FORTIETH DAY

St. Paul, Minnesota, Friday, April 26, 1991

The Senate met at 12:00 noon and was called to order by the President.

CALL OF THE SENATE

Mr. Johnson, D.J. imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rev. William Douglas Allen.

The roll was called, and the following Senators answered to their names:

Adkins	Day	Johnson, J.B.	Merriam	Ranum
Beckman	DeCramer	Johnston	Metzen	Reichgott
Belanger	Dicklich	Kelly	Moe, R.D.	Renneke
Benson, D.D.	Finn	Knaak	Mondale	Riveness
Benson, J.E.	Flynn	Kroening	Morse	Sams
Berg	Frank	Laidig	Neuville	Samuelson
Berglin	Frederickson, D.J.	Langseth	Novak	Solon
Bernhagen	Frederickson, D.R.	Larson	Olson	Spear
Bertram	Gustafson	Lessard	Pappas	Storm
Chmielewski	Halberg	Luther	Pariseau	Stumpf
Cohen	Hottinger	Marty	Piper	Traub
Dahl	Johnson, D.E.	McGowan	Pogemiller	Vickerman
Davis	Johnson, D.J.	Mehrkens	Price	Waldorf

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communication was received.

April 24, 1991

The Honorable Robert E. Vanasek
Speaker of the House of Representatives

The Honorable Jerome M. Hughes
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1991 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	H.F. No.	Session Laws Chapter No.	Time and Date Approved 1991	Date Filed 1991
734		34	4:07 p.m. April 23	April 24
34		35	4:02 p.m. April 23	April 24
254		36	4:05 p.m. April 23	April 24
391		37	4:10 p.m. April 23	April 24
713		38	9:55 a.m. April 24	April 24

Sincerely,
Joan Anderson Growe
Secretary of State

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 539: A bill for an act relating to commerce; restraint of trade; providing an evidentiary presumption in resale price maintenance cases; proposing coding for new law in Minnesota Statutes, chapter 325D.

Senate File No. 539 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned April 25, 1991

CONCURRENCE AND REPASSAGE

Mr. Spear moved that the Senate concur in the amendments by the House to S.F. No. 539 and that the bill be placed on its repassage as amended.

Mr. Neuville moved that the Senate do not concur in the amendments by the House to S.F. No. 539, and that a Conference Committee of 3 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House.

The question was taken on the adoption of the motion of Mr. Neuville.

The roll was called, and there were yeas 22 and nays 35, as follows:

Those who voted in the affirmative were:

Belanger	Day	Johnston	McGowan	Renneke
Benson, J.E.	Frederickson, D.R.	Knaak	Mehrkens	Storm
Berg	Gustafson	Laidig	Neuville	
Bernhagen	Halberg	Larson	Olson	
Davis	Johnson, D.E.	Lessard	Pariseau	

Those who voted in the negative were:

Adkins	DeCramer	Johnson, D.J.	Metzen	Ranum
Beckman	Dicklich	Johnson, J.B.	Moe, R.D.	Reichgott
Berglin	Finn	Kroening	Mondale	Sams
Bertram	Flynn	Langseth	Morse	Samuelson
Chmielewski	Frank	Luther	Novak	Spear
Cohen	Frederickson, D.J.	Marty	Pogemiller	Traub
Dahl	Hottinger	Merriam	Price	Vickerman

The motion did not prevail.

The question recurred on the motion of Mr. Spear. The motion prevailed.

S.F. No. 539 was read the third time, as amended by the House, and placed on its repassage.

The question was taken on the repassage of the bill, as amended.

The roll was called, and there were yeas 36 and nays 23, as follows:

Those who voted in the affirmative were:

Beckman	Dicklich	Kroening	Novak	Spear
Berglin	Finn	Luther	Pogemiller	Traub
Bertram	Flynn	Marty	Price	Vickerman
Chmielewski	Frank	Merriam	Ranum	Waldorf
Cohen	Frederickson, D.J.	Metzen	Reichgott	
Dahl	Hottinger	Moe, R.D.	Sams	
Davis	Johnson, D.J.	Mondale	Samuelson	
DeCramer	Johnson, J.B.	Morse	Solon	

Those who voted in the negative were:

Belanger	Day	Johnston	Lessard	Pariseau
Benson, D.D.	Frederickson, D.R.	Knaak	McGowan	Renneke
Benson, J.E.	Gustafson	Laidig	Mehrkens	Storm
Berg	Halberg	Langseth	Neuville	
Bernhagen	Johnson, D.E.	Larson	Olson	

So the bill, as amended, was repassed and its title was agreed to.

MESSAGES FROM THE HOUSE - CONTINUED

Mr. President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 425, 980 and 1201.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted April 25, 1991

FIRST READING OF HOUSE BILLS

The following bills were read the first time and referred to the committees indicated.

H.F. No. 425: A bill for an act relating to state lands; directing sale of two tracts of state-owned land in St. Louis county.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 490.

H.F. No. 980: A bill for an act relating to the legislature; authorizing joint legislative commissions to issue subpoenas; amending Minnesota Statutes 1990, section 3.153.

Referred to the Committee on Governmental Operations.

H.F. No. 1201: A bill for an act relating to local government; permitting police and fire civil service commissions to expand certified lists in certain circumstances; amending Minnesota Statutes 1990, sections 419.06; and 420.07.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 1190, now on General Orders.

REPORTS OF COMMITTEES

Mr. Moe, R.D. moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Mr. Lessard from the Committee on Environment and Natural Resources, to which was referred

S.F. No. 1289: A bill for an act relating to state lands; prohibiting sale of state lands administered by the department of natural resources to any employee of the department; proposing coding for new law in Minnesota Statutes, chapter 92.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Solon from the Committee on Commerce, to which was referred

S.F. No. 1118: A bill for an act relating to commerce; franchises; regulating assignments, transfers, and sales; amending Minnesota Statutes 1990, section 80C.14, subdivision 5.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1990, section 80C.14, subdivision 5, is amended to read:

Subd. 5. [WITHHOLDING CONSENT TO TRANSFER.] It is unfair and inequitable for a person to unreasonably withhold consent to an assignment, transfer, or sale of the franchise whenever the franchisee to be substituted meets the present qualifications and standards required of the franchisees of the particular franchisor. *Unreasonable withholding of consent within the meaning of this subdivision includes, but is not limited to, the franchisor directly or indirectly requiring a franchisee as part of the assignment, transfer, or sale of the franchise to guarantee or remain contingently liable to the franchisor for the franchise fee, royalty fee, advertising fee, or other financial obligation, other than a lease or sublease, of the successor franchisee for a period of more than two years, provided that the successor franchisee has not defaulted on any obligations under the franchise agreement. If a default occurs, the period shall be extended to run for two years from the date the default is cured.*

Sec. 2. Minnesota Statutes 1990, section 80C.17, subdivision 1, is amended to read:

Subdivision 1. A person who violates any provision of ~~sections 80C.01 to 80C.13 and 80C.16 to 80C.22~~ *this chapter* or any rule or order thereunder shall be liable to the franchisee or subfranchisor who may sue for damages caused thereby, for rescission, or other relief as the court may deem appropriate.

Sec. 3. Minnesota Statutes 1990, section 80C.17, subdivision 5, is amended to read:

Subd. 5. No action may be commenced pursuant to this section more than three years after the ~~franchisee pays the first franchise fee~~ *cause of action accrues.*

Sec. 4. [EFFECTIVE DATE; APPLICATION.]

Sections 1 to 3 are effective the day following final enactment. Section 1 applies to franchise agreements entered into or renewed on or after that date. Sections 2 and 3 apply to causes of action which arise on or after that date."

Delete the title and insert:

"A bill for an act relating to commerce; franchises; regulating assignments, transfers, and sales; amending Minnesota Statutes 1990, sections 80C.14, subdivision 5; and 80C.17, subdivisions 1 and 5."

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Johnson, D.J. from the Committee on Taxes and Tax Laws, to which was re-referred

S.F. No. 431: A bill for an act relating to local government; permitting Pennington county and Thief River Falls to construct, finance, and own student housing.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Johnson, D.J. from the Committee on Taxes and Tax Laws, to which was re-referred

S.F. No. 119: A bill for an act relating to the city of Crookston; permitting the establishment of special service districts in the city of Crookston.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Johnson, D.J. from the Committee on Taxes and Tax Laws, to which was re-referred

S.F. No. 860: A bill for an act relating to the city of Minneapolis; providing that certain special service districts may provide parking facilities; amending Laws 1988, chapter 719, article 16, section 1, subdivision 3.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Johnson, D.J. from the Committee on Taxes and Tax Laws, to which was re-referred

S.F. No. 255: A bill for an act relating to horse racing; increasing per diem rate for members of the racing commission; requiring that pari-mutuel clerks at county fairs be licensed; specifying apportionment and uses of the Minnesota breeders' fund; specifying person who may supervise administration of certain medications; reducing state tax withholding on pari-mutuel winnings; amending Minnesota Statutes 1990, sections 240.02, subdivision 3; 240.09, subdivision 2; 240.18; 240.24, subdivision 2; and 290.92, subdivision 27.

Reports the same back with the recommendation that the bill be amended as follows:

Page 5, line 17, delete "*Section 1 is effective July 1, 1989.*" and delete "2" and insert "*1*"

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Lessard from the Committee on Environment and Natural Resources, to which was referred

H.F. No. 743: A bill for an act relating to the Red River watershed management board; changing the description of the area subject to special authority of watershed districts; requiring the board to adopt criteria for funding applications; clarifying the uses of levy proceeds; expanding the board's authority to cooperate with other entities; amending Laws 1976, chapter 162, sections 1 and 2, as amended, and 3.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, lines 17 to 21, reinstate the stricken language and delete the new language

Page 2, line 12, after the first comma, insert "chapter 162,"

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Lessard from the Committee on Environment and Natural Resources, to which was referred

H.F. No. 1001: A bill for an act relating to game and fish; authorizing radio communication between a handler and dog; amending Minnesota Statutes 1990, section 97B.085, by adding a subdivision.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 11, delete "*or dogs*"

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Lessard from the Committee on Environment and Natural Resources, to which was referred

H.F. No. 744: A bill for an act relating to the environment; petrofund; amending Minnesota Statutes 1990, sections 115C.07, subdivision 3; 115C.09, subdivisions 1, 2, 3, 3b, 5, and by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 103I.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Solon from the Committee on Commerce, to which was re-referred

H.F. No. 205: A bill for an act relating to insurance; prohibiting discrimination against American military personnel; amending Minnesota Statutes 72A.20, subdivision 8.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, delete lines 21 to 25

Page 2, delete line 1

Page 2, line 2, delete "*(c)*" and insert "*(b)*"

Page 2, line 5, delete "*that*" and insert "*whose coverage or dependent coverage*"

Page 2, line 13, delete "*120*" and insert "*90*"

Page 2, line 21, after the period, insert "*Reinstatement is effective upon the payment of any required premiums.*"

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Johnson, D.J. from the Committee on Taxes and Tax Laws, to which was re-referred

H.F. No. 578: A bill for an act relating to Dakota county; permitting cities and towns to transfer assessment review duties to the county; proposing coding for new law in Minnesota Statutes, chapter 383D.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Solon from the Committee on Commerce, to which was referred

S.F. No. 440: A bill for an act relating to insurance; requiring insurers to permit their insureds to inspect medical records obtained in connection with a claim; requiring health care providers to permit access to medical records by persons examined for certain medical review purposes; amending Minnesota Statutes 1990, sections 72A.491, subdivision 19; 144.335, subdivision 1; and 145.64.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. [72A.285] [CLAIM FOR INSURANCE BENEFITS; RELEASE OF SUMMARY INFORMATION.]

Notwithstanding section 145.64, when a review organization, as defined in section 145.61, has conducted a review of health services given or proposed to be given to an insured or claimant in connection with or in anticipation of a claim for insurance benefits, a complete summary of the review findings must be furnished by the insurer to the provider who requested the review or to the insured or claimant, upon that person's request.

The summary must list the qualifications of the reviewer, including any license, certification, or specialty designation. The summary must also describe the relationship between the insured's or claimant's diagnosis and the review criteria used as a basis for the claim decision, including the specific rationale for the reviewer's decision.

Nothing in this section requires the disclosure of the identity of the person conducting the review."

Delete the title and insert:

"A bill for an act relating to insurance; requiring insurers to furnish a summary of claims review findings; proposing coding for new law in Minnesota Statutes, chapter 72A."

And when so amended the bill do pass. Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred

H.F. No. 375 for comparison with companion Senate File, reports the following House File was found identical and recommends the House File be given its second reading and substituted for its companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
375	379				

and that the above Senate File be indefinitely postponed.

Pursuant to Rule 49, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred

H.F. No. 422 for comparison with companion Senate File, reports the following House File was found identical and recommends the House File be given its second reading and substituted for its companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
422	334				

and that the above Senate File be indefinitely postponed.

Pursuant to Rule 49, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred under Rule 35, together with the committee report thereon,

S.F. No. 404: A bill for an act relating to peace officers; requiring the community college system, technical college system, state university system, and private colleges offering professional peace officer education to create and implement a joint plan to integrate components of professional peace officer education into a degree program by January 1, 1992; requiring the state university system to develop a school of law enforcement; amending Minnesota Statutes 1990, sections 626.84, subdivision 1; and 626.861, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter

626.

Reports the same back with the recommendation that the report from the Committee on Education, shown in the Journal for April 23, 1991, be amended to read:

"the bill be amended and when so amended the bill do pass and be re-referred to the Committee on Finance". Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred under Rule 35, together with the committee report thereon,

S.F. No. 937: A bill for an act relating to human services; establishing an investment per bed limit for nursing homes; establishing an equipment allowance for nursing homes; establishing a capital replacement per diem for nursing homes; authorizing the recognition of debt from sales or refinancing occurring after May 22, 1983; amending Minnesota Statutes 1990, section 256B.431, subdivision 3f, and by adding a subdivision.

