subsequently set out in federal rules. To be eligible for the program, noncitizens must provide documentation of their immigration status.

Sec. 75. Minnesota Statutes 2002, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **RENEWAL OF ELIGIBILITY.** (a) Beginning January 1, 1999, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Beginning October 1, 2004, an enrollee's eligibility must be renewed every six months. The first six-month period of eligibility begins in the month after the month the application is approved. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

Sec. 76. Minnesota Statutes 2002, section 256L.05, subdivision 4, is amended to read:

Subd. 4. **APPLICATION PROCESSING.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from

the date that the application is received by the department of human services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare. ~~Once annually at application or reenrollment, to prevent processing delays, applicants or enrollees who, from the information provided on the application, appear to meet eligibility requirements shall be enrolled upon timely payment of premiums. The enrollee must provide all required verifications within 30 days of notification of the eligibility determination or coverage from the program shall be terminated. Enrollees who are determined to be ineligible when verifications are provided shall be disenrolled from the program.~~

**EFFECTIVE DATE.** This section is effective July 1, 2003, or upon federal approval, whichever is later.

Sec. 77. Minnesota Statutes 2002, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **COMMISSIONER'S DUTIES AND PAYMENT.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or ~~annual~~ semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

**EFFECTIVE DATE.** This section is effective October 1, 2004.

Sec. 78. Minnesota Statutes 2002, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **GENERAL REQUIREMENTS.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than ~~175~~ 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than ~~175~~ 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c)(1) Notwithstanding paragraph (b), ~~individuals and~~ families enrolled in MinnesotaCare under section 256L.04, subdivision 1, may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota comprehensive health association. ~~Individuals and~~ Families who are no longer eligible for MinnesotaCare under this subdivision shall be given an 18-month notice period from the date that ineligibility is determined before disenrollment. This clause expires February 1, 2004.

(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota comprehensive health association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

**EFFECTIVE DATE.** The amendments to paragraph (a) are effective July 1, 2003. The amendments to paragraph (c), clause (1), are effective October 1, 2003.

Sec. 79. Minnesota Statutes 2002, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **OTHER HEALTH COVERAGE.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than ~~175~~ 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, Medicare Part A or B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4, is considered health coverage. An applicant or enrollee may not refuse Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) Effective October 1, 2003, applicants who were recipients of medical assistance and had cost-effective health insurance which was paid for by medical assistance are exempt from the four-month requirement under this section.

**EFFECTIVE DATE.** This section is effective July 1, 2003, except where a different effective date is specified in the text.

Sec. 80. Minnesota Statutes 2002, section 256L.12, subdivision 6, is amended to read:

Subd. 6. **COPAYMENTS AND BENEFIT LIMITS.** Enrollees are responsible for all copayments in ~~section~~ sections 256L.03, subdivision 4 5, and 256L.035, and shall pay copayments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Sec. 81. Minnesota Statutes 2002, section 256L.12, subdivision 9, is amended to read:

Subd. 9. **RATE SETTING; PERFORMANCE WITHHOLDS.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2003, to December 31, 2003, the commissioner shall withhold .5 percent of managed care plan payments under this section pending completion of performance targets. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year if performance targets in the contract are achieved. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(c) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

**EFFECTIVE DATE.** This section is effective for services rendered on or after July 1, 2003, except as otherwise provided in the statutory language.

Sec. 82. Minnesota Statutes 2002, section 256L.12, is amending by adding a subdivision to read:

Subd. 9a. **RATE SETTING; RATABLE REDUCTION.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent.

Sec. 83. Minnesota Statutes 2002, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **PREMIUM DETERMINATION.** (a) Families with children and individuals shall pay a premium determined according to ~~a sliding fee based on a percentage of the family's gross family income~~ subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

Sec. 84. Minnesota Statutes 2002, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF GROSS INDIVIDUAL OR FAMILY INCOME.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

(b)(1) Enrolled ~~individuals and~~ families whose gross annual income increases above 275 percent of the federal poverty guideline shall pay the maximum premium. This clause expires effective February 1, 2004.

(2) Effective February 1, 2004, children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium.

**New language is indicated by** underline, **deletions by** ~~strikeout.~~

(3) The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

**EFFECTIVE DATE.** The amendments to this section are effective October 1, 2003, unless specified otherwise in the statutory text.

Sec. 85. Minnesota Statutes 2002, section 256L.15, subdivision 3, is amended to read:

Subd. 3. **EXCEPTIONS TO SLIDING SCALE.** An annual premium of $48 is required for all children in families with income at or less than ~~175~~ 150 percent of federal poverty guidelines.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 86. Minnesota Statutes 2002, section 256L.17, subdivision 2, is amended to read:

Subd. 2. **LIMIT ON TOTAL ASSETS.** (a) Effective July 1, 2002, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than ~~$30,000~~ $20,000 in total net assets, and a household of one person must not own more than ~~$15,000~~ $10,000 in total net assets.

(b) For purposes of this subdivision, assets are determined according to section 256B.056, subdivision 3c.

**EFFECTIVE DATE.** This section is effective July 1, 2003.

Sec. 87. Minnesota Statutes 2002, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **EXEMPTIONS.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57:

(1) payments received for services provided under the Medicare program, including payments received from the government, and organizations governed by sections 1833 and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, and enrollee deductibles, coinsurance, and co-payments, whether paid by the Medicare enrollee or by a Medicare supplemental coverage as defined in section 62A.011, subdivision 3, clause (10). Payments for services not covered by Medicare are taxable;

(2) ~~medical assistance payments including payments received directly from the government or from a prepaid plan;~~

~~(3)~~ payments received for home health care services;

~~(4)~~ (3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), ~~(2), (7), (8), (10)~~ (7), ~~(13)~~ (10), or ~~(20)~~ (17);

~~(5)~~ (4) payments received from health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), ~~(2), (7), (8), (10)~~ (7), ~~(13)~~ (10), or ~~(20)~~ (17);

~~(6)~~ (5) amounts paid for legend drugs, other than nutritional products, to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursements received for legend drugs otherwise exempt under this chapter;

~~(7) payments received under the general assistance medical care program including payments received directly from the government or from a prepaid plan;~~

~~(8) payments received for providing services under the MinnesotaCare program including payments received directly from the government or from a prepaid plan and enrollee deductibles, coinsurance, and copayments. For purposes of this clause, coinsurance means the portion of payment that the enrollee is required to pay for the covered service;~~

~~(9)~~ (6) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

~~(10)~~ (7) payments received from the chemical dependency fund under chapter 254B;

~~(11)~~ (8) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

~~(12)~~ (9) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

~~(13)~~ (10) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under medical assistance, general assistance medical care, or the MinnesotaCare program;

~~(14)~~ (11) payments received for services provided by community residential mental health facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, community support programs and family community support programs approved under Minnesota Rules, parts 9535.1700 to 9535.1760, and community mental health centers as defined in section 245.62, subdivision 2;

~~(15)~~ (12) government payments received by a regional treatment center;

~~(16)~~ (13) payments received for hospice care services;

~~(17)~~ (14) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota;

~~(18)~~ (15) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants. Fee for service payments and payments for extended coverage are taxable;

~~(19)~~ (16) payments received for services provided by: assisted living programs and congregate housing programs; and

~~(20)~~ (17) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990.

(b) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

**EFFECTIVE DATE.** This section is effective for services rendered on or after January 1, 2004.

Sec. 88. Minnesota Statutes 2002, section 297I.15, subdivision 1, is amended to read:

Subdivision 1. **GOVERNMENT PAYMENTS.** Premiums under ~~medical assistance, general assistance medical care, the MinnesotaCare program, and~~ the Minnesota comprehensive health insurance plan and all payments, revenues, and reimbursements received from the federal government for Medicare-related coverage as defined in section 62A.31, subdivision 3, are not subject to tax under this chapter.

**EFFECTIVE DATE.** This section is effective for premiums paid to health carriers on or after January 1, 2004.

Sec. 89. Minnesota Statutes 2002, section 297I.15, subdivision 4, is amended to read:

Subd. 4. **PREMIUMS PAID TO HEALTH CARRIERS BY STATE.** A health carrier as defined in section 62A.011 is exempt from the taxes imposed under this chapter on premiums paid to it by the state. Premiums paid by the state under medical assistance, general assistance medical care, and the MinnesotaCare program are not exempt under this subdivision.

**EFFECTIVE DATE.** This section is effective for premiums paid to health carriers on or after January 1, 2004.

Sec. 90. Minnesota Statutes 2002, section 514.981, subdivision 6, is amended to read:

Subd. 6. **TIME LIMITS; CLAIM LIMITS; LIENS ON LIFE ESTATES AND JOINT TENANCIES.** (a) A medical assistance lien is a lien on the real property it describes for a period of ten years from the date it attaches according to section 514.981, subdivision 2, paragraph (a), except as otherwise provided for in sections 514.980 to 514.985. The agency may renew a medical assistance lien for an additional ten years from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the medical assistance lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The registrar of titles or the recorder shall file, record, index, and return the certificate of renewal in the same manner as provided for medical assistance liens in section 514.982, subdivision 2.

