**National Alliance on Mental Illness of Minnesota**
**2005 Minnesota Legislative Session**
**Summary of Laws Affecting Children and Adults with Mental Illnesses and Their Families**

## Adult Mental Health

### Post Partum Depression

The commissioner of health, working with health care facilities, health and mental health providers, consumers and families, will develop materials and information on post partum depression – including treatment resources. Physicians, midwives and other health care professionals providing prenatal care to women must make this information available to women and their families. Hospitals and other health care facilities must provide departing new mothers and fathers and other family members with the information.

### Mental Health Crisis Services

In some rural areas of the state it was difficult to meet the requirements to be a crisis service provider. The state will now be able to approve a provider if they propose an alternative plan. The provider has to demonstrate that geography or other barriers prevent them from meeting the current standards and that under the alternative plan there will be increased access, and mobile services will be available outside of the traditional 9-to-5 office hours.

### Flexibility to aid Restructuring

The money that is saved by restructuring the regional treatment centers can be moved in order to provide services in the community. State-operated services will be classified as an "enterprise" activity. The state will try to figure out how to transfer the money saved into the main funding categories for mental health services. Basically, what this means is that the money spent on mental health care will be one "big pot," and savings in one area can be used to increase services in another.

### Special Needs Allowance under Minnesota Supplemental Aid

The special needs allowance provided to people who are relocating from a nursing home or institution is now also available to people relocating from an adult mental health residential treatment program. This will help with housing costs because it provides an additional $140 per month for people on MSA who do not have subsidized housing and whose housing costs exceed 40% of their income.

### Fairweather Lodge Treatment

It is clarified that the Fairweather Lodge Treatment model, as defined by standards established by the National Coalition for Community Living, is an Intensive Residential Rehabilitative Mental Health Service and an Intensive Nonresidential Rehabilitative Mental Health Service

**Abuse Prevention Plans**
When a facility knows that an individual has committed a violent crime or an act of physical aggression towards others, the individual abuse prevention plan must include measures to minimize the risk to other residents and visitors and to others outside the facility if allowed to go out unsupervised.

**State Services**
The bonding bill contained $26 million for state-operated services. Some of the funds are to deal with the influx of sex offenders, and other funds are to be used for renovation or demolition of state campuses. $300,000 is to purchase grave markers so that there will be names instead of numbers on the graves of people who are buried at cemeteries located on the sites of regional treatment centers. The cemetery on the grounds of the Cambridge Regional Treatment Center will now be known as the Garden of Remembrance.

**Moving out of Nursing Homes**
Relocation targeted case management services for people coming out of nursing homes can be provided by the county or a private organization. This will allow people a choice of provider. Counties would still approve the service plans. Counties have to let people know if there are different options for this service. The commissioner of human services will contract with the Centers for Independent Living to provide information to people living in nursing homes who want to move to the community. People will also be eligible to receive a one time $3000 grant to pay for rent deposits, furniture and moving expenses. There are more than 3,000 non-elderly individuals with disabilities living in nursing homes.

The Department of Human Services, the Minnesota Housing Finance Agency and the Minnesota State Council on Disabilities shall convene an interagency work group of interested groups (counties, public housing authorities, disability providers and advocates) to identify barriers, strengthen coordination, and recommend policy and funding changes to assist people with disabilities who are attempting to relocate from or avoid placement in institutional settings. The report of their work is due to legislators on October 15, 2006.

**Case Management**
The commissioner must report to the legislature by December 15, 2006 on how to redesign case management services that will streamline administration, improve access, establish performance measures, provide for consumer choice and address the need for a comprehensive universal assessment protocol.

**Commitment**
Under the commitment law, an advance practice nurse certified in mental health can now be an "examiner" or "health officer." This means that he or she can recommend emergency admission to a hospital for a 72-hour hold. An advance practice nurse cannot testify in court on the commitment nor do the assessment for a Rule 20.

**Custody Relinquishment**

Families have struggled with the legal issues surrounding out-of-home placement of their children. Some have been told that they would have to give up (relinquish) custody of their child in order for him/her to continue in their out-of-home placement.

The new law no longer requires the county to file a CHIPS (child in need of protection or services) petition when a parent seeks to voluntarily place their child who has an emotional disturbance out of the home for treatment. Instead, the county will prepare a report to the court within 165 days that includes the treatment plan from the child's mental health treatment professional, and any other plans such as an interagency intervention plan and individual service plan. The situation is still reviewed by the court, but it's a paper review so that parents do not need to actually go to court. The court then must approve the voluntary placement agreement. The county remains legally responsible for the child's placement but cannot transfer legal custody unless there have been allegations of abuse or neglect.

For children placed more than 13 months, the court does not have to transfer legal custody nor rule that the child is need of protection and services if the court finds compelling reasons and approves the continued voluntary placement. The county remains legally responsible for the child's placement. Counties should not tell parents that the only way for the child to remain in placement is to give up custody. If the court agrees that the child continues to need the out-of-home placement, then parents can keep legal custody of their child.