Reports the same back with the recommendation that the report from the Committee on Health and Human Services, shown in the Journal for April 24, 1991, be amended to read:

"the bill be amended and when so amended the bill do pass and be re-referred to the Committee on Governmental Operations". Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was re-referred

S.F. No. 1323: A bill for an act relating to metropolitan government; providing for the appointments and terms of the metropolitan council; assigning duties relating to transit; providing for a part-time chair of the regional transit board; clarifying the districts of the regional transit board; requiring metropolitan agencies to file budgets with the legislature; providing for senate confirmation for the chairs of certain metropolitan agencies; requiring metropolitan council approval of certain regional transit board activity; requiring studies; amending Minnesota Statutes 1990, sections 15A.081, subdivisions 1 and 7; 473.123, subdivisions 2a, 3, and 4; 473.303, subdivision 3; 473.373, subdivisions 4a and 5; 473.375, subdivisions 8, 14, and 15; 473.38, subdivision 2, and by adding a subdivision; 473.404, subdivisions 2 and 6; 473.553, subdivision 3; and 473.604, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 473.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred under Joint Rule 2.03, together with the committee report thereon,

S.F. No. 3: A bill for an act relating to wetlands; providing for preservation, enhancement, restoration, and establishment of wetlands; requiring identification of wetlands; requiring adoption of wetland public value and classification criteria; requiring designation of priority areas to establish and

preserve wetlands; requiring local water plans to include wetlands with high public value; providing for establishment of wetland preservation areas; authorizing a tax exemption for wetland preservation areas; establishing a wetland restoration and compensation fund; requiring permits for alternative uses of wetlands; requiring compensation for denied uses of wetlands; providing authority to establish and restore wetlands on private land; requiring assessment of direct benefits and payment of damages for establishment and restoration of wetlands; requiring a report on simplification and coordination of state and federal wetland permitting procedures; designating and regulating activities in peatland scientific and natural areas; requiring the commissioner of natural resources to accept donated wetlands with certain exceptions; modifying the method of determining agricultural market value for property tax purposes; appropriating money; amending Minnesota Statutes 1990, sections 84.085; 103B.155; 103B.231, subdivision 6; 103B.311, subdivision 6; 103G.005, subdivisions 15 and 18; 103G.221; 103G.225; 103G.231; 103G.235; 124.2131, subdivision 1; 272.02, subdivision 1; 273.11, subdivision 1, and by adding a subdivision; and 273.111, subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 84; 103F; 103G; and 116P; repealing Minnesota Statutes 1990, section 273.11, subdivision 10.

Reports the same back with the recommendation that the report from the Committee on Agriculture and Rural Development, shown in the Journal for April 25, 1991, be adopted; that committee recommendation being:

"the bill be amended and when so amended the bill do pass and be re-referred to the Committee on Taxes and Tax Laws". Amendments adopted. Report adopted.

Mr. Moe, R.D. from the Committee on Rules and Administration, to which was referred under Joint Rule 2.03, together with the committee report thereon,

S.F. No. 467: A bill for an act relating to education; providing for supplemental revenue and minimum allowance revenue in certain cases; amending Minnesota Statutes 1990, section 122.531, by adding a subdivision; repealing Minnesota Statutes 1990, section 122.531, subdivision 5.

Reports the same back with the recommendation that the report from the Committee on Education, shown in the Journal for April 25, 1991, be adopted; that committee recommendation being:

"the bill be amended and when so amended the bill do pass and be re-referred to the Committee on Taxes and Tax Laws". Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. Nos. 1530, 1289, 1118, 431, 119, 860, 255, 440 and 1323 were read the second time.

SECOND READING OF HOUSE BILLS

H.F. Nos. 743, 1001, 744, 205, 578, 375 and 422 were read the second time.

MOTIONS AND RESOLUTIONS

Mr. Samuelson introduced—

Senate Resolution No. 63: A Senate resolution congratulating Harry W. Nysather on his retirement after 27 years of service as president of Brainerd Technical College.

Referred to the Committee on Rules and Administration.

Ms. Berglin moved that S.F. No. 609, No. 31 on General Orders, be stricken and re-referred to the Committee on Health and Human Services. The motion prevailed.

Mr. Novak moved that H.F. No. 744, on General Orders, be stricken re-referred to the Committee on Finance. The motion prevailed.

CONSENT CALENDAR

H.F. No. 894: A bill for an act relating to local government; permitting officers to contract for certain services; amending Minnesota Statutes 1990, section 471.88, by adding subdivisions.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 53 and nays 5, as follows:

Those who voted in the affirmative were:

Adkins	Day	Johnston	Moe, R.D.	Riveness
Beckman	DeCramer	Knaak	Mondale	Sams
Belanger	Dicklich	Kroening	Morse	Samuelson
Benson, D.D.	Frederickson, D.J.	Laidig	Neuville	Solon
Benson, J.E.	Frederickson, D.R.	Larson	Novak	Spear
Berg	Gustafson	Lessard	Olson	Storm
Berglin	Halberg	Luther	Pariseau	Traub
Bertram	Hottinger	Marty	Pogemiller	Vickerman
Chmielewski	Johnson, D.E.	McGowan	Price	Waldorf
Cohen	Johnson, D.J.	Mehrkens	Ranum	
Dahl	Johnson, J.B.	Metzen	Reichgott	

Those who voted in the negative were:

Davis	Finn	Flynn	Frank	Merriam

So the bill passed and its title was agreed to.

GENERAL ORDERS

The Senate resolved itself into a Committee of the Whole, with Mr. Chmielewski in the chair.

After some time spent therein, the committee arose, and Mr. Chmielewski reported that the committee had considered the following:

S.F. Nos. 793, 885, 707, 785, 859, 1074 and H.F. Nos. 274, 877, 1105, 983, 179, which the committee recommends to pass.

H.F. No. 244, which the committee recommends to pass with the following amendment offered by Ms. Flynn:

Amend H.F. No. 244, as amended pursuant to Rule 49, adopted by the Senate April 23, 1991, as follows:

(The text of the amended House File is identical to S.F. No. 354.)

Page 5, delete lines 27 and 28

Renumber the clauses in sequence

The motion prevailed. So the amendment was adopted.

H.F. No. 739, which the committee recommends to pass with the following amendment offered by Mr. Knaak:

Amend H.F. No. 739, as amended pursuant to Rule 49, adopted by the Senate April 23, 1991, as follows:

(The text of the amended House File is identical to S.F. No. 482.)

Page 9, line 18, delete "*or*"

Page 9, line 22, before the period, insert "*; or*

(h) an acquisition subsequent to January 1, 1991, pursuant to an offer to purchase for cash all shares of the voting stock of the issuing public corporation:

(i) which has been approved by a majority vote of the members of a committee comprised of the disinterested members of the board of the issuing public corporation formed pursuant to section 302A.673, subdivision 1, paragraph (d); and

(ii) pursuant to which the acquiring person will become the owner of over 50 percent of the voting stock of the issuing public corporation outstanding at the time of the transaction"

Page 14, after line 20, insert:

"Sec. 17. [EFFECTIVE DATE.]

Section 9, paragraph (h), is effective the day following final enactment."

Amend the title as follows:

Page 1, line 9, after the semicolon, insert "exempting certain transactions from the control share acquisition statute;"

The motion prevailed. So the amendment was adopted.

S.F. No. 804, which the committee recommends to pass with the following amendment offered by Mr. Waldorf:

Page 1, line 27, after "*pay*" insert "*or whether the medical services were necessary*"

Page 2, line 1, after "*services*" insert "*or whether the services are necessary*"

The motion prevailed. So the amendment to the amendment was adopted.

H.F. No. 832, which the committee recommends to pass with the following amendment offered by Mr. Solon:

Pages 1 to 4, delete section 1 and insert:

"Section 1. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 3. [OBLIGATION TO REPURCHASE.] *If a dealership agreement is terminated, canceled, or discontinued, the equipment manufacturer shall*

pay to the dealer, or credit to the dealer's account if the dealer has an outstanding amount owed to the manufacturer, an amount equal to 100 percent of the net cost of all unused heavy and utility equipment in new condition that has been purchased by the dealer from the manufacturer within the 24 months immediately preceding notification by either party of intent to terminate, cancel, or discontinue the agreement. This amount must include transportation charges that have been paid by the dealer, or invoiced to the dealer's account by the manufacturer. The dealer may elect to keep the merchandise instead of receiving payment, if the contract gives the dealer this right.

Sec. 2. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 4. [REPAIR PARTS.] *(a) The manufacturer shall pay the dealer, or credit to the dealer's account if the dealer has an outstanding amount owed to the manufacturer, the following:*

(1) 85 percent of the current net prices on repair parts, including superseded parts listed in current price lists or catalogs in use by the manufacturer on the date of the termination, cancellation, or discontinuance of the agreement;

(2) as to any parts not listed in current price lists or catalogs, 100 percent of the invoiced price of the repair part for which the dealer has an invoice if the parts had previously been purchased by the dealer from the manufacturer and are held by the dealer on the date of the termination, cancellation, or discontinuance of the agreement or received by the dealer from the manufacturer after that date; and

(3) 50 percent of the most recently published price of all other parts if the price list or catalog is not more than ten years old as of the date of the termination, cancellation, or discontinuance of the agreement.

(b) The manufacturer shall pay the dealer, or credit to the dealer's account, if the dealer has an outstanding amount owed to the manufacturer, an amount equal to five percent of the prices required to be paid or credited by this subdivision for all parts returned for the handling, packing, and loading of the parts back to the manufacturer unless the manufacturer elects to perform inventorying, packing, and loading of the parts itself. Upon the payment or allowance of credit to the dealer's account of the sum required by this subdivision, the title to and right to possess the heavy and utility equipment passes to the manufacturer. However, this section does not affect any security interest that the manufacturer may have in the inventory of the dealer.

Sec. 3. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 5. [PAYMENT; INTEREST.] *Payment required to be made under this section must be made not later than 90 days from the date the heavy and utility equipment is returned by the dealer, and if not by then paid, the amount payable by the manufacturer bears interest at the rate of 1-1/2 percent per month from the date the agreement was terminated, canceled, or discontinued until the date payment is received by the dealer.*

Sec. 4. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 6. [NOTICE OF INTENT TO RETURN.] *In lieu of returning the*

heavy and utility equipment to the manufacturer, the dealer may advise the manufacturer that the dealer has heavy and utility equipment that the dealer intends to return. The notice of the dealer's intention to return must be in writing, sworn to before a notary public as to the accuracy of the listing of heavy and utility equipment and that all of the items are in usable condition. The notice must include the name and business address of the person or business who has possession and custody of them and where they may be inspected. The list may be verified by the manufacturer. The notice must also state the name and business address of the person or business who has the authority to serve as the escrow agent of the dealer, to accept payment or a credit to the dealer's account on behalf of the dealer, and to release the heavy and utility equipment to the manufacturer. The notice constitutes the appointment of the escrow agent to act on the dealer's behalf.

Sec. 5. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 7. [MANUFACTURER INSPECTION.] *(a) The manufacturer has 30 days from the date of the mailing of the notice under subdivision 6, which must be by certified mail, in which to inspect the heavy and utility equipment and verify the accuracy of the dealer's list.*

(b) The manufacturer shall, within ten days after inspection:

(1) pay the escrow agent;

(2) give evidence that a credit to the account of the dealer has been made if the dealer has an outstanding amount due the manufacturer; or

(3) send to the escrow agent a "dummy credit list" and shipping labels for the return of the heavy and utility equipment to the manufacturer that are acceptable as returns.

Sec. 6. Minnesota Statutes 1990, section 325E.0681, is amended by adding a subdivision to read:

Subd. 8. [PAYMENT OR CREDIT REQUIREMENTS.] *If the manufacturer sends a credit list as provided under subdivision 7 to the escrow agent, payment or a credit against the dealer's indebtedness in accordance with this subdivision for the acceptable returns must accompany the credit list. On the receipt of the payment, evidence of a credit to the account of the dealer, or the credit list with payment, the title to and the right to possess the heavy and utility equipment acceptable as returns passes to the manufacturer. The escrow agent shall ship or cause to be shipped the heavy and utility equipment acceptable as returns to the manufacturer unless the manufacturer elects to personally perform the inventorying, packing, and loading of the heavy and utility equipment. When they have been received by the manufacturer, notice of their receipt shall be sent by certified mail to the escrow agent who shall then disburse 90 percent of the payment it has received, less its actual expenses and a reasonable fee for its services, to the dealer. The escrow agent shall keep the balance of the funds in the dealer's escrow account until it is notified that an agreement has been reached as to the nonreturnables. After being notified of the agreement, the escrow agent shall disburse the remaining funds and dispose of any remaining heavy and utility equipment as provided in the agreement. If no agreement is reached in a reasonable time, the escrow agent may refer the matter to an arbitrator who has authority to resolve all unsettled issues in the dispute."*

Page 4, line 17, delete "4" and insert "9"

Page 4, line 33, delete "*5*" and insert "*10*"

Page 5, line 9, delete "*6*" and insert "*11*"

Page 5, line 23, delete "*7*" and insert "*12*"

Page 6, line 5, delete "*5*" and insert "*10*"

Renumber the sections in sequence and correct the internal references

The motion prevailed. So the amendment was adopted.

S.F. No. 476, which the committee reports progress, subject to the following motions:

Mr. Halberg raised a point of order as to S.F. No. 476 in regard to Article IV, Section 18 of the Minnesota Constitution.

The Chair ruled that the point of order was not well taken.

Mr. Halberg appealed the decision of the Chair.

The question was taken on "Shall the decision of the Chair be the judgment of the Committee?"