(b) A medical assistance lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the agency's medical assistance lien in whole or in part because of the homestead exemption under section 256B.15, subdivision 4, the rights of the surviving spouse or minor children under section 524.2-403, paragraphs (a) and (b), or claims with a priority under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult children to exempt property under section 524.2-403, paragraph (b), shall not be considered costs of administration under section 524.3-805, paragraph (a), clause (1).

(c) Notwithstanding any law or rule to the contrary, the provisions in clauses (1) to (7) apply if a life estate subject to a medical assistance lien ends according to its terms, or if a medical assistance recipient who owns a life estate or any interest in real property as a joint tenant that is subject to a medical assistance lien dies.

(1) The medical assistance recipient's life estate or joint tenancy interest in the real property shall not end upon the recipient's death but shall merge into the remainder interest or other interest in real property the medical assistance recipient owned in joint tenancy with others. The medical assistance lien shall attach to and run with the remainder or other interest in the real property to the extent of the medical assistance recipient's interest in the property at the time of the recipient's death as determined under this section.

(2) If the medical assistance recipient's interest was a life estate in real property, the lien shall be a lien against the portion of the remainder equal to the percentage factor for the life estate of a person the medical assistance recipient's age on the date the life estate ended according to its terms or the date of the medical assistance recipient's death as listed in the Life Estate Mortality Table in the health care program's manual.

(3) If the medical assistance recipient owned the interest in real property in joint tenancy with others, the lien shall be a lien against the portion of that interest equal to the fractional interest the medical assistance recipient would have owned in the jointly owned interest had the medical assistance recipient and the other owners held title to that interest as tenants in common on the date the medical assistance recipient died.

(4) The medical assistance lien shall remain a lien against the remainder or other jointly owned interest for the length of time and be renewable as provided in paragraph (a).

(5) Subdivision 5, paragraphs (a), clause (4), (b), clauses (1) and (2); and subdivision 6, paragraph (b), do not apply to medical assistance liens which attach to interests in real property as provided under this subdivision.

(6) The continuation of a medical assistance recipient's life estate or joint tenancy interest in real property after the medical assistance recipient's death for the purpose of recovering medical assistance provided for in sections 514.980 to 514.985 modifies common law principles holding that these interests terminate on the death of the holder.

(7) Notwithstanding any law or rule to the contrary, no release, satisfaction, discharge, or affidavit under section 256B.15 shall extinguish or terminate the life estate or joint tenancy interest of a medical assistance recipient subject to a lien under sections 514.980 to 514.985 on the date the recipient dies.

(8) The provisions of clauses (1) to (7) do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

**EFFECTIVE DATE.** This section is effective August 1, 2003, and applies to all medical assistance liens recorded or filed on or after that date.

Sec. 91. Minnesota Statutes 2002, section 641.15, subdivision 2, is amended to read:

Subd. 2. **MEDICAL AID.** Except as provided in section 466.101, the county board shall pay the costs of medical services provided to prisoners. The amount paid

by the Anoka county board for a medical service shall not exceed the maximum allowed medical assistance payment rate for the service, as determined by the commissioner of human services. The county is entitled to reimbursement from the prisoner for payment of medical bills to the extent that the prisoner to whom the medical aid was provided has the ability to pay the bills. The prisoner shall, at a minimum, incur copayment obligations for health care services provided by a county correctional facility. The county board shall determine the copayment amount. Notwithstanding any law to the contrary, the copayment shall be deducted from any of the prisoner's funds held by the county, to the extent possible. If there is a disagreement between the county and a prisoner concerning the prisoner's ability to pay, the court with jurisdiction over the defendant shall determine the extent, if any, of the prisoner's ability to pay for the medical services. If a prisoner is covered by health or medical insurance or other health plan when medical services are provided, the county providing the medical services has a right of subrogation to be reimbursed by the insurance carrier for all sums spent by it for medical services to the prisoner that are covered by the policy of insurance or health plan, in accordance with the benefits, limitations, exclusions, provider restrictions, and other provisions of the policy or health plan. The county may maintain an action to enforce this subrogation right. The county does not have a right of subrogation against the medical assistance program or the general assistance medical care program.

Sec. 92. **PHARMACY PLUS WAIVER.**

(a) The commissioner of human services shall seek a pharmacy plus federal waiver for the prescription drug program in Minnesota Statutes, section 256.955, that uses the accumulated savings from all pharmacy and asset transfer provisions in this act and previously adopted pharmacy savings strategies as the factor to prove fiscal neutrality. If the waiver is approved and federal funds are received for the prescription drug program, the commissioner shall expand eligibility for the program in the following order:

(1) increase income eligibility up to 135 percent of the federal poverty guidelines for individuals eligible under Minnesota Statutes, section 256.955, subdivision 2a; and

(2) increase income eligibility up to 135 percent of the federal poverty guidelines for individuals eligible under Minnesota Statutes, section 256.955, subdivision 2b.

(b) If eligibility is increased, the commissioner shall publish the new income eligibility levels for the program in the State Register and shall inform the agencies and organizations serving senior citizens and persons with disabilities.

Sec. 93. **REVIEW OF SPECIAL TRANSPORTATION ELIGIBILITY CRITERIA AND POTENTIAL COST SAVINGS.**

The commissioner of human services, in consultation with the commissioner of transportation and special transportation service providers, shall review eligibility criteria for medical assistance special transportation services and shall evaluate whether the level of special transportation services provided should be based on the

degree of impairment of the client, as well as the medical diagnosis. The commissioner shall also evaluate methods for reducing the cost of special transportation services, including, but not limited to:

(1) requiring providers to maintain a daily log book confirming delivery of clients to medical facilities;

(2) requiring providers to implement commercially available computer mapping programs to calculate mileage for purposes of reimbursement;

(3) restricting special transportation service from being provided solely for trips to pharmacies;

(4)modifying eligibility for special transportation;

(5) expanding alternatives to the use of special transportation services;

(6) improving the process of certifying persons as eligible for special transportation services; and

(7) examining the feasibility and benefits of licensing special transportation providers.

The commissioner shall present recommendations for changes in the eligibility criteria and potential cost-savings for special transportation services to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human services spending by January 15, 2004. The commissioner is prohibited from using a broker or coordinator to manage special transportation services until July 1, 2005, except for the purposes of checking for recipient eligibility, authorizing recipients for appropriate level of transportation, and monitoring provider compliance with Minnesota Statutes, section 256B.0625, subdivision 17. This prohibition does not apply to the purchase or management of common carrier transportation.

Sec. 94. **FEDERAL APPROVAL.**

If the amendments to Minnesota Statutes, sections 256.046, subdivision 1, and 256.98, subdivision 8, are not effective because of prohibitions in federal law, the commissioner of human services shall seek the federal waivers and authority necessary to implement the provisions.

Sec. 95. **WITHHOLD EXEMPTION.**

The commissioner of human services may exempt from the five percent withhold in Minnesota Statutes, section 256B.69, subdivision 5a, paragraph (c), and the five percent withhold in Minnesota Statutes, section 256L.12, subdivision 9, paragraph (b), a managed care plan that has entered into a managed care contract with the commissioner in accordance with Minnesota Statutes, section 256B.69 or 256L.12, if the contract was the initial contract between the managed care plan and the commissioner, and it was entered into after January 1, 2000.

If an exemption is given, the exemption shall only apply for the first five years of operation of the managed care plan.

Sec. 96. **DRUG PURCHASING PROGRAM.**

The commissioner of human services, in consultation with other state agencies, shall evaluate whether participation in a multistate or multiagency drug purchasing program can reduce costs or improve the operations of the drug benefit programs administered by the commissioner and other state agencies. The commissioner shall also evaluate the possibility of contracting with a vendor or other states for purposes of participating in a multistate or multiagency drug purchasing program. The commissioner shall submit the recommendations to the legislature by January 15, 2004.

Sec. 97. **MAIL ORDER DISPENSING OF PRESCRIPTION DRUGS.**

The commissioner of human services shall assess the cost savings that could be generated by the mail order dispensing of prescription drugs to recipients of medical assistance, general assistance medical care, and the prescription drug program. The report shall include the viability of contracting with mail order pharmacy vendors to provide mail order dispensing for state public programs. The commissioner shall report to the chairs and ranking minority members of the health and human services finance committees by January 7, 2004.

Sec. 98. **NONPROFIT FOUNDATION GRANTS.**

(a) The commissioner of human services may accept grants or donations from a nonprofit charitable foundation for the purpose of increasing dental access in the medical assistance program.

(b) The commissioner may increase the critical access dental payments under Minnesota Statutes, section 256B.76, paragraph (c), and use any money received under paragraph (a) for the nonfederal state share of the medical assistance cost.

Sec. 99. **PHARMACEUTICAL CARE DEMONSTRATION PROJECT.**

(a) The commissioner shall seek federal approval for a demonstration project to provide culturally specific pharmaceutical care to American Indian medical assistance recipients who are age 55 and older. In developing the demonstration project, the commissioner shall consult with organizations and health care providers experienced in developing and implementing culturally competent intervention strategies to manage the use of prescription drugs, over-the-counter drugs, other drug products, and native therapies by American Indian elders.