For children who were removed from the home and ordered into foster care, the court can move the legal custody back to the parent if the conditions that led to the removal have been corrected. If the child continues to need foster care services, this can then become a voluntary placement.

When a court considers terminating parental rights, the court has to look now at the recommendations of the child's health or mental health care provider. The written report that is issued when rights are terminated for a child with an emotional disturbance must also include whether the child has mental health needs that should be addressed by the case plan, what consideration was given to the diagnostic and functional assessments conducted by the child's mental health professional, what consideration was given to the preferences of the parent for services and treatment and what consideration was given to the cultural appropriateness of the child's treatment or services.

They will now include the child's mental health provider in the development of the out-of-home placement plan and will include diagnostic assessment information, specific services relating to meeting the mental health care needs of the child and treatment outcomes. The out-of-home placement plan is developed for any type of out-of-home placement, not just foster care.

**Parental Fees**
The TEFRA and out-of-home placement fees were reduced this session in response to so many families having trouble paying the increase in fees that was passed in 2003. If adjusted income is between 175% of the federal poverty guidelines and less than or equal to 545% of the federal poverty guidelines, the parent fee is based on a sliding scale starting at 1% and increasing up to 7.5%. This means that, for example, a family of four whose adjusted income is $33,862 would pay $338 per year. A family of four whose adjusted income is $105,457 would pay $7,909. Families whose income is between 675% of poverty and 975% of poverty would have a sliding parent fee between 7.5% of income up to 10% of income. This is effective July 1, 2005.

**Mental Health Services in Schools**
The commissioner, in collaboration with the commissioner of education, will create a task force to discuss collaboration between schools and mental health providers in order to: promote collocation and integrated services, identify barriers to collaboration, develop a model contract, and identify examples of successful collaboration. The task force will also develop recommendations on how to pay for children's mental health screenings. The task force will include representatives from school boards, administrators, special education directors, parent advocacy organizations, counties, school social workers, counselors, nurses, psychologists, community mental health professionals, health plans, and any other interested parties. The report is due to the legislature by February 1, 2006.

**Pediatrician Training**
A clinical education program that trains pediatricians is requested to include in its program training in case management and medication management for children with mental illness.

**CTSS**
When a county refers a family to a Children's Therapeutic Services and Supports (CTSS) provider, they must inform the family what other services are offered by the provider (such as case management), the method and the amount they are paid. When the county is arranging services the plan should list all of the services to be provided and who is responsible for what. Supervision can be provided by another CTSS provider under contract. This will allow more providers in rural areas where they could contract for a certain professional but not employ them.

**Referred to Residential Treatment**
The language has been changed from "screening" a child prior to admission to a residential facility, RTC or treatment foster care to "determining the needed level of care" for a child. That determination must be based on an assessment of the child's need for care outside of the home using a validated tool (approved by DHS) which assesses the child's functional status and assigns an appropriate level of care. If a child is admitted for emergency treatment, the determination must be made within three working days. The determination cannot be made by a nongovernmental provider which may be providing those services. This is effective July 1, 2006.

**Diagnostic Assessments**
Children who have autism spectrum disorders or pervasive development disorders may undergo a diagnostic assessment every three years (instead of once a year) at the request of the parent and if the mental health professional agrees that there has been little change in the condition and the yearly assessment is not needed.

**Guardian ad litems**
Guardian ad litems will be required to undergo a background study.

## Criminal Justice

**Discharge Planning**
The commissioner of corrections will develop a model discharge planning process for offenders with a serious mental illness who have been convicted to serve three or more months and are being released from a county jail or a county regional jail. When such an offender is about to be released, the jail staff are to refer him/her to the appropriate staff in the county human services department at least 60 days before being released. The county may carry out provisions of the model discharge planning process such as: providing assistance in filling out applications for medical assistance, GAMC or MinnesotaCare; making a referral to case management; providing assistance in obtaining a state photo identification; securing a timely appointment with a psychiatrist or other appropriate community mental health provider; and providing a 30-day supply of prescriptions for all necessary medications. Discharge planning is not required, but it is encouraged.

**Prescription Drugs**
The commissioner of corrections currently contracts for prescription drugs in order to hold down costs. Now, county jails will be able to participate in this purchasing pool. This means that counties would be able to get a reduced price and would use the same drug formulary as the prisons. A county representative would be a part of any committee formed by the commissioner to look at the prison drug formulary. This will make it less costly for counties to provide medications to people in jail and will provide for more consistency when people transfer from jails to prisons.

**Health Care Benefits**
An inmate of a correctional facility who is conditionally released and is housed in a half-way house or community correction center or is under house arrest may receive medical assistance if he or she would otherwise be eligible.

**Mental Health Courts**
The legislature appropriated $250,000 for mental health and drug courts.

**Prison Services**
An additional $3 million was appropriated for increased health services in the Minnesota prisons.

**Notice**
People who are not guilty by reason of insanity will have to register as a predatory offender. When predatory offenders are admitted to nursing homes, the residents or relatives of residents must be informed.