The roll was called, and there were yeas 43 and nays 18, as follows:

Those who voted in the affirmative were:

Adkins	Dicklich	Johnson, J.B.	Morse	Sams
Beckman	Finn	Langseth	Novak	Samuelson
Benson, D.D.	Flynn	Lessard	Pappas	Solon
Berglin	Frank	Luther	Piper	Spear
Bertram	Frederickson, D.J.	Marty	Pogemiller	Stumpf
Chmielewski	Frederickson, D.R.	Merriam	Price	Traub
Cohen	Gustafson	Metzen	Ranum	Vickerman
Davis	Hottinger	Moe, R.D.	Reichgott	
DeCramer	Johnson, D.J.	Mondale	Riveness	

Those who voted in the negative were:

Belanger	Day	Kelly	Larson	Renneke
Benson, J.E.	Halberg	Knaak	McGowan	Storm
Berg	Johnson, D.E.	Kroening	Olson	
Bernhagen	Johnston	Laidig	Pariseau	

The decision of the Chair was sustained.

Mr. Benson, D.D. moved to amend S.F. No. 476 as follows:

Page 10, after line 36, insert:

"Section 1. Minnesota Statutes 1990, section 270.06, is amended to read:

270.06 [POWERS AND DUTIES.]

The commissioner of revenue shall:

(1) have and exercise general supervision over the administration of the assessment and taxation laws of the state, over assessors, town, county, and city boards of review and equalization, and all other assessing officers in the performance of their duties, to the end that all assessments of property be made relatively just and equal in compliance with the laws of the state;

(2) confer with, advise, and give the necessary instructions and directions to local assessors and local boards of review throughout the state as to their duties under the laws of the state;

(3) direct proceedings, actions, and prosecutions to be instituted to enforce

the laws relating to the liability and punishment of public officers and officers and agents of corporations for failure or negligence to comply with the provisions of the laws of this state governing returns of assessment and taxation of property, and cause complaints to be made against local assessors, members of boards of equalization, members of boards of review, or any other assessing or taxing officer, to the proper authority, for their removal from office for misconduct or negligence of duty;

(4) require county attorneys to assist in the commencement of prosecutions in actions or proceedings for removal, forfeiture and punishment for violation of the laws of this state in respect to the assessment and taxation of property in their respective districts or counties;

(5) require town, city, county, and other public officers to report information as to the assessment of property, collection of taxes received from licenses and other sources, and such other information as may be needful in the work of the department of revenue, in such form and upon such blanks as the commissioner may prescribe;

(6) require individuals, copartnerships, companies, associations, and corporations to furnish information concerning their capital, funded or other debt, current assets and liabilities, earnings, operating expenses, taxes, as well as all other statements now required by law for taxation purposes;

(7) summon witnesses, at a time and place reasonable under the circumstances, to appear and give testimony, and to produce books, records, papers and documents relating to any tax matter which the commissioner may have authority to investigate or determine. Provided, that any summons which does not identify the person or persons with respect to whose tax liability the summons is issued may be served only if (a) the summons relates to the investigation of a particular person or ascertainable group or class of persons, (b) there is a reasonable basis for believing that such person or group or class of persons may fail or may have failed to comply with any tax law administered by the commissioner, (c) the information sought to be obtained from the examination of the records (and the identity of the person or persons with respect to whose liability the summons is issued) is not readily available from other sources, (d) the summons is clear and specific as to the information sought to be obtained, and (e) the information sought to be obtained is limited solely to the scope of the investigation. Provided further that the party served with a summons which does not identify the person or persons with respect to whose tax liability the summons is issued shall have the right, within 20 days after service of the summons, to petition the district court for the judicial district in which lies the county in which that party is located for a determination as to whether the commissioner of revenue has complied with all the requirements in (a) to (e), and thus, whether the summons is enforceable. If no such petition is made by the party served within the time prescribed, the summons shall have the force and effect of a court order;

(8) cause the deposition of witnesses residing within or without the state, or absent therefrom, to be taken, upon notice to the interested party, if any, in like manner that depositions of witnesses are taken in civil actions in the district court, in any matter which the commissioner may have authority to investigate or determine;

(9) investigate the tax laws of other states and countries and to formulate and submit to the legislature such legislation as the commissioner may deem expedient to prevent evasions of assessment and taxing laws, and secure

just and equal taxation and improvement in the system of assessment and taxation in this state;

(10) consult and confer with the governor upon the subject of taxation, the administration of the laws in regard thereto, and the progress of the work of the department of revenue, and furnish the governor, from time to time, such assistance and information as the governor may require relating to tax matters;

(11) transmit to the governor, on or before the third Monday in December of each even-numbered year, and to each member of the legislature, on or before November 15 of each even-numbered year, the report of the department of revenue for the preceding years, showing all the taxable property in the state and the value of the same, in tabulated form;

(12) inquire into the methods of assessment and taxation and ascertain whether the assessors faithfully discharge their duties, particularly as to their compliance with the laws requiring the assessment of all property not exempt from taxation;

(13) administer and enforce the assessment and collection of state taxes and, from time to time, make, publish, and distribute rules for the administration and enforcement of state tax laws. The rules have the force of law;

(14) prepare blank forms for the returns required by state tax law and distribute them throughout the state, furnishing them subject to charge on application;

(15) prescribe rules governing the qualification and practice of agents, attorneys, or other persons representing taxpayers before the commissioner. The rules may require that those persons, agents, and attorneys show that they are of good character and in good repute, have the necessary qualifications to give taxpayers valuable services, and are otherwise competent to advise and assist taxpayers in the presentation of their case before being recognized as representatives of taxpayers. After due notice and opportunity for hearing, the commissioner may suspend and disbar from further practice before the commissioner any person, agent, or attorney who is shown to be incompetent or disreputable, who refuses to comply with the rules, or who with intent to defraud, willfully or knowingly deceives, misleads, or threatens a taxpayer or prospective taxpayer, by words, circular, letter, or by advertisement. This clause does not curtail the rights of individuals to appear in their own behalf or partners or corporations' officers to appear in behalf of their respective partnerships or corporations;

(16) appoint agents as the commissioner considers necessary to make examinations and determinations. The agents have the rights and powers conferred on the commissioner to examine books, records, papers, or memoranda, subpoena witnesses, administer oaths and affirmations, and take testimony. Upon demand of an agent, the clerk or court administrator of any court shall issue a subpoena for the attendance of a witness or the production of books, papers, records, or memoranda before the agent. The commissioner may also issue subpoenas. Disobedience of subpoenas issued under this chapter shall be punished by the district court of the district in which the subpoena is issued, or in the case of a subpoena issued by the commissioner, by the district court of the district in which the party served with the subpoena is located, in the same manner as contempt of the district court;

(17) appoint and employ additional help, purchase supplies or materials,

or incur other expenditures in the enforcement of state tax laws as considered necessary. The salaries of all agents and employees provided for in this chapter shall be fixed by the appointing authority, subject to the approval of the commissioner of administration;

(18) execute and administer any agreement with the secretary of the treasury of the United States or a representative of another state regarding the exchange of information and administration of the tax laws;

(19) ~~administer and enforce the provisions of sections 325D.30 to 325D.42, the Minnesota unfair cigarette sales act;~~

~~(20)~~ authorize the use of unmarked motor vehicles to conduct seizures or criminal investigations pursuant to the commissioner's authority; and

~~(21)~~ *(20)* exercise other powers and perform other duties required of or imposed upon the commissioner of revenue by law."

Page 11, after line 22, insert:

"Sec. 4. Minnesota Statutes 1990, section 297.04, subdivision 9, is amended to read:

Subd. 9. [REVOCATION.] The commissioner may revoke, cancel, or suspend the license or licenses of any distributor or subjobber for violation of sections 297.01 to 297.13, or any other act applicable to the sale of cigarettes, or any rule promulgated by the commissioner, and may also revoke any such license or licenses of any distributor or subjobber for the violation of sections 297.31 to 297.39, or any other act applicable to the sale of tobacco products, or any rule promulgated by the commissioner in furtherance of sections 297.31 to 297.39. ~~The commissioner may revoke, cancel, or suspend the license or licenses of any distributor or subjobber for violation of sections 325D.31 to 325D.42.~~

No license shall be revoked, canceled, or suspended except after notice and a hearing by the commissioner as provided in section 297.09.

Sec. 5. Minnesota Statutes 1990, section 297.06, subdivision 3, is amended to read:

Subd. 3. [RETAILER AND SUBJOBBER TO PRESERVE PURCHASE INVOICES.] Every retailer and subjobber shall procure itemized invoices of all cigarettes purchased. The invoices shall show the name and address of the seller and the date of purchase. The retailer and subjobber shall preserve a legible copy of each such invoice for one year from the date of purchase.

At any time during normal business hours, the commissioner or the commissioner's agents may enter any place of business of a retailer or subjobber and inspect the premises, the records required to be kept for this subdivision, and the packages of cigarettes, tobacco products, and vending devices contained on the premises to determine whether all provisions of this chapter ~~and sections 325D.30 to 325D.40~~ are being fully complied with."

Page 13, after line 32, insert:

"Sec. 9. [REPEALER.]

Minnesota Statutes 1990, sections 325D.30 to 325D.42, are repealed."

Renumber the sections of article 2 in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

The question was taken on the recommendation to pass S.F. No. 476.

The roll was called, and there were yeas 16 and nays 49, as follows:

Those who voted in the affirmative were:

Belanger	Flynn	Luther	Piper	Spear
Benson, D.D.	Johnson, D.J.	Merriam	Pogemiller	Storm
Bernhagen	Knaak	Moe, R.D.	Reichgott	Stumpf
Dicklich				

Those who voted in the negative were:

Adkins	Day	Johnson, J.B.	Mehrkens	Ranum
Beckman	DeCramer	Johnston	Metzen	Renneke
Benson, J.E.	Finn	Kelly	Mondale	Riveness
Berg	Frank	Kroening	Morse	Sams
Berglin	Frederickson, D.J.	Laidig	Neuville	Samuelson
Bertram	Frederickson, D.R.	Langseth	Novak	Solon
Chmielewski	Gustafson	Larson	Olson	Traub
Cohen	Halberg	Lessard	Pappas	Vickerman
Dahl	Hottinger	Marty	Pariseau	Waldorf
Davis	Johnson, D.E.	McGowan	Price	

The motion did not prevail. S.F. No. 476 was then progressed.

H.F. No. 1017 which the committee recommends to pass, subject to the following motion:

Mr. Bertram moved that the amendment made to H.F. No. 1017 by the Committee on Rules and Administration in the report adopted April 22, 1991, pursuant to Rule 49, be stricken. The motion prevailed. So the amendment was stricken.

S.F. No. 687, which the committee recommends to pass with the following amendment offered by Mr. Dahl:

Amend S.F. No. 687 as follows:

Page 1, line 10, before "*Recycled*" insert "*(a) Except as provided in paragraph (b),*"

Page 1, after line 17, insert:

"*(b) Recycled CFCs that are used to replace or supplement CFCs in mobile air conditioning equipment must comply with the J1991 Standard of Purity for Use in Mobile Air Conditioning Systems of the Society of Automotive Engineers.*

Subd. 3. [WARRANTIES NOT AFFECTED.] *Use of recycled CFCs that meet the standards in this section does not affect a manufacturer's warranty of a product's condition or fitness for use, including any terms or conditions precedent to the enforcement of obligations under the warranty.*

Sec. 2. [REFRIGERATION EQUIPMENT AND SYSTEMS; TRAINING AND LICENSING RECOMMENDATIONS.]

The pollution control agency shall by January 1, 1992, make recommendations to the legislature on methods for the use, recapture, and recycling of CFCs and appropriate training and licensing provisions for persons engaged in the installation or repair of refrigeration equipment and systems that use CFC refrigerants. The agency shall consult with contractors and

representatives of these installations and repair workers before making these recommendations."

Renumber the sections in sequence

The motion prevailed. So the amendment was adopted.

H.F. No. 238, which the committee recommends to pass with the following amendment offered by Mr. Finn:

Amend H.F. No. 238, the unofficial engrossment, as follows:

Page 2, after line 1, insert:

"Sec. 2. [325F.982] [CONSUMER IDENTIFICATION INFORMATION.]

Subdivision 1. [PROHIBITED USE.] *A person may not write down or request to be written down the address or telephone number of a credit cardholder on a credit card transaction form as a condition of accepting a credit card as payment for consumer credit, goods, or services.*

Subd. 2. [EXCEPTION.] *A person may record the address or telephone number of a credit cardholder if the information is necessary for the shipping, delivery, or installation of consumer goods, or special orders of consumer goods or services.*"

Amend the title as follows:

Page 1, line 4, after the semicolon, insert "prohibiting certain uses of consumer identification information;"

The motion prevailed. So the amendment was adopted.

S.F. No. 971, which the committee recommends to pass with the following amendment offered by Mr. Morse:

Amend S.F. No. 971 as follows:

Page 2, line 33, before "*Sections*" insert "*(a) Except as provided in paragraph (b),*"

Page 2, line 35, delete "*(a)*" and insert "*(1)*" and delete "*(b)*" and insert "*(2)*"

Page 3, after line 12, insert:

"*(b) Sections 1 to 4 are effective the day after final enactment and the commissioner of agriculture is not required to publish notice in the State Register if restrictions on the general use of biosynthetic bovine somatotropin are effective in the state of Wisconsin on that date.*"

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 34 and nays 21, as follows:

Those who voted in the affirmative were:

Adkins	DeCramer	Kelly	Mondale	Reichgott
Beckman	Finn	Larson	Morse	Sams
Berglin	Flynn	Luther	Pappas	Spear
Bertram	Frederickson, D.J.	Marty	Piper	Stumpf
Chmielewski	Hottinger	Merriam	Pogemiller	Vickerman
Cohen	Johnson, D.J.	Metzen	Price	Waldorf
Davis	Johnson, J.B.	Moe, R.D.	Ranum	

Those who voted in the negative were:

Belanger	Day	Johnston	Neuville	Storm
Benson, D.D.	Frederickson, D.R.	Knaak	Olson	
Benson, J.E.	Gustafson	Laidig	Pariseau	
Berg	Halberg	Lessard	Renneke	
Bernhagen	Johnson, D.E.	Mehrkens	Samuelson	

The motion prevailed. So the amendment was adopted.