(b) For purposes of this section, "pharmaceutical care" means the provision of drug therapy and native therapy for the purpose of improving a patient's quality of life by: (1) curing a disease; (2) eliminating or reducing a patient's symptoms; (3) arresting or slowing a disease process; or (4) preventing a disease or a symptom. Pharmaceutical care involves the documented process through which a pharmacist cooperates with a patient and other professionals in designing, implementing, and monitoring a thera-

peutic plan that is expected to produce specific therapeutic outcomes, through the identification, resolution, and prevention of drug-related problems. Nothing in this project shall be construed to expand or modify the scope of practice of the pharmacist as defined in Minnesota Statutes, section 151.01, subdivision 27.

(c) Upon receipt of federal approval, the commissioner shall report to the legislature for legislative approval for implementation of the demonstration project.

Sec. 100. **HEALTH CARE PROGRAM REDUCTIONS.**

The commissioner of human services may implement changes to the medical assistance, general assistance medical care, and MinnesotaCare programs, which will result in a reduction in state expenditures during the period of July 1, 2004, through June 30, 2005. The commissioner may use the following options to achieve this savings:

(1) require providers to use generally accepted clinical practice guidelines for specific services;

(2) implement clinical care coordination programs, including chronic and acute care disease management programs; and

(3) volume purchase health services as established in Minnesota Statutes, section 256B.04, subdivision 14, except that special transportation services shall be subject to the timelines established in Minnesota Statutes, section 256B.0625, subdivision 17.

The commissioner shall notify the chairs of the house and senate health and human services policy and finance committees of any changes implemented as a result of this section.

Sec. 101. **REPEALER.**

(a) Minnesota Statutes 2002, sections 256.955, subdivision 8; and 256B.057, subdivision 1b, are repealed July 1, 2003.

(b) Minnesota Statutes 2002, section 256B.055, subdivision 10a, is repealed July 1, 2003, or upon federal approval, whichever is later.

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## ARTICLE 13A

## HEALTH AND HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The dollar amounts shown in the columns marked "APPROPRIATIONS" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws

2001, First Special Session chapter 9, as amended by Laws 2002, chapter 220, and Laws 2002, chapter 374, and are appropriated from the general fund, or any other fund named, to the agencies and for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2003" used in this article means that the appropriation or appropriations listed under it are available for the fiscal year ending June 30, 2003.

SUMMARY BY FUND

| | 2003 |
|---|---|
| General | $103,756,000 |
| Health Care Access | (1,492,000) |
| Federal TANF | 20,419,000 |

APPROPRIATIONS
Available for the Year
Ending June 30, 2003

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation $128,203,000

Summary by Fund

| | |
|---|---|
| General | 109,276,000 |
| Health Care Access | (1,492,000) |
| Federal TANF | 20,419,000 |

Subd. 2. Administrative Reimbursement/Pass-through 1,180,000

Subd. 3. Basic Health Care Grants

| | |
|---|---|
| General | 59,364,000 |
| Health Care Access | (1,492,000) |

The amounts that may be spent from this appropriation for each purpose are as follows:

| | |
|---|---|
| (a) MinnesotaCare Grants | |
| Health Care Access | (1,492,000) |
| (b) MA Basic Health Care Grants - Families and Children | |
| General | 14,708,000 |
| (c) MA Basic Health Care Grants - Elderly and Disabled | |
| General | 15,137,000 |
| (d) General Assistance Medical Care Grants | |
| General | 29,519,000 |
| Subd. 4. Continuing Care Grants | |
| General | 56,615,000 |
| The amounts that may be spent from this appropriation for each purpose are as follows: | |
| (a) Medical Assistance Long-Term Care Waivers and Home Care Grants | |
| General | 57,388,000 |
| (b) Medical Assistance Long-Term Care Facilities Grants | |
| General | 678,000 |
| (c) Group Residential Housing Grants | |
| General | (1,451,000) |
| Subd. 5. Economic Support Grants | |
| General | (6,703,000) |
| Federal TANF | 19,239,000 |
| The amounts that may be spent from the appropriation for each purpose are as follows: | |

| | |
|---|---|
| (a) Assistance to Families Grants | |
| General | (9,306,000) |
| Federal TANF | 19,239,000 |
| (b) General Assistance Grants | |
| General | 3,491,000 |
| (c) Minnesota Supplemental Aid Grants | |
| General | (888,000) |

Sec. 3. COMMISSIONER OF HEALTH

| | |
|---|---|
| Subdivision 1. Total Appropriation | (5,520,000) |
| Summary by Fund | |
| General | (5,520,000) |
| Subd. 2. Access and Quality Improvement | (5,520,000) |

Sec. 4. **EFFECTIVE DATE.**

Sections 1 to 3 are effective the day following final enactment.

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## ARTICLE 13B

## DEPARTMENT OF CHILDREN, FAMILIES, AND LEARNING FORECAST ADJUSTMENT

Section 1. **ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2001, First Special Session chapter 6, as amended by Laws 2002, chapter 220, and Laws 2002, chapter 374, or other law, and are appropriated from the general fund to the department of children, families, and learning for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2003" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2003.

| | 2003 APPROPRIATION CHANGE |
|---|---|
| Sec. 2. APPROPRIATIONS; EARLY CHILDHOOD AND FAMILY EDUCATION | |
| MFIP Child Care | 6,817,000 |

## ARTICLE 13C

## APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other fund named, to the agencies and for the purposes specified in the sections of this article, to be available for the fiscal years indicated for each purpose. The figures "2004" and "2005" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 2004, or June 30, 2005, respectively. Where a dollar amount appears in parentheses, it means a reduction of an appropriation.

SUMMARY BY FUND

| | 2004 | 2005 | BIENNIAL TOTAL |
|---|---|---|---|
| General | $3,765,212,000 | $3,727,319,000 | $7,492,531,000 |
| State Government Special Revenue | 45,337,000 | 45,104,000 | 90,441,000 |
| Health Care Access | 294,090,000 | 308,525,000 | 602,615,000 |
| Federal TANF | 261,552,000 | 270,364,000 | 531,916,000 |
| Lottery Prize Fund | 1,556,000 | 1,556,000 | 3,112,000 |
| Special Revenue | 3,340,000 | 3,340,000 | 6,680,000 |
| TOTAL | $4,371,087,000 | $4,356,208,000 | $8,727,295,000 |

| | | APPROPRIATIONS Available for the Year Ending June 30 | |
|---|---|---|---|
| | | 2004 | 2005 |
| Sec. 2. COMMISSIONER OF HUMAN SERVICES | | | |
| Subdivision 1. Total Appropriation | | $4,111,558,000 | $4,110,496,000 |
| | Summary by Fund | | |
| General | 3,566,163,000 | 3,541,854,000 | |
| State Government Special Revenue | 534,000 | 534,000 | |
| Health Care Access | 287,753,000 | 302,188,000 | |
| Federal TANF | 255,552,000 | 264,364,000 | |
| Lottery Cash Flow | 1,556,000 | 1,556,000 | |

**FEDERAL CONTINGENCY APPROPRIATION.** (a) Any additional federal Medicaid funds made available under title IV of the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 are appropriated to the commissioner of human services for use in the state's medical assistance and MinnesotaCare programs. The commissioners of human services and finance shall report to the legislative advisory committee on the additional federal Medicaid matching funds that will be available to the state.

(b) Contingent upon the availability of these funds, the following policies shall become effective and necessary funds are appropriated for those purposes:

(1) medical assistance and MinnesotaCare eligibility and local financial participation changes provided for in this act may be implemented prior to September 2, 2003,

or may be delayed as necessary to maximize the use of federal funds received under title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003;

(2) the aggregate cap on the services identified in Minnesota Statutes, section 256L.035, paragraph (a), clause (3), shall be increased from $2,000 to $5,000. This increase shall expire at the end of fiscal year 2007. Funds may be transferred from the general fund to the health care access fund as necessary to implement this provision; and

(3) the following payment shifts shall not be implemented:

(i) MFIP payment shift found in subdivision 11;

(ii) the county payment shift found in subdivision 1; and

(iii) the delay in medical assistance and general assistance medical care fee-for-service payments found in subdivision 6.

(c) Notwithstanding section 14, paragraphs (a) and (b) shall expire June 30, 2007.

**RECEIPTS FOR SYSTEMS PROJECTS.** Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota office of technology, funded by the legislature, and approved by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

**GIFTS.** Notwithstanding Minnesota Statutes, chapter 7, the commissioner may accept on behalf of the state additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

**SYSTEMS CONTINUITY.** In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the department of human services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

**NONFEDERAL SHARE TRANSFERS.** The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

**TANF FUNDS APPROPRIATED TO OTHER ENTITIES.** Any expenditures from the TANF block grant shall be expended in accordance with the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall assure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assur-

ance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

**TANF FUNDS TRANSFERRED TO OTHER FEDERAL GRANTS.** The commissioner must authorize transfers from TANF to other federal block grants so that funds are available to meet the annual expenditure needs as appropriated. Transfers may be authorized prior to the expenditure year with the agreement of the receiving entity. Transferred funds must be expended in the year for which the funds were appropriated unless appropriation language permits otherwise. In accelerating transfer authorizations, the commissioner must aim to preserve the future potential transfer capacity from TANF to other block grants.

**TANF MAINTENANCE OF EFFORT.** (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care admin-

istrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) By August 31 of each year, the commissioner shall make a preliminary calculation to determine the likelihood that the state will meet its annual federal work participation requirement under Code of Federal Regulations, title 45, sections 261.21 and 261.23, after adjustment for any caseload reduction credit under Code of Federal Regulations, title 45, section 261.41. If the commissioner determines that the state will meet its federal work participation rate for the federal fiscal year ending that September, the commissioner may reduce the expenditure under para-

graph (a), clause (1), to the extent allowed under Code of Federal Regulations, title 45, section 263.1(a)(2).

(d) For fiscal years beginning with state fiscal year 2003, the commissioner shall assure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 25 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(e) If nonfederal expenditures for the programs and purposes listed in paragraph (a) are insufficient to meet the state's TANF/MOE requirements, the commissioner shall recommend additional allowable sources of nonfederal expenditures to the legislature, if the legislature is or will be in session to take action to specify additional sources of nonfederal expenditures for TANF/MOE before a federal penalty is imposed. The commissioner shall otherwise provide notice to the legislative commission on planning and fiscal policy under paragraph (g).

(f) If the commissioner uses authority granted under section 11, or similar authority granted by a subsequent legislature, to meet the state's TANF/MOE requirement in a reporting period, the commissioner shall inform the chairs of the appropriate legislative committees about all transfers made under that authority for this purpose.

(g) If the commissioner determines that nonfederal expenditures under paragraph (a) are insufficient to meet TANF/MOE expenditure requirements, and if the legislature is not or will not be in session to take timely action to avoid a federal penalty, the

commissioner may report nonfederal expenditures from other allowable sources as TANF/MOE expenditures after the requirements of this paragraph are met. The commissioner may report nonfederal expenditures in addition to those specified under paragraph (a) as nonfederal TANF/MOE expenditures, but only ten days after the commissioner of finance has first submitted the commissioner's recommendations for additional allowable sources of nonfederal TANF/MOE expenditures to the members of the legislative commission on planning and fiscal policy for their review.

(h) The commissioner of finance shall not incorporate any changes in federal TANF expenditures or nonfederal expenditures for TANF/MOE that may result from reporting additional allowable sources of nonfederal TANF/MOE expenditures under the interim procedures in paragraph (g) into the February or November forecasts required under Minnesota Statutes, section 16A.103, unless the commissioner of finance has approved the additional sources of expenditures under paragraph (g).

(i) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(j) Notwithstanding section 14, paragraph (a), clauses (1) to (6), and paragraphs (b) to (j) expire June 30, 2007.

**WORKING FAMILY CREDIT EXPENDITURES AS TANF MOE.** The commissioner may claim as TANF maintenance of effort up to the following amounts of working family credit expenditures for the following fiscal years:

(1) fiscal year 2004, $7,013,000;

(2) fiscal year 2005, $25,133,000;

(3) fiscal year 2006, $6,942,000; and

(4) fiscal year 2007, $6,707,000.

**FISCAL YEAR 2003 APPROPRIATIONS CARRYFORWARD.** Effective the day following final enactment, notwithstanding Minnesota Statutes, section 16A.28, or any other law to the contrary, state agencies and constitutional offices may carry forward unexpended and unencumbered nongrant operating balances from fiscal year 2003 general fund appropriations into fiscal year 2004 to offset general budget reductions.

**TRANSFER OF GRANT BALANCES.** Effective the day following final enactment, the commissioner of human services, with the approval of the commissioner of finance and after notification of the chair of the senate health, human services and corrections budget division and the chair of the house of representatives health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2003, in fiscal year 2003 among the MFIP, MFIP child care assistance under Minnesota Statutes, section 119B.05, 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.

**TANF APPROPRIATION CANCELLATION.** Notwithstanding the provisions of Laws 2000, chapter 488, article 1, section 16, any prior appropriations of TANF funds

to the department of trade and economic development or to the job skills partnership board or any transfers of TANF funds from another agency to the department of trade and economic development or to the job skills partnership board are not available until expended, and if unobligated as of June 30, 2003, these appropriations or transfers shall cancel to the TANF fund.

**SHIFT COUNTY PAYMENT.** The commissioner shall 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. This is a onetime payment shift. Calendar year 2006 and future payments for these grants are not affected by this shift. This provision expires June 30, 2006.

**CAPITATION RATE INCREASE.** Of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill, $2,157,000 in fiscal year 2004 and $2,157,000 in fiscal year 2005 are to be used to increase the capitation payments under Minnesota Statutes, section 256B.69. Notwithstanding the provisions of section 14, this provision shall not expire.

Subd. 2. Agency Management

| | Summary by Fund | |
|---|---|---|
| General | 41,473,000 | 27,868,000 |
| State Government Special Revenue | 415,000 | 415,000 |
| Health Care Access | 3,673,000 | 3,673,000 |
| Federal TANF | 320,000 | 320,000 |

The amounts that may be spent from the

appropriation for each purpose are as follows:

| | | |
|---|---|---|
| (a) Financial Operations | | |
| General | 8,751,000 | 9,056,000 |
| Health Care Access | 828,000 | 828,000 |
| Federal TANF | 220,000 | 220,000 |

**SPECIAL REVENUE FUND TRANSFER.** Notwithstanding any law to the contrary, excluding accounts authorized under Minnesota Statutes, section 16A.1286, and chapter 254B, the commissioner shall transfer $1,400,000 of uncommitted special revenue fund balances to the general fund upon final enactment. The actual transfers shall be identified within the standard information provided to the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division in December 2003.

| | | |
|---|---|---|
| (b) Legal and Regulation Operations | | |
| General | 7,896,000 | 8,168,000 |
| State Government Special Revenue | 415,000 | 415,000 |
| Health Care Access | 244,000 | 244,000 |
| Federal TANF | 100,000 | 100,000 |
| (c) Management Operations | | |
| General | 17,373,000 | 3,076,000 |
| Health Care Access | 1,623,000 | 1,623,000 |
| (d) Information Technology Operations | | |
| General | 7,453,000 | 7,568,000 |
| Health Care Access | 978,000 | 978,000 |
| Subd. 3. Revenue and Pass-Through | | |
| Federal TANF | 55,855,000 | 53,315,000 |

**TANF TRANSFER TO SOCIAL SERVICES BLOCK GRANT.** $3,137,000 in fiscal year 2005 is appropriated to the commissioner for the purposes of providing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation. The funds shall be distributed to counties for the children and community services grant according to the formula for the state appropriations in Minnesota Statutes, chapter 256M.

**TANF FUNDS FOR FISCAL YEAR 2006 AND FISCAL YEAR 2007 REFINANCING.** $12,692,000 in fiscal year 2006 and $9,192,000 in fiscal year 2007 in TANF funds are available to the commissioner to replace general funds in the amount of $12,692,000 in fiscal year 2006 and $9,192,000 in fiscal year 2007 in expenditures that may be counted toward TANF maintenance of effort requirements or as an allowable TANF expenditure.

**ADJUSTMENTS IN TANF TRANSFER TO CHILD CARE AND DEVELOPMENT FUND.** Transfers of TANF to the child care development fund for the purposes of MFIP child care assistance shall be reduced by $116,000 in fiscal year 2004 and shall be increased by $1,976,000 in fiscal year 2005.

Subd. 4. Children's Services Grants

| Summary by Fund | | |
|---|---|---|
| General | 111,264,000 | 94,020,000 |
| Federal TANF | -0- | 3,137,000 |

**ADOPTION ASSISTANCE INCENTIVE GRANTS.** Federal funds available during fiscal year 2004 and fiscal year 2005, for adoption incentive grants are appropriated to the commissioner for these purposes.

**ADOPTION ASSISTANCE AND RELATIVE CUSTODY ASSISTANCE.** The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

**CHILDREN AND COMMUNITY SERVICES GRANTS.** Counties shall not reduce children and community service grant expenditures for services to adults with disabilities by more than the overall percentage of the reduction in the county's allocation of children and community service grant funds when compared to the county's calendar year 2003 allocation of former children's services and community service grants defined under Minnesota Statutes, section 256M.10, subdivision 5.

**OUT-OF-HOME PLACEMENT.** Minnesota youth who require out-of-home placement through a corrections order must be placed in a Minnesota program or facility unless a program in a border state is closer to the youth's home or there is no vacancy in an appropriate in-state program or facility. If no appropriate, cost-effective regional or in-state program is available, this must be documented in the case plan prior to placement in an out-of-state facility. Justification for out-of-state placement of Minnesota youth must be included in reports to the Minnesota department of corrections.

Subd. 5. Children's Services Management

| | | |
|---|---|---|
| General | 5,221,000 | 5,283,000 |

Subd. 6. Basic Health Care Grants

| | Summary by Fund | |
|---|---|---|
| General | 1,499,941,000 | 1,533,016,000 |
| Health Care Access | 268,151,000 | 282,605,000 |

**UPDATING FEDERAL POVERTY GUIDELINES.** Annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services for health care programs under Minnesota Statutes, chapters 256, 256B, 256D, and 256L.

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

| | | |
|---|---|---|
| Health Care Access | 267,401,000 | 281,855,000 |

**MINNESOTACARE FEDERAL RECEIPTS.** Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

**MINNESOTACARE FUNDING.** The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants - Families and Children

| | | |
|---|---|---|
| General | 568,254,000 | 582,161,000 |

**SERVICES TO PREGNANT WOMEN.** The commissioner shall use available fed-

eral money for the State-Children's Health Insurance Program for medical assistance services provided to pregnant women who are not otherwise eligible for federal financial participation beginning in fiscal year 2003. This federal money shall be deposited in the federal fund and shall offset general funds for payments to providers. Notwithstanding section 14, this paragraph shall not expire.