Mr. Benson, D.D. moved to amend S.F. No. 971 as follows:

Pages 2 and 3, delete section 5 and insert:

"Sec. 5. [EFFECTIVE DATE.]

Sections 1 to 4 are effective 30 days after the commissioner of agriculture publishes notice in the State Register that the states of Minnesota, California, Iowa, New York, Pennsylvania, and Wisconsin have adopted provisions that restrict general use of biosynthetic bovine somatotropin (BST). So that no Minnesota dairy farmers are put out of business by unfair competition from other dairy states, sections 1 to 4 remain in effect only so long as restrictions are effective in the states of California, Iowa, New York, Pennsylvania, and Wisconsin. On the date that restrictions on the general use of biosynthetic bovine somatotropin are no longer in effect in the states of California, Iowa, New York, Pennsylvania, and Wisconsin, sections 1 to 4 have no effect and biosynthetic bovine somatotropin may be sold for general use."

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 19 and nays 38, as follows:

Those who voted in the affirmative were:

Belanger	Bernhagen	Johnson, D.E.	Lessard	Pariseau
Benson, D.D.	Frederickson, D.R.	Johnston	Mehrkens	Renneke
Benson, J.E.	Gustafson	Knaak	Neuville	Storm
Berg	Halberg	Laidig	Olson	

Those who voted in the negative were:

Adkins	Dicklich	Langseth	Morse	Sams
Beckman	Finn	Larson	Novak	Samuelson
Berglin	Flynn	Luther	Piper	Spear
Bertram	Frederickson, D.J.	Marty	Pogemiller	Stumpf
Chmielewski	Hottinger	Merriam	Price	Traub
Cohen	Johnson, D.J.	Metzen	Ranum	Vickerman
Davis	Johnson, J.B.	Moe, R.D.	Reichgott	
DeCramer	Kroening	Mondale	Riveness	

The motion did not prevail. So the amendment was not adopted.

Mr. Berg moved to amend S.F. No. 971 as follows:

Page 1, line 11, strike "June"

Page 1, line 12, strike "12," and delete the new language and insert "*the United States Food and Drug Administration approves biosynthetic bovine somatotropin for use in dairy cattle*"

Page 1, line 20, strike "June 12,"

Page 1, line 21, delete the new language and insert "*the United States Food and Drug Administration approves biosynthetic bovine somatotropin for use in dairy cattle*"

Page 2, line 20, strike "June 12," and delete the new language and insert "*the United States Food and Drug Administration approves biosynthetic bovine somatotropin for use in dairy cattle*"

Page 2, line 31, delete "*June 12, 1992*" and insert "*the United States Food and Drug Administration approves biosynthetic bovine somatotropin for use in dairy cattle*"

Page 3, line 11, after the comma, insert "*or when the United States Food and Drug Administration approves biosynthetic bovine somatotropin for use in dairy cattle,*"

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 23 and nays 36, as follows:

Those who voted in the affirmative were:

Belanger	Dahl	Johnson, D.E.	McGowan	Renneke
Benson, D.D.	Day	Johnston	Mehrkens	Solon
Benson, J.E.	Frederickson, D.R.	Knaak	Neuville	Storm
Berg	Gustafson	Laidig	Olson	
Bernhagen	Halberg	Lessard	Pariseau	

Those who voted in the negative were:

Adkins	Finn	Larson	Novak	Spear
Beckman	Flynn	Luther	Pappas	Traub
Berglin	Frederickson, D.J.	Marty	Price	Vickerman
Bertram	Hottinger	Merriam	Ranum	Waldorf
Cohen	Johnson, D.J.	Metzen	Reichgott	
Davis	Johnson, J.B.	Moe, R.D.	Riveness	
DeCramer	Kroening	Mondale	Sams	
Dicklich	Langseth	Morse	Samuelson	

The motion did not prevail. So the amendment was not adopted.

On motion of Mr. Moe, R.D., the report of the Committee of the Whole, as kept by the Secretary, was adopted.

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Order of Business of Reports of Committees.

REPORTS OF COMMITTEES

Mr. Moe, R.D. moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Ms. Berglin from the Committee on Health and Human Services, to which was referred

S.F. No. 1082: A bill for an act relating to human services; establishing requirements for home care services and preadmission screenings; clarifying requirements for alternative care; providing for alternative care programs; establishing a senior agenda for independent living; amending Minnesota Statutes 1990, sections 144A.31; 144A.45, subdivision 2; 144A.46, subdivision 2; 256B.04, subdivision 16; 256B.0625, subdivision 7, and by adding subdivisions; 256B.0627; 256B.093; 256B.64; 256D.44, by adding a subdivision; and Laws 1988, chapter 689, article 2, section 256, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 256 and 256B; repealing Minnesota Statutes 1990, sections 144A.31, subdivisions 2 and 3; 256B.0625, subdivisions 6 and 19; 256B.0627, subdivision 3; and 256B.71, subdivision 5.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1990, section 144A.31, is amended to read:

144A.31 [INTERAGENCY ~~BOARD FOR QUALITY ASSURANCE~~ *LONG-TERM CARE PLANNING COMMITTEE*.]

Subdivision 1. [INTERAGENCY ~~BOARD~~ *LONG-TERM CARE PLANNING COMMITTEE*.] The commissioners of health and human services shall establish, by July 1, 1983, an interagency ~~board~~ *committee* of *managerial* employees of their respective departments who are knowledgeable and employed in the areas of long-term care, geriatric care, *community services for the elderly,* long-term care facility inspection, or quality of care assurance. The number of interagency ~~board~~ *committee* members shall not exceed ~~eight~~ *twelve*; ~~three~~ *four* members each to represent the commissioners of health and human services and one member each to represent the commissioners of state planning ~~and~~, housing finance, *finance, and the chair of the Minnesota board on aging*. ~~The board shall identify long-term care issues requiring coordinated interagency policies and shall conduct analyses, coordinate policy development, and make recommendations to the commissioners for effective implementation of these policies.~~ The commissioner of human services and the commissioner of health or their designees shall annually alternate chairing and convening the ~~board~~ *committee*. The ~~board~~ *committee* may utilize the expertise and time of other individuals employed by ~~either~~ *each* department as needed. The ~~board~~ *committee* may recommend that the commissioners contract for services as needed. The ~~board~~ *committee* shall meet as often as necessary to accomplish its duties, but at least quarterly. The ~~board~~ *committee* shall establish procedures, including public hearings, for allowing regular opportunities for input from ~~residents, nursing homes~~ *consumers of long-term care services, advocates, trade associations, facility administrators, county agency administrators*, and other interested persons.

~~Subd. 2. [INSPECTIONS.] No later than January 1, 1988, the board shall develop and recommend implementation and enforcement of an effective system to ensure quality of care in each nursing home in the state. Quality of care includes evaluating, using the resident's care plan, whether the resident's ability to function is optimized and should not be measured solely by the number or amount of services provided.~~

~~The board shall assist the commissioner of health in developing methods to ensure that inspections and reinspections of nursing homes are conducted with a frequency and in a manner calculated to most effectively and appropriately fulfill its quality assurance responsibilities and achieve the greatest benefit to nursing home residents. The board shall identify and recommend criteria and methods for identifying those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. The commissioner of health shall require a higher frequency and extent of inspections with respect to those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. These concerns include but are not limited to: complaints about care, safety, or rights; situations where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; instances of frequent change in administration in excess of normal turnover rates; and situations where persons involved in ownership or administration of the nursing home have been convicted of engaging in criminal~~

~~activity. A nursing home that presents none of these concerns or any other concern or condition recommended by the board and established by the commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years for compliance with key requirements as determined by the board.~~

~~The board shall develop and recommend to the commissioners mechanisms beyond the inspection process to protect resident care, safety, and rights, including but not limited to coordination with the office of health facility complaints and the nursing home ombudsman program.~~

~~Subd. 3. [METHODS FOR DETERMINING RESIDENT CARE NEEDS.] The board shall develop and recommend to the commissioners definitions for levels of care and methods for determining resident care needs for implementation on July 1, 1985, in order to adjust payments for resident care based on the mix of resident needs in a nursing home. The methods for determining resident care needs shall include assessments of ability to perform activities of daily living and assessments of medical and therapeutic needs.~~

Subd. 2a. [DUTIES.] *The interagency committee shall identify long-term care issues requiring coordinated interagency policies and shall conduct analyses, coordinate policy development, and make recommendations to the commissioners for effective implementation of these policies. The committee shall refine state long-term goals, establish performance indicators, and develop other methods or measures to evaluate program performance, including client outcomes. The committee shall review the effectiveness of programs in meeting their objectives. The committee shall also:*

(1) facilitate the development of regional and local bodies to plan and coordinate regional and local services;

(2) recommend a single regional or local point of access for persons seeking information on long-term care services;

(3) recommend changes in state funding and administrative policies that are necessary to maximize the use of home and community-based care and that promote the use of the least costly alternative without sacrificing quality of care; and

(4) develop methods of identifying and serving seniors who need minimal services to remain independent but who are likely to develop a need for more extensive services in the absence of these minimal services.

Subd. 2b. [GOALS OF THE COMMITTEE.] *The long-term goals of the committee are:*

(1) to achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) to develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) to develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care; and

(4) to maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly served in institutional settings.

These goals are designed to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and

human resources.

Subd. 4. [ENFORCEMENT.] The ~~board~~ *committee* shall develop and recommend for implementation effective methods of enforcing quality of care standards. The ~~board~~ *committee* shall develop and monitor, and the commissioner of human services shall implement, a resident relocation plan that instructs a county in which a nursing home or certified boarding care home is located of procedures to ensure that the needs of residents in nursing homes or certified boarding care homes about to be closed are met. The duties of a county under the relocation plan also apply when residents are to be discharged from a nursing home or certified boarding care home as a result of a change in certification, closure, or loss or termination of the facility's medical assistance provider agreement. The resident relocation plans and county duties required in this subdivision apply to the voluntary or involuntary closure, or reduction in services or size of, an intermediate care facility for the mentally retarded. The relocation plan for intermediate care facilities for the mentally retarded must conform to Minnesota Rules, parts 4655.6810 to 4655.6830, 9525.0015 to 9525.0165, and 9546.0010 to 9546.0060, or their successors. The commissioners of health and human services may waive a portion of existing rules that the commissioners determine does not apply to persons with mental retardation or related conditions. The county shall ensure appropriate placement of residents in licensed and certified facilities or other alternative care such as home health care and foster care placement. In preparing for relocation, the ~~board~~ *committee* shall ensure that residents and their families or guardians are involved in planning the relocation.

Subd. 5. [REPORTS.] The ~~board~~ *committee* shall prepare a *biennial* report and the commissioners of health and human services shall deliver this report to the legislature ~~no later than January 15, 1984, on the board's proposals and progress on implementation of the methods~~ *beginning January 31, 1993, listing progress, achievements, and current goals and objectives as* required under subdivision 2. The commissioners shall recommend changes in or additions to legislation necessary or desirable to fulfill their responsibilities. ~~The board shall prepare an annual report and the commissioners shall deliver this report annually to the legislature, beginning in January 1985, on the implementation of the provisions of this section.~~

Subd. 6. [DATA.] The interagency ~~board may~~ *committee shall* have access to data from the commissioners of health, human services, ~~and public safety~~ *housing finance, and state planning* for carrying out its duties under this section. The commissioner of health and the commissioner of human services may each have access to data on persons, including data on vendors of services, from the other to carry out the purposes of this section. If the interagency ~~board~~ *committee*, the commissioner of health, or the commissioner of human services receives data on persons, including data on vendors of services, that is collected, maintained, used or disseminated in an investigation, authorized by statute and relating to enforcement of rules or law, the ~~board~~ *committee* or the commissioner shall not disclose that information except:

(a) pursuant to section 13.05;

(b) pursuant to statute or valid court order; or

(c) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense.

Data described in this subdivision is classified as public data upon its submission to an administrative law judge or court in an administrative or judicial proceeding.

Subd. 7. [LONG-TERM CARE RESEARCH AND DATABASE.] *The interagency long-term care planning committee shall collect and analyze state and national long-term care data and research, including relevant health data and information and research relating to long-term care and social needs, service utilization, costs, and client outcomes. The committee shall make recommendations to state agencies and other public and private agencies for methods of improving coordination of existing data, develop data needed for long-term care research, and promote new research activities. Research and data activities must be designed to:*

(1) improve the validity and reliability of existing data and research information;

(2) identify sources of funding and potential uses of funding sources;

(3) evaluate the effectiveness and client outcomes of existing programs; and

(4) identify and plan for future changes in the number, level, and type of services needed by seniors.

Sec. 2. Minnesota Statutes 1990, section 144A.46, subdivision 4, is amended to read:

Subd. 4. [RELATION TO OTHER REGULATORY PROGRAMS.] In the exercise of the authority granted under sections 144A.43 to 144A.49, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. ~~For home care providers certified under the Medicare program, the state standards must not be inconsistent with the Medicare standards for Medicare services.~~ *The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers.* To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.48 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Sec. 3. [256.9751] [CONGREGATE HOUSING SERVICES PROJECTS.]