**MANAGED CARE RATE INCREASE.** (a) Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed care plans under Minnesota Statutes, section 256B.69, by an amount equal to the cost increases to the managed care plans from by the elimination of: (1) the exemption from the taxes imposed under Minnesota Statutes, section 297I.05, subdivision 5, for premiums paid by the state for medical assistance, general assistance medical care, and the MinnesotaCare program; and (2) the exemption of gross revenues subject to the taxes imposed under Minnesota Statutes, sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.

(b) The commissioner of human services shall increase by two percent the fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under Minnesota Statutes, sections 295.50 to 295.57, effective for services rendered on or after January 1, 2004.

(c) The commissioner of finance shall transfer from the health care access fund to the general fund the following amounts in the fiscal years indicated: 2004, $16,587,000; 2005, $46,322,000; 2006, $49,413,000; and 2007, $52,659,000.

(d) For fiscal years after 2007, the commissioner of finance shall transfer from the health care access fund to the general fund an amount equal to the revenue collected by the commissioner of revenue on the following:

(1) gross revenues received by hospitals, surgical centers, and health care providers as payments for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program, including payments received directly from the state or from a prepaid plan, under Minnesota Statutes, sections 295.50 to 295.57; and

(2) premiums paid by the state under medical assistance, general assistance medical care, and the MinnesotaCare program under Minnesota Statutes, section 297I.05, subdivision 5.

The commissioner of finance shall monitor and adjust if necessary the amount transferred each fiscal year from the health care access fund to the general fund to ensure that the amount transferred equals the tax revenue collected for the items described in clauses (1) and (2) for that fiscal year.

(e) Notwithstanding section 14, these provisions shall not expire.

| | | |
|---|---|---|
| (c) MA Basic Health Care Grants - Elderly and Disabled | | |
| General | 695,421,000 | 741,605,000 |

**DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE.** The following payments in fiscal year 2005 from the Medicaid Management Information System that would otherwise have been made to providers for medical assistance and general assistance medical care services shall be delayed and included in the first payment in fiscal year 2006:

(1) for hospitals, the last two payments; and

(2) for nonhospital providers, the last payment.

This payment delay shall not include payments to skilled nursing facilities, intermediate care facilities for mental retardation, prepaid health plans, home health agencies, personal care nursing providers, and providers of only waiver services. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 14, this provision shall not expire.

**DEAF AND HARD-OF-HEARING SERVICES.** If, after making reasonable efforts, the service provider for mental health services to persons who are deaf or hearing impaired is not able to earn $227,000 through participation in medical assistance intensive rehabilitation services in fiscal year 2005, the commissioner shall transfer $227,000 minus medical assistance earnings achieved by the grantee to deaf and hard-of-hearing grants to enable the provider to continue providing services to eligible persons.

(d) General Assistance Medical Care Grants

| | | |
|---|---|---|
| General | 223,960,000 | 196,617,000 |

(e) Health Care Grants - Other Assistance

| | | |
|---|---|---|
| General | 3,067,000 | 3,407,000 |
| Health Care Access | 750,000 | 750,000 |

**MINNESOTA PRESCRIPTION DRUG DEDICATED FUND.** Of the general fund appropriation, $284,000 in fiscal year 2005 is appropriated to the commissioner for the prescription drug dedicated fund established under the prescription drug discount program.

**DENTAL ACCESS GRANTS CARRY-OVER AUTHORITY.** Any unspent portion of the appropriation from the health care access fund in fiscal years 2002 and 2003 for dental access grants under Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed to carry forward to be spent in the biennium beginning July 1, 2003, for these purposes.

**STOP-LOSS FUND ACCOUNT.** The appropriation to the purchasing alliance stop-loss fund account established under Minnesota Statutes, section 256.956, subdivision 2, for fiscal years 2004 and 2005 shall only be available for claim reimbursements for qualifying enrollees who are members of purchasing alliances that meet the requirements described under Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3).

(f) Prescription Drug Program

| | | |
|---|---|---|
| General | 9,239,000 | 9,226,000 |

**PRESCRIPTION DRUG ASSISTANCE PROGRAM.** Of the general fund appropriation, $702,000 in fiscal year 2004 and $887,000 in fiscal year 2005 are for the commissioner to establish and administer the prescription drug assistance program through the Minnesota board on aging.

**REBATE REVENUE RECAPTURE.** Any funds received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate are appropriated to the commissioner to augment funding of the prescription drug program established in Minnesota Statutes, section 256.955.

Subd. 7. Health Care Management

| Summary by Fund | | |
|---|---|---|
| General | 24,845,000 | 26,199,000 |
| Health Care Access | 14,522,000 | 14,533,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Health Care Policy Administration

| | | |
|---|---|---|
| General | 5,523,000 | 7,223,000 |
| Health Care Access | 1,066,000 | 1,200,000 |

**PAYMENT CODE STUDY.** Of this appropriation, $345,000 each year is for a study to determine the appropriateness of eliminating reimbursement for certain payment codes under medical assistance, general assistance medical care, or MinnesotaCare. As part of the study, the commissioner shall also examine covered services under the Minnesota health care programs and make recommendations on possible modification of the services covered under the program. The commissioner shall report to the legislature by January 15, 2005, with an analysis of the feasibility of this approach, a list of codes, if any, to be eliminated from the payment system, and estimates of savings to be obtained from this approach.

**TRANSFERS FROM HEALTH CARE ACCESS FUND.** (a) Notwithstanding Minnesota Statutes, section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund during fiscal years 2005 to 2007, the excess annual funds shall be transferred from the health care access fund to the general fund on June 30 of fiscal years 2005, 2006, and 2007. These transfers shall not be reduced to accommodate MinnesotaCare expansions. The estimated amounts to be transferred are:

(1) in fiscal year 2005, $192,442,000;

(2) in fiscal year 2006, $52,943,000; and

(3) in fiscal year 2007, $59,105,000.

These estimates shall be updated with each forecast, but in no case shall the transfers exceed the amounts listed in clauses (1) to (3).

(b) The commissioner shall limit transfers under paragraph (a) in order to avoid implementation of Minnesota Statutes, section 256L.02, subdivision 3, paragraph (b).

(c) For fiscal years 2004 to 2007, MinnesotaCare shall be a forecasted program and, if necessary, the commissioner shall reduce transfers under paragraph (a) to meet forecasted expenditures.

(d) The department of human services in recommending its 2007-2008 budget shall consider the repayment of the amount transferred in fiscal years 2006 and 2007 from the health care access fund to the general fund to the health care access fund.

(e) Notwithstanding section 14, this section is in effect until June 30, 2007.

**MINNESOTACARE OUTREACH REIMBURSEMENT.** Federal administrative

reimbursement resulting from MinnesotaCare outreach is appropriated to the commissioner for this activity.

**MINNESOTA SENIOR HEALTH OPTIONS REIMBURSEMENT.** Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

**UTILIZATION REVIEW.** Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to the commissioner for these purposes. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

(b) Health Care Operations

| | | |
|---|---|---|
| General | 19,322,000 | 18,976,000 |
| Health Care Access | 13,456,000 | 13,333,000 |

**PREPAID MEDICAL PROGRAMS.** For all counties in which the PMAP program has been operating for 12 or more months, state funding for the nonfederal share of prepaid medical assistance program administration costs for county managed care advocacy and enrollment operations is eliminated. State funding will continue for these activities for counties and tribes establishing new PMAP programs for a maximum of 16 months (four months prior to beginning PMAP enrollment and through the first 12 months of their PMAP program operation). Those counties operating PMAP programs for less than 12 months can continue to receive state funding for advocacy and enrollment activities through their first year of operation.

Subd. 8. State-operated Services

| | | |
|---|---|---|
| General | 195,062,000 | 186,775,000 |

**MITIGATION RELATED TO STATE-OPERATED SERVICES RESTRUCTURING.** Money appropriated to finance mitigation expenses related to restructuring state-operated services programs and administrative services may be transferred between fiscal years within the biennium.

**REPAIRS AND BETTERMENTS.** The commissioner may transfer unencumbered appropriation balances between fiscal years within the biennium for the state residential facilities repairs and betterments account and special equipment.

**ONETIME REDUCTION TO DEDICATED REVENUES.** (a) For fiscal year 2003 only, the commissioner shall transfer $4,700,000 of state-operated services fund balances from the accounts indicated to the general fund as follows:

(1) $3,200,000 from traumatic brain injury enterprises;

(2) $1,000,000 from lease income; and

(3) $500,000 from ICF/MR depreciation.

(b) Paragraph (a) is effective the day following final enactment.

Subd. 9. Continuing Care Grants

| | Summary by Fund | |
|---|---|---|
| General | 1,504,933,000 | 1,490,958,000 |
| Lottery Prize Fund | 1,408,000 | 1,408,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Community Social Services

| | | |
|---|---|---|
| General | 496,000 | 371,000 |

(b) Aging and Adult Service Grant

| | | |
|---|---|---|
| General | 12,998,000 | 13,951,000 |

**LONG-TERM CARE PROGRAM REDUCTIONS.** For the biennium ending June 30, 2005, state funding for the following state long-term care programs is reduced by 15 percent from the level of state funding provided on June 30, 2003: SAIL project grants under Minnesota Statutes, section 256B.0917; senior nutrition programs under Minnesota Statutes, section 256.9752; foster grandparents program under Minnesota Statutes, section 256.976; retired senior volunteer program under Minnesota Statutes, section 256.9753; and the senior companion program under Minnesota Statutes, section 256.977.

(c) Deaf and Hard-of-hearing Service Grants

| | | |
|---|---|---|
| General | 1,719,000 | 1,490,000 |

(d) Mental Health Grants

| | | |
|---|---|---|
| General | 53,479,000 | 34,690,000 |
| Lottery Prize Fund | 1,408,000 | 1,408,000 |

**RESTRUCTURING OF ADULT MENTAL HEALTH SERVICES.** The commissioner may make transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

**COMPULSIVE GAMBLING.** Of the appropriation from the lottery prize fund, $250,000 each year is for the following purposes:

(1) $100,000 each year is for a grant to the Southeast Asian Problem Gambling Consortium. The consortium must provide statewide compulsive gambling prevention and treatment services for Lao, Hmong, Vietnamese, and Cambodian families, adults, and adolescents. The appropriation

in this clause shall not become part of base level funding for the biennium beginning July 1, 2005. Any unencumbered balance of the appropriation in the first year does not cancel but is available for the second year; and

(2) $150,000 each year is for a grant to a compulsive gambling council located in St. Louis county. The gambling council must provide a statewide compulsive gambling prevention and education project for adolescents. Any unencumbered balance of the appropriation in the first year of the biennium does not cancel but is available for the second year.

(e) Community Support Grants

| | | |
|---|---|---|
| General | 12,523,000 | 9,093,000 |

**CENTERS FOR INDEPENDENT LIVING STUDY.** The commissioner of human services, in consultation with the commissioner of economic security, the centers for independent living, and consumer representatives, shall study the financing of the centers for independent living authorized under Minnesota Statutes, section 268A.11, and make recommendations on options to maximize federal financial participation. Study components shall include:

(1) the demographics of individuals served by the centers for independent living;

(2) the range of services the centers for independent living provide to these individuals;

(3) other publicly funded services received by individuals supported by the centers; and

(4) strategies for maximizing federal financial participation for eligible activities carried out by centers for independent living.

The commissioner shall report with fiscal and programmatic recommendations to the chairs of the appropriate house of representatives and senate finance and policy committees by January 15, 2004.

(f) Medical Assistance Long-Term Care Waivers and Home Care Grants

General 659,211,000 718,665,000

**RATE AND ALLOCATION DECREASES FOR CONTINUING CARE PROGRAMS.** Notwithstanding any law or rule to the contrary, the commissioner of human services shall decrease reimbursement rates or reduce allocations to assure the necessary reductions in state spending for the providers or programs listed in paragraphs (a) to (d). The decreases are effective for services rendered on or after July 1, 2003.

(a) Effective July 1, 2003, the commissioner shall reduce payment rates for services and individual or service limits by one percent. The rate decreases described in this section must be applied to:

(1) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(2) day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46;

(3) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(4) chemical dependency residential and nonresidential service rates under Minnesota Statutes, section 245B.03;

(5) consumer support grants under Minnesota Statutes, section 256.476; and

(6) home and community-based services for alternative care services under Minnesota Statutes, section 256B.0913.

(b) The commissioner shall reduce allocations made available to county agencies for home and community-based waivered services to assure a one-percent reduction in state spending for services rendered on or after July 1, 2003. The commissioner shall apply the allocation decreases described in this section to:

(1) persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501;

(2) waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(3) community alternative care waivered services under Minnesota Statutes, section 256B.49; and

(4) traumatic brain injury waivered services under Minnesota Statutes, section 256B.49.

County agencies will be responsible for 100 percent of any spending in excess of the allocation made by the commissioner. Nothing in this section shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

(c) The commissioner shall reduce deaf and hard-of-hearing grants by one percent on July 1, 2003.

(d) Effective July 1, 2003, the commissioner shall reduce payment rates for each facility reimbursed under Minnesota Statutes, section 256B.5012, by decreasing the

total operating payment rate for intermediate care facilities for the mentally retarded by one percent. For each facility, the commissioner shall multiply the adjustment by the total payment rate, excluding the property-related payment rate, in effect on June 30, 2003. A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not subject to an adjustment otherwise taken under this subdivision.

Notwithstanding section 14, these adjustments shall not expire.

**REDUCE GROWTH IN MR/RC WAIVER.** The commissioner shall reduce the growth in the MR/RC waiver by not allocating the 300 additional diversion allocations that are included in the February 2003 forecast for the fiscal years that begin on July 1, 2003, and July 1, 2004.

**MANAGE THE GROWTH IN THE TBI WAIVER.** During the fiscal years beginning on July 1, 2003, and July 1, 2004, the commissioner shall allocate money for home and community-based programs covered under Minnesota Statutes, section 256B.49, to assure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 150 in each year of the biennium. Priorities for the allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

**TARGETED CASE MANAGEMENT FOR HOME CARE RECIPIENTS.** Implementation of the targeted case management benefit for home care recipients, according to Minnesota Statutes, section 256B.0621, subdivisions 2, 3, 5, 6, 7, 9, and 10, will be delayed until July 1, 2005.

**COMMON SERVICE MENU.** Implementation of the common service menu option within the home and community-based waivers, according to Minnesota Statutes, section 256B.49, subdivision 16, will be delayed until July 1, 2005.

**LIMITATION ON COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS CASELOAD GROWTH.** For the biennium ending June 30, 2005, the commissioner shall limit the allocations made available in the community alternatives for disabled individuals waiver program in order not to exceed average caseload growth of 95 per month from June 2003 program levels, plus any additional legislatively authorized program growth. The commissioner shall allocate available resources to achieve the following outcomes:

(1) the establishment of feasible and viable alternatives for persons in institutional or hospital settings to relocate to home and community-based settings;

(2) the availability of timely assistance to persons at imminent risk of institutional or hospital placement or whose health and safety is at immediate risk; and

(3) the maximum provision of essential community supports to eligible persons in need of and waiting for home and community-based service alternatives. The commissioner may reallocate resources from one county or region to another if available funding in that county or region is not likely to be spent and the reallocation is necessary to achieve the outcomes specified in this paragraph.

(g) Medical Assistance Long-term Care Facilities Grants

| | | |
|---|---|---|
| General | 543,999,000 | 514,483,000 |

(h) Alternative Care Grants

| | | |
|---|---|---|
| General | 75,206,000 | 66,351,000 |

**ALTERNATIVE CARE TRANSFER.** Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

**ALTERNATIVE CARE APPROPRIATION.** The commissioner may expend the money appropriated for the alternative care program for that purpose in either year of the biennium.

**ALTERNATIVE CARE IMPLEMENTATION OF CHANGES TO FEES AND ELIGIBILITY.** Changes to Minnesota Statutes, section 256B.0913, subdivision 4, paragraph (d), and subdivision 12, are effective July 1, 2003, for all persons found eligible for the alternative care program on or after July 1, 2003. All recipients of alternative care funding as of June 30, 2003, shall be subject to Minnesota Statutes, section 256B.0913, subdivision 4, paragraph (d), and subdivision 12, on the annual reassessment and review of their eligibility after July 1, 2003, but no later than January 1, 2004.

(i) Group Residential Housing Grants

| | | |
|---|---|---|
| General | 94,996,000 | 80,472,000 |

**GROUP RESIDENTIAL HOUSING COSTS REFINANCED.** (1) Effective July 1, 2004, the commissioner shall increase the home and community-based service rates and county allocations provided to programs for persons with disabilities

established under section 1915(c) of the Social Security Act to the extent that these programs will be paying for the costs above the rate established in Minnesota Statutes, section 256I.05, subdivision 1.

(2) For persons in receipt of services under Minnesota Statutes, section 256B.0915, who reside in licensed adult foster care beds for which a supplemental room and board payment was being made under Minnesota Statutes, section 256I.05, subdivision 1, counties may request an exception to the individual caps specified in Minnesota Statutes, section 256B.0915, subdivision 3, paragraph (b), not to exceed the difference between the individual cap and the client's monthly service expenditures plus the amount of the supplemental room and board rate. The county must submit a request to exceed the individual cap to the commissioner for approval.

| | | |
|---|---|---|
| (j) Chemical Dependency Entitlement Grants | | |
| General | 49,251,000 | 50,337,000 |
| (k) Chemical Dependency Nonentitlement Grants | | |
| General | 1,055,000 | 1,055,000 |
| Subd. 10. Continuing Care Management | | |
| Summary by Fund | | |
| General | 21,697,000 | 21,206,000 |
| State Government Special Revenue | 119,000 | 119,000 |
| Lottery Prize Fund | 148,000 | 148,000 |

**APPROPRIATION; REPORT ON LONG-TERM CARE FINANCING REFORM.** Money appropriated to the commissioner for fiscal year 2004 for the report on long-term care financing reform and

long-term care insurance purchase incentives shall not cancel but shall be available to the commissioner for that purpose in fiscal year 2005.