Subdivision 1. [DEFINITIONS.] *For the purposes of this section, the following terms have the meanings given them.*

(a) [CONGREGATE HOUSING.] *"Congregate housing" means federally or locally subsidized housing, designed for the elderly, consisting of private apartments and common areas which can be used for activities and for serving meals.*

(b) [CONGREGATE HOUSING SERVICES PROJECTS.] *"Congregate*

housing services project" means a project in which services are or could be made available to older persons who live in subsidized housing and which helps delay or prevent nursing home placement. To be considered a congregate housing services project, a project must have: (1) an on-site coordinator, and (2) a plan for providing a minimum of one meal per day, for each elderly participant, seven days a week.

(c) [ON-SITE COORDINATOR.] *"On-site coordinator" means a person who works on-site in a building or buildings and who serves as a contact for older persons who need services, support, and assistance in order to delay or prevent nursing home placement.*

(d) [CONGREGATE HOUSING SERVICES PROJECT PARTICIPANTS OR PROJECT PARTICIPANTS.] *"Congregate housing services project participants" or "project participants" means elderly persons 60 years old or older, who are currently residents of or who are applying for residence in housing sites, and who need support services to remain independent.*

Subd. 2. [ADVISORY COMMITTEE.] *An advisory committee shall be appointed to advise the Minnesota board on aging on the development and implementation of the congregate housing services projects. The advisory committee shall review procedures and provide advice and technical assistance to the Minnesota board on aging regarding the grant program established under this section. The advisory committee shall consist of not more than 15 people appointed by the Minnesota board on aging, and shall be comprised of representatives from public and nonprofit service and housing providers and consumers from all areas of the state. Members of the advisory committee shall not be compensated for service.*

Subd. 3. [GRANT PROGRAM.] *The Minnesota board on aging shall establish a congregate housing services grant program which will enable communities to provide on-site coordinators to serve as a contact for older persons who need services and support, and assistance to access services in order to delay or prevent nursing home placement.*

Subd. 4. [USE OF GRANT FUNDS.] *Grant funds shall be used to develop and fund on-site coordinator positions. Grant funds shall not be used to duplicate existing funds, to modify buildings, or to purchase equipment.*

Subd. 5. [GRANT ELIGIBILITY.] *A public or nonprofit agency or housing unit may apply for funds to provide a coordinator for congregate housing services to an identified population of frail elderly persons in a subsidized multi-unit apartment building or buildings in a community. The board shall give preference to applicants that meet the requirements of this section, and that have a common dining site. Local match may be required. State money received may also be used to match federal money allocated for congregate housing services. Grants shall be awarded to urban and rural sites.*

Subd. 6. [CRITERIA FOR SELECTION.] *The Minnesota board on aging shall select projects under this section according to the following criteria:*

(1) the extent to which the proposed project assists older persons to age-in-place to prevent or delay nursing home placement;

(2) the extent to which the proposed project identifies the needs of project participants;

(3) the extent to which the proposed project identifies how the on-site coordinator will help meet the needs of project participants;

(4) the extent to which the proposed project ensures the availability of one meal a day, seven days a week, for participants in need;

(5) the extent to which the proposed project demonstrates involvement of participants and family members in the project; and

(6) the extent to which the proposed project demonstrates involvement of housing providers and public and private service agencies, including area agencies on aging.

Subd. 7. [GRANT APPLICATIONS.] *The Minnesota board on aging shall request proposals for grants and award grants using the criteria in subdivision 6. Grant applications shall include:*

(1) documentation of the need for congregate services so the residents can remain independent;

(2) a description of the resources, such as social services and health services, that will be available in the community to provide the necessary support services;

(3) a description of the target population, as defined in subdivision 1, paragraph (d);

(4) a performance plan that includes written performance objectives, outcomes, timelines, and the procedure the grantee will use to document and measure success in meeting the objectives; and

(5) letters of support from appropriate public and private agencies and organizations, such as area agencies on aging and county human service departments that demonstrate an intent to work with and coordinate with the agency requesting a grant.

Subd. 8. [REPORT.] *By January 1, 1993, the Minnesota board on aging shall submit a report to the legislature evaluating the programs. The report must document the project costs and outcomes that helped delay or prevent nursing home placement. The report must describe steps taken for quality assurance and must also include recommendations based on the project findings.*

Sec. 4. Minnesota Statutes 1990, section 256B.04, subdivision 16, is amended to read:

Subd. 16. [PERSONAL CARE SERVICES.] (a) ~~The commissioner shall adopt permanent rules to implement, administer, and operate personal care services. The rules must incorporate the standards and requirements adopted by the commissioner of health under section 144A.45 which are applicable to the provision of personal care.~~ *Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.*

The commissioner of human services shall establish an advisory group

including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rules the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the department of health to the legislature by February 15, 1992.

Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by the registered nurse supervising the personal care assistant;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) ~~For personal care assistants under contract with an agency under paragraph (a), the provision of training and supervision by the agency does not create an employment relationship.~~ The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county.

Sec. 5. Minnesota Statutes 1990, section 256B.0625, is amended by adding a subdivision to read:

Subd. 6a. [HOME HEALTH SERVICES.] *Home health services are those services specified in Minnesota Rules, part 9505.0290. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services at a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless the commissioner has prior authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with mental retardation, to prevent an admission to a hospital or nursing facility. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to section 256B.0627.*

Sec. 6. Minnesota Statutes 1990, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. [PRIVATE DUTY NURSING.] Medical assistance covers private duty nursing services *in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home and when, without the provision of private duty nursing, their health and safety would be jeopardized. Medical assistance does not cover private duty nursing services at a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the spouse of the recipient or the parent or foster care provider of a recipient who is under age 18, or the recipient's legal guardian.*

Sec. 7. Minnesota Statutes 1990, section 256B.0625, is amended by adding a subdivision to read:

Subd. 19a. [PERSONAL CARE SERVICES.] *Medical assistance covers personal care services in a recipient's home. Recipients who can direct their own care, or persons who cannot direct their own care when accompanied by the responsible party, may use approved hours outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Medical assistance does not cover personal care services at a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse of the recipient or the parent of a recipient under age 18, the responsible party, the foster care provider of a recipient who cannot direct their own care or the recipient's legal guardian. Parents of adult recipients, adult children of the recipient, or adult siblings of the recipient may be reimbursed for personal care services if they are granted a waiver under section 256B.0627.*

Sec. 8. Minnesota Statutes 1990, section 256B.0627, is amended to read:

256B.0627 [COVERED SERVICE; HOME CARE SERVICES.]

Subdivision 1. [DEFINITION.] "Home care services" means a ~~medically necessary~~ health service, *determined by the commissioner as medically necessary,* that is ordered by a physician and documented in a *care* plan ~~of care~~ that is reviewed ~~and revised as medically necessary~~ by the physician at least once every 60 days~~. Home care services include personal care and nursing supervision of personal care services which is reviewed and revised as medically necessary by the physician at least once every 365 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. "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to*

9505.0475. "Care plan" means a written description of the services needed which shall include a detailed description of the covered home care services, who is providing the services, frequency of those services, and duration of those services. The care plan shall also include expected outcomes and goals including expected date of goal accomplishment.

Subd. 2. [SERVICES COVERED.] Home care services covered under this section include:

(1) nursing services *under section 256B.0625, subdivision 6a*;

(2) private duty nursing services *under section 256B.0625, subdivision 7*;

(3) home health aide services *under section 256B.0625, subdivision 6a*;

(4) personal care services *under section 256B.0625, subdivision 19a*; and

(5) nursing supervision of personal care services *under section 256B.0625, subdivision 19a.*

~~Subd. 3. [PRIVATE DUTY NURSING SERVICES; WHO MAY PROVIDE.] Private duty nursing services may be provided by a registered nurse or licensed practical nurse who is not the recipient's spouse, legal guardian, or parent of a minor child.~~

Subd. 4. [PERSONAL CARE SERVICES.] (a) ~~Personal care services may be provided by a qualified individual who is not the recipient's spouse, legal guardian, or parent of a minor child.~~

~~(b)~~ The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) range of motion exercises;

(4) respiratory assistance;

(5) transfers;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is normally self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) ~~services provided for the recipient's personal health and safety;~~

~~(15)~~ helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules;

(15) supervision and observation that are medically necessary because of the recipient's diagnosis or disability; and

(16) incidental household services that are an integral part of a personal care service described in clauses (1) to (15).

~~(c)~~ *(b)* The personal care services that are not eligible for payment are the following:

(1) personal care services that are not in the *care* plan ~~of care~~ developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or ~~family~~ *the responsible party directing the care* of the recipient;

(2) services that are not supervised by the registered nurse;

(3) services provided by the recipient's spouse, legal guardian, ~~or~~ parent of a minor child, *or foster care provider of a recipient who cannot direct their own care*;

(4) sterile procedures; ~~and~~

(5) injections of fluids into veins, muscles, or skin~~.~~*;*

(6) services provided by parents of adult recipients, adult children, or adult siblings unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a 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, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(7) homemaker services that are not an integral part of a personal care services; and

(8) home maintenance, or chore services.

Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance payments for home care services shall be limited according to ~~paragraphs (a) to (e)~~ *this subdivision*.

(a) [EXEMPTION FROM PAYMENT LIMITATIONS.] The level, or the number of hours or visits of a specific service, of home ~~health~~ care services to a recipient that began before and is continued without increase on or after December 1987, shall be exempt from the payment limitations of this section, as long as the services are medically necessary.

(b) [~~LEVEL I HOME CARE~~ *LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION*.] ~~For all new cases after December 1987, medically necessary home care services up to $800 may be provided in a calendar month.~~

~~If the services in the recipient's home care plan will exceed the $800 threshold for 30 days or less, the medically necessary services may be provided.~~ *A recipient may receive the following amounts of home care services during a calendar year:*

(1) a total of 40 home health aide visits, skilled nurse visits, health promotions, or health assessments under section 256B.0625, subdivision 6a; and

(2) a total of ten hours of nursing supervision under section 256B.0625, subdivision 7 or 19a.

(c) [PRIOR AUTHORIZATION; EXCEPTIONS.] *All home care services above the limits in paragraph (b) must receive the commissioner's prior authorization, except when:*

(1) the home care services were required to treat an emergency medical condition that, if not immediately treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened; or

(3) a third party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request.

(d) [RETROACTIVE AUTHORIZATION.] *A request for retroactive authorization under paragraph (c) will be evaluated according to the same criteria applied to prior authorization requests. Implementation of this provision shall begin no later than October 1, 1991, except that recipients who are currently receiving medically necessary services above the limits established under paragraph (b) may have a reasonable amount of time to arrange for waivered services under section 256B.49 or to establish an alternative living arrangement. All current recipients shall be phased down to the limits established under paragraph (b) on or before April 1, 1992.*

~~(e)~~ *(e)* [~~LEVEL II HOME CARE~~ *ASSESSMENT AND CARE PLAN.*] ~~If the services in the recipient's home care plan exceed $800 for more than 30 days, a public health nurse from the local preadmission screening team shall determine the recipient's maximum level of home care according to this paragraph.~~ *The home care provider shall conduct an assessment and complete a care plan using forms specified by the commissioner. For the recipient to receive, or continue to receive, home care services, the provider must submit evidence necessary for the commissioner to determine the medical necessity of the home care services. The provider shall submit to the commissioner the assessment, the care plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries.*

~~(1)~~ *(f)* [PRIOR AUTHORIZATION.] The ~~public health nurse from the local preadmission screening team shall base the determination of the recipient's maximum level of care on the need and eligibility of the recipient for one of the following placements~~ *commissioner, or the commissioner's designee, shall review the assessment, the care plan, and any additional information that is submitted. The commissioner shall, within 30 days after*

receiving a request for prior authorization, authorize home care services as follows:

~~(i) residential facility for persons with mental retardation or related conditions operated under section 256B.501;~~

~~(ii) inpatient hospital care for a ventilator dependent recipient. "Ventilator dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to or has been dependent for at least 30 consecutive days; or~~

~~(iii) all other recipients not appropriate for one of the above placements.~~

~~(2) If the recipient is eligible under clause (1)(i), the monthly medical assistance reimbursement for home care services shall not exceed the total monthly statewide average payment rate for residential facilities for children or adults with mental retardation or related conditions as appropriate for the recipient's age and level of self-preservation as determined according to Minnesota Rules, parts 9553.0010 to 9553.0080.~~

(l) [HOME HEALTH SERVICES.] *All home health services provided by a nurse or a home health aide that exceed the limits established in paragraph (b) must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost effectiveness when compared with other care options.*

(2) [PERSONAL CARE SERVICES.] *(i) All personal care services must be prior authorized by the commissioner or the commissioner's designee except for the limits on supervision established in paragraph (b). The amount of personal care services authorized must be based on the recipient's case mix classification according to section 256B.0911, except that a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:*

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's case mix level;

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs;

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have complex behaviors;

(D) up to the rate, as of July 1, 1991, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.091 or 256B.092.

(ii) The number of direct care hours shall be determined according to annual cost reports which are submitted to the department by nursing facilities each year. The average number of direct care hours, as established by May 1, shall be incorporated into the home care limits on July 1 each year.

(iii) The case mix level shall be determined by the commissioner or the

commissioner's designee based on information submitted to the commissioner by the personal care provider on forms specified by the commissioner. The forms shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of children and non-elderly adults who need home care. The commissioner shall establish these forms and protocols under this section and shall use the advisory group established in section 256B.04, subdivision 16, for consultation in establishing the forms and protocols by October 1, 1991.

(iv) A recipient shall qualify as having complex medical needs if they require:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care; or

(G) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having complex behavior if they exhibit on a daily basis the following:

(A) self-injurious behavior;

(B) unusual or repetitive habits;

(C) withdrawal behavior;

(D) hurtful to others;

(E) socially or offensive behavior;

(F) destruction of property; or

(G) needs constant supervision one-to-one for self preservation.

(vi) The complex behaviors in clauses (A) to (G) have the meanings developed under section 256B.501.

(3) [PRIVATE DUTY NURSING SERVICES.] *All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services when:*

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize up to 16 hours per day of private duty

nursing services or up to 24 hours per day of private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined that a health benefit plan is required to pay for medically necessary nursing services. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

~~(3)~~ *(4)* [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ~~eligible under clause (1)(ii)~~ *ventilator dependent*, the monthly medical assistance ~~reimbursement~~ *authorization* for home care services shall not exceed the monthly cost of care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. *"Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.*

~~(4) If the recipient is not eligible under either clause (1)(i) or (1)(ii), the monthly medical assistance reimbursement for home care services shall not exceed the total monthly statewide average payment for the case mix classification most appropriate to the recipient. The case mix classification is established under section 256B.431.~~

~~(5) The determination of the recipient's maximum level of home care by the public health nurse is called a home care cost assessment. The home care cost assessment must be requested by the home care provider before the end of the first 30 days of provided service and must be conducted by the public health nurse within ten working days following request.~~

~~(6) A home care provider shall request a new home care cost assessment when the needs of the individual have changed enough to require that a revised care plan be implemented that will increase costs beyond what was approved by the previous home care cost assessment and the change is anticipated to last for more than 30 days. The home care provider must request the home care cost assessment before the end of the first 30 days of provided service. Whenever a home care cost assessment is completed, the public health nurse that completes the home care cost assessment, in consultation with the home care provider,~~

(g) [PRIOR AUTHORIZATION; TIME LIMITS.] *The commissioner or the commissioner's designee* shall determine the time period for which a ~~home care cost assessment~~ *prior authorization* shall remain valid. If the recipient continues to require home care services beyond the ~~limited~~ duration of the ~~home care cost assessment~~ *prior authorization*, the home care provider must request a ~~reassessment through the home care cost assessment~~ *new prior authorization through the* process described above. Under no circumstances shall a ~~home care cost assessment~~ *prior authorization* be valid for more than 12 months.

~~(7) Reimbursement for the home care cost assessment shall be made through the Medicaid administrative authority. The state shall pay the nonfederal share.~~

(h) [APPROVAL OF HOME CARE SERVICES.] *The commissioner or the commissioner's designee shall determine the medical necessity of home*

care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, the care plan, the recipient's age, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

~~(d) [LEVEL III HOME CARE.] If the home care provider determines that the recipient's needs exceed the amount approved for the appropriate level of care as determined in paragraph (c), the home care provider may refer the case to the department for a level III determination. Based on the client needs, physician orders, diagnosis, condition, and plan of care, the department may give prior approval for care that exceeds level II described in paragraph (c). The amount approved shall not exceed the maximum cost for the appropriate level of care as determined in paragraph (c), clause (1), which will be the maximum ICF/MR rate for intermediate care facilities for persons with mental retardation or related conditions, or the maximum nursing home case mix payment, or the highest hospital cost for the state.~~

(i) [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] The department has 30 days from receipt of the request to complete the ~~level III determination~~ *prior authorization*, during which time it may approve ~~the higher level while reviewing the case~~ *a temporary level of home care service. Authorization under this authority for a temporary level of home care services is limited to the time specified by the commissioner.*

~~Case reviews or approval of home care services in levels II and III may result in assignment of a case manager.~~

~~(e)~~ *(j)* [PRIOR ~~APPROVAL~~ *AUTHORIZATION* REQUIRED IN FOSTER CARE SETTING.] ~~Any~~ Home care ~~service~~ *services* provided in an adult or child foster care setting must receive prior ~~approval~~ *authorization* by the department *according to the limits established in paragraph (b).*

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or the recipient is referred to the commissioner by a regional treatment center preadmission evaluation team;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless the recipient is referred to the commissioner by a regional treatment center preadmission evaluation team;

(4) home care services when the number of foster care residents is greater than four; or

(5) home care services when combined with foster care payments, less the base rate, that exceed the total amount that medical assistance would pay for the recipient's care in a medical institution.

Subd. 6. [RECOVERY OF EXCESSIVE PAYMENTS.] The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section.

Sec. 9. [256B.0628] [PRIOR AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.]

Subdivision 1. [STATE COORDINATION.] *The commissioner shall supervise the coordination of the prior authorization and review of home care services that are reimbursed by medical assistance.*

Subd. 2. [CONTRACTOR DUTIES.] *(a) The commissioner may contract with qualified registered nurses, or qualified agencies, to provide home care prior authorization and review services for medical assistance recipients who are receiving home care services.*

(b) Reimbursement for the prior authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The contractor must:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a care plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost-effectiveness of medical assistance home care services;

(4) recommend to the commissioner the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner; and

(6) conduct on-site assessments when determined necessary by the commissioner.

(c) In addition, the contractor may be requested by the commissioner to:

(1) review care plans and reimbursement data for utilization of services that exceed community-based standards for home care, inappropriate home care services, home care services that do not meet quality of care standards, or unauthorized services and make appropriate referrals to the commissioner or other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

(3) coordinate home care services with other medical assistance services under section 256B.0625;

(4) assist the recipient with problems related to the provision of home care services; and

(5) assure the quality of home care services.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

Sec. 10. [256B.0911] [NURSING HOME PREADMISSION SCREENING.]

Subdivision 1. [PURPOSE AND GOAL.] *The purpose of the preadmission screening program is to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs. Further, the goal of the program is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.*

Subd. 2. [PERSONS REQUIRED TO BE SCREENED; EXEMPTIONS.] *All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:*

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities;

(3) individuals whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team prior to admission and provides an update to the screening team on the 30th day after admission;

(4) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration;

(5) individuals who are screened by another state within three months before admission to a certified nursing facility; or

(6) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project at the time of application to a nursing home.

Regardless of the exemptions in clauses (2) to (4), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must be screened before admission unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 101-508.

Persons transferred from an acute care facility to a certified nursing facility may be admitted to the nursing facility before screening, if authorized by the county agency; however, the person must be screened within ten working days after the admission.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Subd. 3. [PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING.] *(a) A local screening team shall be established by the county agency and the county public health nursing service of the local board of health. Each local screening team shall be composed of a social worker and a public health nurse from their respective county agencies. Two or more counties may collaborate to establish a joint local screening team or teams.*

(b) Both members of the team must conduct the screening. However, individuals who are being transferred from an acute care facility to a certified nursing facility may be screened by only one member of the screening team in consultation with the other member.

(c) In assessing a person's needs, each screening team shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included on the screening team if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

(d) If a person who has been screened must be reassessed to assign a case mix classification because admission to a nursing facility occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team.

Subd. 4. [RESPONSIBILITIES OF THE COUNTY AGENCY AND THE SCREENING TEAM.] *(a) The county agency shall:*

(1) provide information and education to the general public regarding availability of the preadmission screening program;

(2) accept referrals from individuals, families, human service and health professionals, and hospital and nursing facility personnel;

(3) assess the health, psychological, and social needs of referred individuals and identify services needed to maintain these persons in the least restrictive environments;

(4) determine if the individual screened needs nursing facility level of care;

(5) assess active treatment needs in cooperation with:

(i) a qualified mental health professional for persons with a primary or secondary diagnosis of mental illness; and

(ii) a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this clause, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional in Code of Federal Regulations, title 42, section 483.430;

(6) make recommendations for individuals screened regarding cost-effective community services which are available to the individual;

(7) make recommendations for individuals screened regarding nursing home placement when there are no cost-effective community services available;

(8) develop an individual's community care plan and provide follow-up services as needed; and

(9) prepare and submit reports that may be required by the commissioner of human services.

The county agency may determine in cooperation with the local board of health that the public health nursing agency of the local board of health is the lead agency which is responsible for all of the activities above except clause (5).

(b) The screening team shall document that the most cost-effective alternatives available were offered to the individual or the individual's legal representative. For purposes of this section, "cost-effective alternatives" means community services and living arrangements that cost the same or

less than nursing facility care.

The screening shall be conducted within ten working days after the date of referral or, for those approved for transfer from an acute care facility to a certified nursing facility, within ten working days after admission to the nursing facility. For persons who are eligible for medical assistance or who would be eligible within 180 days of admission to a nursing facility and who are admitted to a nursing facility, the nursing facility must include the screening team or the case manager in the discharge planning process for those individuals who the team has determined have discharge potential. The screening team or the case manager must ensure a smooth transition and follow-up for the individual's return to the community.

Local screening teams shall cooperate with other public and private agencies in the community, in order to offer a variety of cost-effective services to the disabled and elderly. The screening team shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

Subd. 5. [SIMPLIFICATION OF FORMS.] *The commissioner shall minimize the number of forms required in the preadmission screening process and shall limit the screening document to items necessary for care plan approval, reimbursement, program planning, evaluation, and policy development.*

Subd. 6. [REIMBURSEMENT FOR PREADMISSION SCREENING.] *(a) The total screening cost for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's estimate of the total annual cost of screenings allowed in the county for the following rate year by 12 to determine the monthly cost estimate and allocating the monthly cost estimate to each nursing facility based on the number of licensed beds in the nursing facility.*

(b) The rate allowed for a screening where two team members are present shall be the actual costs up to $195. The rate allowed for a screening where only one team member is present shall be the actual costs up to $117. Annually on July 1, the commissioner shall adjust the rate up to the percentage change forecast in the fourth quarter of the prior calendar year by the Home Health Agency Market Basket of Operating Costs, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc.

(c) The monthly cost estimate for each certified nursing facility must be submitted to the state by the county no later than February 15 of each year for inclusion in the nursing facility's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing facility as an operating cost of that nursing facility in accordance with section 256B.431, subdivision 2b, paragraph (g). The monthly cost estimates approved by the commissioner must be sent to the nursing facility by the county no later than April 15 of each year.

(d) If in more than ten percent of the total number of screenings performed by a county in a fiscal year for all individuals regardless of payment source, the screening timelines were not met because a county was late in screening the individual, the county is solely responsible for paying the cost of those delayed screenings that exceed ten percent.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening teams.

Subd. 7. [REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.] *Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screening team has determined does not meet the level of care criteria for nursing facility placement.*

An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation. However, the local county mental health authority or the local mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or does need active treatment as defined in Public Law Numbers 100-203 and 101-508.

Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.

Subd. 8. [ADVISORY COMMITTEE.] *The commissioner shall appoint an advisory committee to advise the commissioner on the preadmission screening program, the alternative care program under section 256B.0913, and the home and community-based services waiver programs for the elderly and the disabled. The advisory committee shall review policies and procedures and provide advice and technical assistance to the commissioner regarding the effectiveness and the efficient administration of the programs. The advisory committee must consist of not more than 20 people appointed by the commissioner and must be comprised of representatives from public agencies, public and private service providers, and consumers from all areas of the state. Members of the advisory committee must not be compensated for service.*

Sec. 11. [256B.0913] [ALTERNATIVE CARE PROGRAM.]

Subdivision 1. [PURPOSE AND GOALS.] *The purpose of the alternative care program is to provide funding for or access to home and community-based services for frail elderly persons, in order to limit nursing facility placements. The program is designed to support frail elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for frail elderly people. Further, the goals of the program are:*

(1) to contain medical assistance expenditures by providing care in the community at a cost the same or less than nursing facility costs; and

(2) to maintain the moratorium on new construction of nursing home beds.

Subd. 2. [ELIGIBILITY FOR SERVICES.] *Alternative care services are available to all frail older Minnesotans. This includes:*

(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;

(2) persons who would be eligible for medical assistance within 180 days

of admission to a nursing facility and served under subdivisions 4 to 13; and

(3) persons who are paying for their services out-of-pocket.

Subd. 3. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR MEDICAL ASSISTANCE RECIPIENTS.] *Funding for services for persons who are eligible for medical assistance is available under section 256B.0627, governing home care services, or 256B.0915, governing the Medicaid waiver for home and community-based services.*

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 screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse;

(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 screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

(5) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; and

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the regional average monthly medical assistance payment for nursing facility care at the individual's case mix classification to which the individual would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.

(c) The regional payment for nursing facility care is the monthly average nursing facility rate for the applicable nursing home geographic group in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) 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 spend-down if the person applied, unless authorized by the commissioner.

(f) Alternative care funding is not available for a person who resides in a licensed nursing home or boarding care home, except for case management services which are being provided in support of the discharge planning process.

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; and

(9) care-related supplies and equipment.

(b) The county agency may use up to ten percent of the annual allocation of alternative care funding for payment of costs of meals delivered to the home, transportation, skilled nursing, chore services, companion services, nutrition services, and training for direct informal caregivers. The commissioner shall determine the impact on alternative care costs of allowing these additional services to be provided and shall report the findings to the legislature by February 15, 1993, including any recommendations regarding provision of the additional services.

(c) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

(d) These services must be provided by a licensed provider, a home health agency certified for reimbursement under Titles XVIII and XIX of the Social Security Act, or by persons or agencies employed by or contracted with the county agency or the public health nursing agency of the local board of health.

(e) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board.

(f) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(g) Costs for supplies and equipment that exceed $150 per item per month must have prior approval from the commissioner.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to two or more alternative care grant clients who reside in the same apartment building of ten or more units. These services may include care coordination, the costs of preparing one or more nutritionally balanced meals per day, general oversight, and other supportive services which the vendor is licensed to provide according to sections 144A.43 to 144A.49, and which would otherwise be available to individual alternative care grant clients. Reimbursement from the lead agency shall be made to the vendor as a monthly capitated rate negotiated with the county agency. The capitated rate shall not exceed the state share of the average monthly medical assistance nursing facility payment rate of

the case mix resident class to which the 180-day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The capitated rate may not cover rent and direct food costs. A person's eligibility to reside in the building must not be contingent on the person's acceptance or use of the assisted living services. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.01 to 157.031.