Subd. 11. Economic Support Grants

| | Summary by Fund | |
|---|---|---|
| General | 122,647,000 | 117,198,000 |
| Federal TANF | 199,009,000 | 207,224,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Minnesota Family Investment Program

| | | |
|---|---|---|
| General | 59,922,000 | 39,375,000 |
| Federal TANF | 106,535,000 | 110,543,000 |

(b) Work Grants

| | | |
|---|---|---|
| General | 666,000 | 14,678,000 |
| Federal TANF | 92,474,000 | 96,681,000 |

**MFIP SUPPORT SERVICES COUNTY AND TRIBAL ALLOCATION.** When determining the funds available for the consolidated MFIP support services grant in the 18-month period ending December 31, 2004, the commissioner shall apportion the funds appropriated for fiscal year 2005 in such manner as necessary to provide $14,000,000 more to counties and tribes for the period ending December 31, 2004, than would have been available had the funds been evenly divided within the fiscal year between the period before December 31, 2004, and the period after December 31, 2004.

For allocations for the calendar years starting January 1, 2005, the commissioner shall apportion the funds appropriated for each fiscal year in such manner as neces-

sary to provide $14,000,000 more to counties and tribes for the period ending December 31 of that year than would have been available had the funds been evenly divided within the fiscal year between the period before December 31 and the period after December 31.

(c) Economic Support Grants - Other Assistance

| | | |
|---|---|---|
| General | 3,358,000 | 3,463,000 |

**SUPPORTIVE HOUSING.** Of the general fund appropriation, $500,000 each year is to provide services to families who are participating in the supportive housing and managed care pilot project under Minnesota Statutes, section 256K.25. This appropriation shall not become part of base level funding for the biennium beginning July 1, 2007.

(d) Child Support Enforcement Grants

| | | |
|---|---|---|
| General | 3,571,000 | 3,503,000 |

(e) General Assistance Grants

| | | |
|---|---|---|
| General | 24,901,000 | 24,732,000 |

**GENERAL ASSISTANCE STANDARD.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

**EMERGENCY GENERAL ASSISTANCE.** The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in each fiscal year of 2004 and 2005. Funds to counties shall be allocated by the commissioner using the allocation method speci-

fied in Minnesota Statutes, section 256D.06.

(f) Minnesota Supplemental Aid Grants

| | | |
|---|---|---|
| General | 30,229,000 | 31,447,000 |

**EMERGENCY MINNESOTA SUPPLEMENTAL AID FUNDS.** The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $1,138,707 in fiscal year 2004 and $1,017,000 in fiscal year 2005. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

Subd. 12. Economic Support Management

Summary by Fund

| | | |
|---|---|---|
| General | 39,080,000 | 39,331,000 |
| Health Care Access | 1,407,000 | 1,377,000 |
| Federal TANF | 368,000 | 368,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Economic Support Policy Administration

| | | |
|---|---|---|
| General | 5,360,000 | 5,587,000 |
| Federal TANF | 368,000 | 368,000 |

(b) Economic Support Operations

| | | |
|---|---|---|
| General | 33,720,000 | 33,744,000 |
| Health Care Access | 1,407,000 | 1,377,000 |

**SPENDING AUTHORITY FOR FOOD STAMPS ENHANCED FUNDING.** In the event that Minnesota qualifies for the U.S. Department of Agriculture Food and Nutrition Services Food Stamp Program

enhanced funding beginning in federal fiscal year 2002, the funding is appropriated to the commissioner. The commissioner shall retain 25 percent of the funding, with the other 75 percent divided among the counties according to a formula that takes into account each county's impact on the statewide food stamp error rate.

**CHILD SUPPORT PAYMENT CENTER.** Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

**CHILD SUPPORT COST RECOVERY FEES.** The commissioner shall transfer $247,000 of child support cost recovery fees collected in fiscal year 2005 to the PRISM special revenue account to offset PRISM system costs of implementing the fee.

**FINANCIAL INSTITUTION DATA MATCH AND PAYMENT OF FEES.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2004 and fiscal year 2005 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

**CONSISTENT ACCOUNTING FOR PROGRAMS TO BE TRANSFERRED.**

To ensure consistent accounting, including forecasting, budgeting, cost allocation, and financial reporting, the commissioner may establish accounts and processes in the state's accounting system so the programs being transferred from other state agencies are integrated into the department's standard accounting policies and procedures.

Sec. 3. COMMISSIONER OF HEALTH

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 104,995,000 | 106,328,000 |
| Summary by Fund | | |
| General | 59,842,000 | 61,438,000 |
| State Government Special Revenue | 32,880,000 | 32,617,000 |
| Health Care Access | 6,273,000 | 6,273,000 |
| Federal TANF | 6,000,000 | 6,000,000 |
| Subd. 2. Health Improvement | | |
| Summary by Fund | | |
| General | 44,595,000 | 46,459,000 |
| State Government Special Revenue | 1,987,000 | 1,987,000 |
| Health Care Access | 3,510,000 | 3,510,000 |
| Federal TANF | 6,000,000 | 6,000,000 |

**TOBACCO PREVENTION ENDOWMENT FUND TRANSFERS.** (a) On July 1, 2003, the commissioner of finance shall transfer $4,000,000 from the tobacco use prevention and local public health endowment expendable trust fund to the general fund.

(b) Notwithstanding Minnesota Statutes, section 16A.62, any remaining unexpended balance in the fund after the transfer in paragraph (a) shall be transferred to the miscellaneous special revenue fund and

dedicated to the commissioner of health for local tobacco prevention grants under Minnesota Statutes, section 144.396, subdivision 6. Of this amount the commissioner may retain up to $150,000 for administration and evaluation costs.

(c) Of the general fund appropriation for fiscal year 2005, $3,280,000 is to the commissioner for the grants specified in paragraph (b).

**TANF APPROPRIATIONS.** TANF funds appropriated to the commissioner are available for home visiting and nutritional activities listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7), and eliminating health disparities activities under Minnesota Statutes, section 145.928, subdivision 10. Funding shall be distributed to community health boards and tribal governments based on the formula in Minnesota Statutes, section 145A.131, subdivisions 1 and 2.

**TANF CARRYFORWARD.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

**MINNESOTA CHILDREN WITH SPECIAL HEALTH NEEDS CARRYFORWARD.** General fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.

**TRANSFER OF ENDOWMENT FUNDS.** On July 1, 2003, the commissioner of finance shall transfer the tobacco use prevention and local public health endowment fund and the medical education endowment fund to the general fund.

Subd. 3. Health Quality and Access

| Summary by Fund | | |
|---|---|---|
| General | 868,000 | 606,000 |
| State Government Special Revenue | 8,888,000 | 8,888,000 |
| Health Care Access | 2,763,000 | 2,763,000 |

**STATE GOVERNMENT SPECIAL REVENUE FUND TRANSFERS.** On July 1, 2003, the commissioner of finance shall transfer $4,000,000 from the state government special revenue fund to the general fund.

**NURSING HOME RECEIVERSHIP COSTS.** In the event that other funds are not available, the commissioner is authorized to expend up to $230,000 from the fiscal year 2003 state government special revenue appropriation for nursing home regulation for those costs associated with nursing home receiverships necessary to protect the health and safety of residents. The commissioner shall assert claims against any and all appropriate parties seeking reimbursement of any funds expended. This provision is effective the day following final enactment.

**NURSING PROVIDERS WORK GROUP.** The commissioner shall establish a working group consisting of nursing home and boarding care home providers, representatives of nursing home residents, and other health care providers to review current licensure provisions and evaluate the continued appropriateness of these provisions. The commissioner shall present recommendations to the legislature by November 1, 2004.

**MERC FUNDING.** Amounts in the medical education and research costs (MERC)

special account not to exceed $8,660,000 in fiscal year 2004 and $8,616,000 in fiscal year 2005 are appropriated to the commissioner for medical education and research funding.

Subd. 4. Health Protection

| | Summary by Fund | |
|---|---|---|
| General | 9,130,000 | 9,130,000 |
| State Government Special Revenue | 22,005,000 | 21,742,000 |

Subd. 5. Management and Support Services

| | | |
|---|---|---|
| General | 5,249,000 | 5,243,000 |

Sec. 4. VETERANS NURSING HOMES BOARD

| | | |
|---|---|---|
| General | 30,030,000 | 30,030,000 |

**VETERANS HOMES SPECIAL REVENUE ACCOUNT.** The general fund appropriations made to the board may be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts are deposited according to Minnesota Statutes, section 198.34, and are appropriated to the board for the operation of board facilities and programs.

Sec. 5. HEALTH-RELATED BOARDS

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 11,441,000 | 11,471,000 |
| Summary by Fund | | |
| State Government Special Revenue | 11,377,000 | 11,407,000 |
| Health Care Access | 64,000 | 64,000 |

**STATE GOVERNMENT SPECIAL REVENUE FUND.** The appropriations in this section are from the state government special revenue fund, except where noted.