(i) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or nonprofit organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage, or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(j) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] *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.*

Subd. 7. [CASE MANAGEMENT.] *The lead agency shall appoint a social worker from the county agency or a registered nurse from the county public health nursing service of the local board of health to be the case manager for any person receiving services funded by the alternative care program. The case manager must ensure the health and safety of the individual client and is responsible for the cost effectiveness of the alternative care individual care plan.*

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] *The case manager shall implement the plan of care for each 180-day eligible client and ensure that a client's service needs and eligibility are reassessed at least every six 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 to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program. The lead agency shall provide documentation in each individual's plan of care and 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.

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] *The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.*

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of county administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. The county shall provide a written statement of the reasons for not selecting providers.

Subd. 10. [ALLOCATION FORMULA.] *(a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only 180-day eligible clients.*

(b) Prior to 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. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.

(c) If the county expenditures for 180-day eligible clients are 95 percent or more of its 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 county expenditures for 180-day eligible clients are less than 95 percent of its 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) For fiscal year 1992 only, a county under paragraph (d) may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (c). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (d) shall be used.

(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of 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 by June 1 of that year.

Subd. 11. [TARGETED FUNDING.] *(a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.*

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care grant spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph

(c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) If the commissioner does not approve a county's application for targeted funds, the funds shall be reallocated to the next ranking county according to paragraph (c), clause (2), that has not yet received funds. Counties that receive such reallocated funds must comply with this section.

(f) The commissioner shall request applications by June 1 each year, for county agencies to apply for targeted funds. The counties selected for targeted funds shall be notified of the amount of their additional funding by August 1 of each year. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

(g) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.

Subd. 12. [CLIENT PREMIUMS.] *A premium is required for all 180-day eligible clients to help pay for the cost of participating in the program. The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. The commissioner shall establish a premium schedule ranging from $25 to $75 per month based on the client's income and assets. Until July 1, 1993, the schedule is not subject to chapter 14. The commissioner shall publish the schedule and any later changes in the State Register and allow a period of 20 working days from the publication date for interested persons to comment before adopting the schedule in final form. The commissioner shall adopt a permanent rule governing client premiums by July 1, 1993, including criteria for determining when services to a client must be terminated due to failure to pay a premium.*

Subd. 13. [COUNTY ALTERNATIVE CARE BIENNIAL PLAN.] *The commissioner shall establish by rule, in accordance with chapter 14, procedures for the submittal and approval of a biennial county plan for the administration of the alternative care program and the coordination with other planning processes for the older adult. In addition to the procedures in rule, this county biennial plan shall also include:*

(1) information on the administration of the preadmission screening program;

(2) information on the administration of the home and community-based services waiver under section 256B.0915;

(3) an application for targeted funds under subdivision 11; and

(4) an optional notice of intent to apply to participate in the long-term care projects under section 256B.0917.

Subd. 14. [REIMBURSEMENT AND RATE ADJUSTMENTS.] *(a) Reimbursement for expenditures for the alternative care services shall be through the invoice processing procedures of the department's Medicaid management information system (MMIS), only with the approval of the client's case manager. To receive reimbursement, the county or vendor must*

submit invoices within 120 days following the month of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) Beginning July 1, 1991, the state will reimburse counties, up to the limits of state appropriations, according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who would be eligible for medical assistance within 180 days of admission to a nursing home.

(d) Annually on July 1, the commissioner must adjust the rates allowed for alternative care services by the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

Sec. 12. [256B.0915] [MEDICAID WAIVER FOR HOME AND COMMUNITY-BASED SERVICES.]

Subdivision 1. [AUTHORITY.] *The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to medical assistance recipients must comply with the criteria approved in the waiver.*

Subd. 2. [SPOUSAL IMPOVERISHMENT POLICIES.] *The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized in Code of Federal Regulations, title 42, section 435.726(1924), and as implemented in sections 256B.0575, 256B.058, and 256B.059 to be applied to persons who are served on the home and community-based services waiver.*

Subd. 3. [LIMITS OF CASES, RATES, REIMBURSEMENT, 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) The monthly limit for the cost of waivered services to an individual waiver client shall be the regional average payment rate of the case mix resident class to which the waiver client would be assigned under medical assistance case mix reimbursement system, for the applicable nursing home geographic group. The regional average payment rate is calculated by determining the monthly average nursing home rate for the applicable nursing home geographic group in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home

residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. 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

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(c) Medical assistance funding for skilled nursing services, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) Expenditures for extended medical supplies and equipment that cost over $150 per month must have the commissioner's prior approval.

(e) Annually on July 1, the commissioner must adjust the rates allowed for services by the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

(f) 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.

(g) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

Sec. 13. [256B.0917] [SENIORS AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS FOR A NEW LONG-TERM CARE STRATEGY.]

Subdivision 1. [PURPOSE, MISSION, GOALS, AND OBJECTIVES.] *(a) The purpose of implementing SAIL projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota. The projects are part of the initial biennial plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:*

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care; and

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly served in institutional settings.

(b) The objective for the fiscal years 1992 and 1993 biennial plan is to implement at least four but not more than six projects in anticipation of a statewide program. These projects will begin the process of implementing: (1) a coordinated planning and administrative process; (2) a refocused function of the preadmission screening program; (3) the development of additional home, community, and residential alternatives to nursing homes; (4) a program to support the informal caregivers for elderly persons; and (5) programs to strengthen the use of volunteers. This is done in conjunction with an expanded role of the interagency long-term care planning committee as described in section 144A.31. The services offered through these projects will be available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Subd. 2. [DESIGN OF SAIL PROJECTS; LOCAL LONG-TERM CARE COORDINATING TEAM.] *(a) The commissioner of human services shall establish SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.*

(b) To be selected for the project, the county social service agencies, public health nursing service agencies, local boards of health, and the area agencies on aging in a geographic area must establish a local long-term care coordinating team which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under Title III of the Social Security Act, Community Social Services Act, Title XX of the Social Security Act and the Local Public Health Act;

(4) ensuring efficient services provision and nonduplication of funding; and

(5) designating a local lead agency and cooperating agencies to implement the local strategy. For purposes of this section, the local lead agency shall be a county agency, a public health nursing service under the local board of health, or an area agency on aging. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must evaluate the success of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(c) The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order

to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(d) The local long-term care coordinating team shall apply to be selected as a project. Once the team is selected as a project, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(e) Projects shall be selected according to the following conditions:

(1) No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

(2) If only two projects are selected, at least one of them must be from a metropolitan statistical area as determined by the United States Census Bureau; if three or four projects are selected, at least one but not more than two projects must be from a metropolitan statistical area; and if more than four projects are selected, at least two but not more than three projects must be from a metropolitan statistical area.

(3) Counties or groups of counties that submit a proposal for a project shall be assigned to types defined by institutional utilization rate and population growth rate in the following manner:

(i) Each county or group of counties shall be measured by the utilization rate of nursing homes and boarding care homes and by the projected growth rate of its population aged 85 and over between 1990 and 2000. For the purposes of this section, "utilization rate" means the proportion of the seniors aged 65 or older in the county or group of counties who reside in a licensed nursing home or boarding care home as determined by the most recent census of residents available from the department of health and the population estimates of the state demographer or the census, whichever is more recent. The "projected growth rate" is the rate of change in the county or group of counties of the population group aged 85 or older between 1990 and 2000 according to the projections of the state demographer.

(ii) The institutional utilization rate of a county or group of counties shall be converted to a category by assigning a "high utilization" category if the rate is above the median rate of all counties, and a "low utilization" category

otherwise. The projected growth rate of a county or group of counties shall be converted to a category by assigning a score of "high growth" category if the rate is above the median rate of all counties, and a "low growth" category otherwise.

(iii) Types of areas shall be defined by the four combinations of the scores defined in item (ii): type 1 is low utilization - high growth, type 2 is high utilization - high growth, type 3 is high utilization - low growth, and type 4 is low utilization - low growth. Each county or group of counties making a proposal shall be assigned to one of these types.

(4) Projects shall be selected from each of the types in the order that the types are listed in paragraph 3, item (iii), with available funding allocated to projects until it is exhausted, with no more than 30 percent of available funding allocated to any one project. Available funding includes state administrative funds which have been appropriated for screening functions in subdivision 4, paragraph (b), clause (3), and for service developers and incentive grants in subdivision 5.

(5) If more than one county or group of counties within one of the types defined by paragraph (3) proposes a special project that meets all of the other conditions in paragraphs (1) and (2), the project that demonstrates the most cost-effective proposals in terms of the number of nursing home placements that can be expected to be diverted or converted to alternative care services per unit of cost shall be selected.

Subd. 3. [LOCAL LONG-TERM CARE STRATEGY.] *The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:*

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an application for expansion of alternative care targeted funds under section 256B.0913, for serving 180-day eligible clients, including those who are relocated from nursing homes;

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects; and

(4) development and implementation of strategies for advocating, promoting, and developing long-term care insurance and encouraging insurance companies to offer long-term care insurance policies that are affordable and offer a wide range of benefits.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening as defined in section 256B.0911, subdivisions 1 to 6, are waived for those counties selected as part of a long-term care strategy project. For persons who are eligible for medical assistance or who are 180-day eligible clients and who are screened after nursing facility admission, the nursing facility must include a screener in the discharge planning process for those individuals who the screener has determined have discharge potential. The agency responsible for the screening function in subdivision 4 must ensure a smooth

transition and follow-up for the individual's return to the community. Requirements for an access, screening, and assessment function replace the preadmission screening requirements and are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. [ACCESSIBLE INFORMATION, SCREENING, AND ASSESSMENT FUNCTION.] *(a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone triage as defined in paragraph (f), home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.*

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed by the nursing homes in the counties of the project, through the same policy that is in place in fiscal year 1992 as established in section 256B.0911. The amount a nursing home pays to the county agency is that amount identified and approved in the February 15, 1991, estimated number of screenings and associated expenditures. This amount remains the same for fiscal year 1993;

(2) The level I screenings and the level II assessments required by Public Law Numbers 100-203 and 101-508 (OBRA) for persons with mental illness, mental retardation, or related conditions, are reimbursed through administrative funds with 75 percent federal funds and 25 percent state funds, as allowed by federal regulations and established in the contract; and

(3) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clauses (1) and (2). This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) The amounts available under paragraph (b) are available to the county or counties involved in the project to cover staff salaries and expenses to provide the services in this subdivision. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide the services listed in this subdivision.

(d) Any information and referral functions funded by other sources, such as Title III and Title XX of the Social Security Act and the Community Social Services Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

(e) The staffing for the screening and assessment function must include, but is not limited to, a county social worker and a county public health

nurse. The social worker and public health nurse are responsible for all assessments that are required to be completed by a professional. However, only one of these professionals is required to be present for the assessment.

(f) All persons entering a Medicaid certified nursing home or boarding care home must be screened through an assessment process, although the decision to conduct a face-to-face interview is left with the county social worker and the county public health nurse. All applicants to nursing homes must be screened and approved for admission by the county social worker or the county public health nurse named by the lead agency or the agencies which are under contract with the lead agency to manage the access, screening, and assessment functions. For applicants who have a diagnosis of mental illness, mental retardation, or a related condition, and are subject to the provisions of Public Law Numbers 100-203 and 101-508, their admission must be approved by the local mental health authority or the local developmental disabilities case manager. The commissioner shall develop instructions and assessment forms for telephone triage and on-site screenings to ensure that federal regulations and waiver provisions are met. For purposes of this section, the term "telephone triage" refers to a telephone or face-to-face consultation between health care and social service professionals during which the clients' circumstances are reviewed and the county agency professional sorts the individual into categories: (1) needs no screening, (2) needs an immediate screening, or (3) needs a screening after admission to a nursing home or after a return home. The county agency professional shall authorize admission to a nursing home according to the provisions in section 256B.0911, subdivision 7.

(g) The requirements for case mix assessments by a preadmission screening team may be waived and the nursing home shall complete the case mix assessments which are not conducted by the county public health nurse according to the procedures established under Minnesota Rules, part 9549.0059. The appropriate county or the lead agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

(h) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. [SERVICE DEVELOPMENT AND SERVICE DELIVERY.] *(a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:*

(1) expansion of alternative care to serve an increased caseload, over the fiscal year 1991 average caseload, of at least 100 persons each year who are assessed prior to nursing home admission and persons who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload;

(2) the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(3) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(4) a plan to apply for a congregate housing service project as identified in section 256.9751, authorized by the Minnesota board on aging, to the extent that funds are available;

(5) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(6) one or more caregiver support and respite care projects, as described in subdivision 6; and

(7) an expansion of local volunteer efforts and the organization of a local committee in a selected community for the purpose of developing a community care manager program. For purposes of this paragraph, a community care manager program is a community-based project which hires a registered nurse or social worker to coordinate the volunteers and services for the frail older residents within a neighborhood or community. The project must demonstrate the support of local community organizations, churches, and service agencies.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 14. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the medical assistance management information system (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (5), and grant funds for paragraph (a), clauses (6) and (7), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 6. [STATEWIDE CAREGIVER SUPPORT AND RESPITE CARE RESOURCE CENTER; CAREGIVER SUPPORT AND RESPITE CARE PROJECTS.] *(a) The commissioner shall establish and maintain a statewide resource center for caregiver support and respite care. The resource center shall:*

(1) provide information, technical assistance, and training statewide to county agencies and organizations on direct service models of caregiver support and respite care services;

(2) identify and address issues, concerns, and gaps in the statewide network for caregiver support and respite care;

(3) maintain a statewide caregiver support and respite care directory;

(4) educate caregivers on the availability and use of caregiver and respite care services;

(5) promote and expand caregiver training and support groups using existing networks when possible; and

(6) apply for and manage grants related to caregiver support and respite care.

(b) The commissioner shall establish up to 36 projects to expand the respite care network in the state and to support caregivers in their responsibilities for care. The purpose of each project shall be to:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite workers to clients and care receivers and ensure the health and safety of the client; and

(3) provide training for caregivers and ensure that support groups are available in the community.

(c) The caregiver support and respite care funds shall be available to the four to six local long-term care strategy projects designated in subdivisions 1 to 5.

(d) The commissioner shall publish a notice in the state register to solicit proposals from public or private nonprofit agencies for the projects not included in the four to six local long-term care strategy projects defined in subdivision 2. A county agency may, alone or in combination with other county agencies, apply for caregiver support and respite care project funds. A public or nonprofit agency may apply for project funds if the agency has a letter of agreement with the county or counties in which services will be developed, stating the intention of the county or counties to coordinate their activities with the agency requesting a grant.

(e) The commissioner shall select grantees based on the following criteria:

(1) the ability of the proposal to demonstrate need in the area served, as evidenced by a community needs assessment or other demographic data;

(2) the ability of the proposal to clearly describe how the project will achieve the purpose defined in paragraph (b);

(3) the ability of the proposal to reach underserved populations;

(4) the ability of the proposal to demonstrate community commitment to the project, as evidenced by letters of support and cooperation as well as formation of a community task force;

(5) the ability of the proposal to clearly describe the process for recruiting, training, and retraining volunteers; and

(6) the inclusion in the proposal of the plan to promote the project in the community, including outreach to persons needing the services.

(f) Funds for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and

paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) train caregivers;

(4) ensure the development of support groups for caregivers;

(5) advertise the availability of the caregiver support and respite care project; and

(6) purchase equipment to maintain a system of assigning workers to clients.

(g) Project funds may not be used to supplant existing funding sources.

(h) An advisory committee shall be appointed to advise the caregiver support project on the development and implementation of the caregiver support and respite care services projects. The advisory committee shall review procedures and provide advice and technical assistance to the caregiver support project regarding the grant program established under this section. The advisory committee shall consist of not more than 12 people appointed by the commissioner and shall be comprised of representatives from public and private agencies, service providers, and consumers from all areas of the state. Members of the advisory committee shall not be compensated for service.

Subd. 7. [EVALUATION AND EXPANSION.] *The commissioner shall evaluate the success of the projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, 1993.*

Subd. 8. [PUBLIC AWARENESS CAMPAIGN.] *The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, and foster care.*

Sec. 14. [256B.0919] [ADULT FOSTER CARE AND FAMILY ADULT DAY CARE.]

Subdivision 1. [ADULT FOSTER CARE LICENSURE CAPACITY.] *Notwithstanding contrary provisions of the human services licensing act and rules adopted under it, an adult foster care license holder may care for five adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability. The license holder under this section shall not be a corporate business which operates more than two facilities.*

Subd. 2. [ADULT FOSTER CARE; FAMILY ADULT DAY CARE.] *An adult foster care license holder may also provide family adult day care for adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability. The maximum combined license capacity for adult foster care and family adult day care is five adults. A separate license is not required to provide family adult day care under this subdivision. Foster care homes providing services to five adults 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.

Subd. 3. [COUNTY CERTIFICATION OF PERSONS PROVIDING ADULT FOSTER CARE TO RELATED PERSONS.] *A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under sections 256B.0913 and 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full-time job or takes a leave of absence without pay from a full-time job to care for the client.*

Sec. 15. Minnesota Statutes 1990, section 256B.093, is amended to read:

256B.093 [SERVICES FOR PERSONS WITH *TRAUMATIC* BRAIN INJURIES.]

Subdivision 1. [STATE COORDINATOR.] The commissioner of human services shall designate a full-time position within the long-term care management division of the department of human services to supervise and coordinate services for persons with *traumatic* brain injuries.

An advisory committee shall be established to provide recommendations to the department regarding program and service needs of persons with traumatic brain injuries.

Subd. 2. [ELIGIBILITY.] The commissioner may contract with qualified agencies or ~~persons~~ *employ staff* to provide *statewide* case management services to medical assistance recipients who are at risk of institutionalization and ~~meet one of the following criteria: (a) The person has a~~ *who have traumatic* brain injury.

~~(b) The person is receiving home care services or is in an institution and has a discharge plan requiring the provision of home care services and meets one of the following criteria:~~

~~(1) the person suffers from a brain abnormality or degenerative brain disease resulting in significant destruction of brain tissue and loss of brain function that requires extensive services over an extended period of time;~~

~~(2) the person is unable to direct the person's own care;~~

~~(3) the person has medical home care costs that exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;~~

~~(4) the person is eligible for medical assistance under the option for certain disabled children in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA);~~

~~(5) the person receives home care from two or more providers who are unable to effectively coordinate the services; or~~

~~(6) the person has received or will receive home care services for longer than six months.~~

Subd. 3. [CASE MANAGEMENT DUTIES.] The department shall fund

~~the~~ case management ~~contracts~~ *under this subdivision* using medical assistance administrative funds. ~~The contractor must~~ *Case management duties include*:

(1) ~~assess~~ *assessing* the person's individual needs for services required to prevent institutionalization;

(2) ~~assure~~ *ensuring* that a care plan that ~~meets~~ *addresses* the person's needs is developed, *implemented, and monitored on an ongoing basis* by the appropriate agency or individual;

(3) ~~assist~~ *assisting* the person in obtaining services necessary to allow the person to remain in the community;

(4) ~~coordinate~~ *coordinating* home care services with other medical assistance services under section 256B.0625;

(5) ~~assure cost effectiveness of~~ *ensuring appropriate, accessible, and cost-effective* medical assistance services;

(6) ~~make recommendations~~ *recommending* to the commissioner ~~on~~ the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(7) ~~assist~~ *assisting* the person with problems related to the provision of home care services;

(8) ~~assure~~ *ensuring* the quality of home care services; ~~and~~

(9) ~~reassess~~ *reassessing* the person's need for and level of home care services at a frequency determined by the commissioner*; and*

(10) recommending to the commissioner the approval or denial of medical assistance funds for out-of-state placements for traumatic brain injury services.

Subd. 4. [DEFINITIONS.] For purposes of this section, the following definitions apply:

(a) "*Traumatic* brain injury" means a sudden insult or damage to the brain or its coverings, not of a degenerative *or congenital* nature. The insult or damage may produce an altered state of consciousness ~~or~~ *and may result in* a decrease in ~~mental,~~ cognitive, behavioral, *emotional,* or physical functioning resulting in partial or total disability.

(b) "Home care services" means medical assistance home care services defined under section 256B.0625, subdivisions ~~6~~ *6a*, 7, and ~~19~~ *19a*.

Sec. 16. Minnesota Statutes 1990, section 256B.64, is amended to read:

256B.64 [ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.]

A ventilator-dependent recipient of medical assistance who has been receiving the services of a private duty nurse or personal care assistant in the recipient's home may continue to have a private duty nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

The personal care assistant or private duty nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. ~~After the 120 hour transition period, an assessment may be made by the ventilator-dependent patient, the attending physician, and the patient's primary care nurse to determine whether continued services of communicator or interpreter for the patient by the private duty nurse or personal care assistant are necessary and appropriate for the patient's needs. If continued service is necessary and appropriate, the physician must certify this need to the commissioner of human services in order for payments to continue.~~ *Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section.* The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

Sec. 17. Minnesota Statutes 1990, section 256D.44, is amended by adding a subdivision to read:

Subd. 7. [RATE LIMITATION; WAIVERED SERVICES ELIGIBILITY.] *If a current negotiated rate for a foster care placement is for an individual who is eligible for the home and community-based services waiver for the elderly, the negotiated rate must include only the room and board portion of the rate. The room and board portion of the negotiated rate is an amount equal to the difference between the medical assistance income limit for a single disabled or aged adult minus the amount of the medical assistance personal needs allowance for persons residing in a nursing facility.*

Sec. 18. Laws 1988, chapter 689, article 2, section 256, subdivision 1, is amended to read:

Subdivision 1. [SELECTION OF PROJECTS.] The commissioner of human services shall establish pilot projects to demonstrate the feasibility and cost-effectiveness of alternatives to nursing home care that involve providing coordinated alternative care grant services for all eligible residents in an identified apartment building or complex or other congregate residential setting. The commissioner shall solicit proposals from counties and shall select up to four counties to participate, including at least one metropolitan county and one county in greater Minnesota. The commissioner shall select counties for participation based on the extent to which a proposed project is likely to:

(1) meet the needs of low-income, frail elderly;

(2) enable clients to live as independently as possible;

(3) result in cost-savings by reducing the per person cost of alternative care grant services through the efficiencies of coordinated services; and

(4) facilitate the discharge of elderly persons from nursing homes to less restrictive settings or delay their entry into nursing homes.

Participating counties shall use existing alternative care grant allocations to pay for pilot project services. The counties must contract with a medical assistance-certified home care agency to coordinate and deliver services and must demonstrate to the commissioner that quality assurance and auditing systems have been established. Notwithstanding Minnesota Statutes, section 256B.091, and rules of the commissioner of human services relating to the alternative care grants program, the commissioner may authorize pilot projects to use *a monthly* pre-capitated ~~rates~~ *rate up to 75 percent of the regional monthly average nursing facility payment rate as defined in Minnesota Statutes, section 256B.0913*; to provide expanded services such as chore services, activities, and meal planning, preparation, and serving; and to waive freedom of choice of vendor to the extent necessary to allow one vendor to provide services to all eligible persons in a residence or building. The commissioner may apply for a waiver of federal requirements as necessary to implement the pilot projects.

Sec. 19. [APPROPRIATION.]

$ . . . . . is appropriated from the general fund to the Minnesota board on aging for the biennium ending June 30, 1993, for the congregate housing services demonstration projects in section 3.

Sec. 20. [REPEALER.]

Minnesota Statutes 1990, sections 144A.31, subdivisions 2 and 3; 256B.0625, subdivisions 6 and 19; 256B.0627, subdivision 3; 256B.091; and 256B.71, subdivision 5, are repealed."

Delete the title and insert:

"A bill for an act relating to human services; establishing requirements for home care services and preadmission screenings; clarifying requirements for alternative care; providing for alternative care programs; establishing seniors agenda for independent living (SAIL) projects; appropriating money; amending Minnesota Statutes 1990, sections 144A.31; 144A.46, subdivision 4; 256B.04, subdivision 16; 256B.0625, subdivision 7, and by adding subdivisions; 256B.0627; 256B.093; 256B.64; and 256D.44, by adding a subdivision; Laws 1988, chapter 689, article 2, section 256, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 256 and 256B; repealing Minnesota Statutes 1990, sections 144A.31, subdivisions 2 and 3; 256B.0625, subdivisions 6 and 19; 256B.0627, subdivision 3; 256B.091; and 256B.71, subdivision 5."

And when so amended the bill do pass and be re-referred to the Committee on Finance. Amendments adopted. Report adopted.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time and referred to the committees indicated.

Mr. Marty introduced—

S.F. No. 1531: A bill for an act relating to taxation; reducing the property tax class rate applied to certain residential property; adjusting the income tax rates; establishing the Minnesota working family credit; appropriating money; amending Minnesota Statutes 1990, sections 273.13, subdivisions 22 and 25; and 290.06, subdivision 2c; proposing coding for new law in Minnesota Statutes, chapter 290.

Referred to the Committee on Taxes and Tax Laws.

Ms. Flynn, Messrs. Solon; Johnson, D.J.; Benson, D.D. and Frederickson, D.J. introduced—

S.F. No. 1532: A bill for an act relating to health; establishing a state board of physical therapy; providing licensing requirements for physical therapists; amending Minnesota Statutes 1990, sections 148.66; 148.67; 148.70; 148.705; 148.71; 148.72, subdivisions 1, 2, and 4; 148.73; 148.74; 148.75; 148.76; 148.78; and 214.01, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 148.

Referred to the Committee on Health and Human Services.

Mr. Merriam, for the Committee on Finance, introduced—

S.F. No. 1533: A bill for an act relating to the organization and operation of state government; appropriating money for the protection of the state's environment and natural resources; amending Minnesota Statutes 1990, sections 14.18; 41A.09, subdivision 3; 85A.02, subdivision 17; 103B.321, subdivision 1; and 116P.11.

Under the rules of the Senate, laid over one day.

Mr. Hottinger introduced—

S.F. No. 1534: A bill for an act relating to occupations and professions; changing education requirements for certification and licensure as a certified public accountant; amending Minnesota Statutes 1990, section 326.19.

Referred to the Committee on Commerce.

Mr. Merriam, for the Committee on Finance, introduced—

S.F. No. 1535: A bill for an act relating to public administration; appropriating money for education and related purposes to the higher education coordinating board, state board of technical colleges, state board for community colleges, state university board, University of Minnesota, higher education board, and the Mayo medical foundation, with certain conditions; amending Minnesota Statutes 1990, sections 135A.03, subdivision 3; 135A.05; 136.11, subdivisions 3, 5, and by adding a subdivision; 136.142, subdivision 1, and by adding a subdivision; 136A.121, subdivision 10, and by adding subdivisions; 136A.233, subdivision 3; and 298.28, subdivisions 4, 7, 10, 11, and by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 135A; 136; 136A; and 298; repealing Minnesota Statutes 1990, section 136A.05, subdivision 2.

Under the rules of the Senate, laid over one day.

MEMBERS EXCUSED

Mrs. Brataas and Mr. Hughes were excused from the Session of today. Mr. Frank was excused from the Session of today at 4:30 p.m. Ms. Pappas was excused from the Session of today from 1:15 to 1:50 p.m. Ms. Piper was excused from the Session of today from 1:30 to 1:45 p.m.

ADJOURNMENT

Mr. Moe, R.D. moved that the Senate do now adjourn until 8:30 a.m., Saturday, April 27, 1991. The motion prevailed.

Patrick E. Flahaven, Secretary of the Senate