**NO SPENDING IN EXCESS OF REVENUES.** The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

**STATE GOVERNMENT SPECIAL REVENUE FUND TRANSFERS.** On July 1, 2003, the commissioner of finance shall transfer $7,500,000 from the state government special revenue fund to the general fund. Of this amount, $3,500,000 shall be transferred from the health-related boards and $4,000,000 shall be transferred as designated by the commissioner of finance.

| | | |
|---|---|---|
| Subd. 2. Board of Chiropractic Examiners | 384,000 | 384,000 |

**CONTESTED CASE EXPENSES.** In fiscal year 2003, $70,000 in state government special revenue funds is transferred from Laws 2001, First Special Session chapter 10, article 1, section 33, to the board of chiropractic examiners to pay for contested case activity. These funds are available until September 30, 2003.

| | | |
|---|---|---|
| Subd. 3. Board of Dentistry | | |
| State Government Special Revenue Fund | 858,000 | 858,000 |
| Health Care Access Fund | 64,000 | 64,000 |
| Subd. 4. Board of Dietetic and Nutrition Practice | 101,000 | 101,000 |
| Subd. 5. Board of Marriage and Family Therapy | 118,000 | 118,000 |

| | | |
|---|---|---|
| Subd. 6. Board of Medical Practice | 3,498,000 | 3,498,000 |
| Subd. 7. Board of Nursing | 2,405,000 | 2,405,000 |
| Subd. 8. Board of Nursing Home Administrators | 198,000 | 198,000 |
| Subd. 9. Board of Optometry | 96,000 | 96,000 |
| Subd. 10. Board of Pharmacy | 1,386,000 | 1,386,000 |

**ADMINISTRATIVE SERVICES UNIT.** Of this appropriation, $359,000 the first year and $359,000 the second year are for the health boards administrative services unit. The administrative services unit may receive and expend reimbursements for services performed for other agencies.

| | | |
|---|---|---|
| Subd. 11. Board of Physical Therapy | 197,000 | 197,000 |
| Subd. 12. Board of Podiatry | 45,000 | 45,000 |
| Subd. 13. Board of Psychology | 680,000 | 680,000 |
| Subd. 14. Board of Social Work | 1,073,000 | 1,073,000 |
| Subd. 15. Board of Veterinary Medicine | 163,000 | 163,000 |
| Subd. 16. Board of Behavioral Health and Therapy | 175,000 | 205,000 |

**ADDITIONAL FUNDING.** This amount is from the state government special revenue fund and is in addition to the appropriation in Laws 2003, chapter 118, section 27. Licensure fees will be increased accordingly to reimburse the fund balance.

Sec. 6. EMERGENCY MEDICAL SERVICES BOARD

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 3,027,000 | 3,027,000 |
| Summary by Fund | | |
| General | 2,481,000 | 2,481,000 |

| | | |
|---|---|---|
| State Government Special Revenue | 546,000 | 546,000 |

**HEALTH PROFESSIONAL SERVICES ACTIVITY.** $546,000 each year from the state government special revenue fund is for the health professional services activity.

**COMPREHENSIVE ADVANCED LIFE SUPPORT ADMINISTRATIVE COSTS.** Of the appropriation for the comprehensive advanced life support program, not more than $5,000 each year may be retained by the board for administrative costs.

**ROYALTY PAYMENTS DEDICATED TO BOARD.** Royalty payments from the sale of the Internet-based ambulance reporting program are appropriated to the board and shall remain available until expended. Notwithstanding section 14, this provision shall not expire.

**EMERGENCY MEDICAL SERVICES REGIONAL GRANTS.** Of this appropriation, $657,000 each year is for the purposes of Minnesota Statutes, section 144E.50.

**AMBULANCE TRAINING GRANT CARRYFORWARD AND TRANSFER.** (a) Effective for fiscal year 2003 and succeeding fiscal years, any unspent portion of the appropriation for ambulance training grants shall not cancel but shall carry forward and be used in the following fiscal year for the purposes of Minnesota Statutes, section 144E.50. The board shall not retain any portion of the appropriation carried forward for administrative costs.

(b) Notwithstanding section 14, this provision shall not expire.

(c) This provision is effective the day following final enactment.

| | | | |
|---|---|---|---|
| Sec. 7. COUNCIL ON DISABILITY | | | |
| General | | 500,000 | 500,000 |
| Sec. 8. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION | | | |
| General | | 1,462,000 | 1,462,000 |
| Sec. 9. OMBUDSMAN FOR FAMILIES | | | |
| General | | 245,000 | 245,000 |
| Sec. 10. DEPARTMENT OF CHILDREN, FAMILIES, AND LEARNING | | | |
| Subdivision 1. Total Appropriation | | $ 107,829,000 | $ 92,649,000 |
| | Summary by Fund | | |
| General | 104,489,000 | 89,309,000 | |
| State Special Revenue | 3,340,000 | 3,340,000 | |

Subd. 2. Child Care

**BASIC SLIDING FEE CHILD CARE.** Of this appropriation, $27,628,000 in fiscal year 2004 and $18,771,000 in fiscal year 2005 are for child care assistance according to Minnesota Statutes, section 119B.03. These appropriations are available to be spent either year. The fiscal years 2006 and 2007 general fund base for basic sliding fee child care is $30,312,000 each year.

**MFIP CHILD CARE.** Of this appropriation, $69,543,000 in fiscal year 2004 and $63,720,000 in fiscal year 2005 are for MFIP child care.

**CHILD CARE PROGRAM INTEGRITY.** Of this appropriation, $425,000 in fiscal year 2004, and $376,000 in fiscal year 2005 are for the administrative costs of program integrity and fraud prevention for child care assistance under Minnesota Statutes, chapter 119B.

**CHILD CARE DEVELOPMENT.** Of this appropriation, $1,115,000 in fiscal year 2004, and $1,164,000 in fiscal year 2005 are for child care development grants according to Minnesota Statutes, section 119B.21.

| | | |
|---|---|---|
| Subd. 3. Child Care Assistance Special Revenue Account | 3,340,000 | 3,340,000 |

**CHILD SUPPORT SPECIAL REVENUE ACCOUNT.** Appropriations and transfers in this subdivision are from the child support collection payments in the special revenue fund, pursuant to Minnesota Statutes, section 119B.074. The sums indicated are appropriated to the department of children, families, and learning for the fiscal years designated.

**CHILD CARE ASSISTANCE.** Of this appropriation, $3,340,000 in fiscal year 2004, and $3,340,000 in fiscal year 2005 are for child care assistance according to Minnesota Statutes, section 119B.03.

**SPECIAL REVENUE ACCOUNT UNOBLIGATED FUND TRANSFER.** On July 1, 2003, the commissioner of finance shall transfer $1,800,000 from the special revenue fund to the general fund.

Subd. 4. Child Care Assistance TANF Funds

**FEDERAL TANF TRANSFERS.** The sums indicated in this section are transferred from the federal TANF fund to the child care and development fund and are appropriated to the department of children, families, and learning for the fiscal years indicated. The commissioner shall ensure that all transferred funds are expended according to the child care and development fund regulations and that maximum

allowable transferred funds are used for the following programs:

(a) For basic sliding fee child care, $17,686,000 in fiscal year 2004 and $17,700,000 in fiscal year 2005 are for child care assistance under Minnesota Statutes, section 119B.03.

(b) For MFIP/TY, $7,312,000 in fiscal year 2004 and $4,919,000 in fiscal year 2005 are for child care assistance under Minnesota Statutes, section 119B.05.

(c) For child care development grants under Minnesota Statutes, section 119B.21, $14,000 is available in fiscal year 2004.

Subd. 5. Self-Sufficiency Programs

| | | |
|---|---|---|
| General | 5,278,000 | 5,278,000 |

**MINNESOTA ECONOMIC OPPORTUNITY GRANTS.** Of this appropriation, $4,000,000 in fiscal year 2004 and $4,000,000 in fiscal year 2005 are for Minnesota economic opportunity grants. Any balance in the first year does not cancel but is available in the second year.

**FOOD SHELF PROGRAMS.** Of this appropriation, $1,278,000 in fiscal year 2004 and $1,278,000 in fiscal year 2005 are for food shelf programs under Minnesota Statutes, section 119A.44. Any balance in the first year does not cancel but is available in the second year.

Subd. 6. Family Assets for Independence

| | |
|---|---|
| 500,000 | -0- |

Any balance in the first year does not cancel but is available in the second year.

Sec. 11. **TRANSFERS.**

Subdivision 1. **GRANTS.** The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate health, human services and corrections budget division and the chair of the house

health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2005, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, MFIP child care assistance under Minnesota Statutes, section 119B.05, 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.** Positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the house health and human services finance committee and the senate health, human services and corrections budget division quarterly about transfers made under this provision.

Subd. 3. **PROHIBITED TRANSFERS.** Grant money shall not be transferred to operations within the departments of human services and health and within the programs operated by the veterans nursing homes board without the approval of the legislature.

Sec. 12. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 13. **CARRYOVER LIMITATION.**

The appropriations in this article which are allowed to be carried forward from fiscal year 2004 to fiscal year 2005 shall not become part of the base level funding for the 2006-2007 biennial budget, unless specifically directed by the legislature.

Sec. 14. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2005, unless a different expiration date is explicit.

Sec. 15. **REPEALER.**

Laws 2002, chapter 374, article 9, section 8, is repealed effective upon final enactment.

Sec. 16. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2003, unless a different effective date is specified.

Presented to the governor May 30, 2003

Signed by the governor June 5, 2003, 4:27 p.m.

**New language is indicated by underline, deletions by ~~strikeout.~~**