**Vagrancy**
The vagrancy law was repealed. People who are homeless were often picked up under this law and brought to jail. The vagrancy statute made it illegal to loiter, to be without a job or to beg. Homelessness will no longer be a crime.

## Education and Special Education

**Behavior Interventions**
Positive behavioral interventions are defined now in statute to mean those strategies used to improve the school environment and teach pupils skills likely to increase pupil ability to exhibit appropriate behaviors.

Time-out is also defined. It includes when a child stays in the room but does not participate in the activity, when a child leaves the classroom to go to another area and when a child is put in a locked time-out room that they cannot leave.

The Department of Education must consult with parent organizations and advocacy groups along with the organizations representing special education teachers, administrators, school boards, police officers, principals and teachers in developing amendments to the rule governing the use of aversive and deprivation procedures. At a minimum the rules will be changed so that these procedures can only be used after a functional behavior assessment and behavior intervention plan is completed. Schools that use them must have an oversight committee to review data on the use of aversive deprivation procedures. Parents must be notified right away if a procedure was used in an emergency or within two school days if the school cannot reach the parents. Time-out rooms must have a locking mechanism where a person has to hold down the lock which will mean that a child will always be observed while in a time-out room. Rooms used for time-out have to be registered with the department. A child can be placed in a locked time-out room only if it is part of their behavior plan or used in an emergency but only while the emergency exists.

If a child is restrained or removed from the school by a police officer at the request of the staff twice in a 30 day period, the IEP team must meet to determine if the Individualized Education Program (IEP) is adequate or additional evaluation is needed.

**Suspension and Expulsion**
A school administrator can, in a readmission plan after a suspension, require a student to complete a character education program. A readmission plan must, where appropriate, provide alternative education services (but not as a way to extend the suspension). The plan cannot require the parent to provide psychotropic drugs to their student as a condition of returning to

school. School officials cannot use the parents' refusal to provide psychotropic drugs, or to consent to a psychiatric evaluation, screening or examination as a ground, by itself, to prohibit the student from attending class or participating in school activities or as a basis of a charge of child abuse, child neglect or medical or educational neglect.

As an alternative to suspension, the school administrator can encourage the parent to attend school with the pupil for a day, assign the student to attend school on Saturday or petition the juvenile court that the student is in need of child protection.

Data on exclusions or expulsions must include the student's age, grade, gender, race and special education status.

**Attendance Policies**
Many parents have complained that their child was deemed truant because he/she missed school due to mental health treatment, counseling appointments, etc. The new law allows schools to require in their attendance policy that parents verify in writing why the child missed school. Additionally, state law clarifies that the child may miss school due to: their illness; medical, dental, orthodontic or counseling appointments; family emergencies; the death or serious illness or funeral of an immediate family member; active duty in the military; and other exemptions according to the school district's policy.

The commissioner of public safety may not link or condition issuing, suspending, or revoking a person's driver's license to attendance at a high school.

**Safe Schools**
School districts are encouraged to offer instruction on character development. Character development teaches behaviors such as attentiveness, truthfulness, respect for authority, diligence, gratefulness, self-discipline, patience, forgiveness, respect for others, peacemaking and resourcefulness. Violence prevention curriculum should also include now self-protection. Each school board shall develop a policy prohibiting the bullying or intimidation of any student. The Minnesota School Board Association has agreed to include consideration of child's disability when consequences for bullying are applied.

**Nonpublic Students**
A task force will be formed to study the delivery of special education services to nonpublic school students by public schools. A report is due to the legislature by January 15, 2006. Local parent advisory committees must also include a parent of a nonpublic student with a disability if there is a private school in their community. These advisory committees must meet at least once a year.

**Online Learning**
An Online Learning advisory committee is established to look at quality, teacher qualifications, special education, attendance, program design, etc. For some students with a mental illness, online learning is their only viable option to obtain an education.

**Early Childhood**
Pre-kindergarten screening will begin at age 3 instead of 3 ½. NAMI's efforts to include socio-emotional screening were unsuccessful. However, the commissioners of education, human services and health are required to identify how they will coordinate activities and resources to increase school readiness in all children. Children's mental health is considered a resource to families in this new law. They are also supposed to look at amending the state Medicaid plan to expand the use of the child and teen checkup funding for allowable child development services such as early childhood screening. For children ages 3 to 5 in the child welfare system they are to be referred to the Interagency Early Intervention System for developmental screening and referral.

**Student Support Services**
School districts and the Department of Education will seek out funds to improve students' access to school nurses, school counselors, school psychologists, school social workers, and school alcohol and drug abuse counselors. They are also required to look at what the nationally recommended staff-to-student ratios, work loads and best practices are for these support staff.

**School Records**
The omnibus data practices bill contained a little section related to educational records. It states that parents of a child with a disability can look at their child's educational records as often as they want until the child reaches the age of majority. An agency or institution cannot charge a fee to look at the records but can charge to make copies except if that would interfere with a parent's rights to review and inspect the records.

**School Funding**
Funding for schools was increased by 4% with an additional $22.9 million for special education excess cost aid.

**Testing**
The Department of Education must seek waivers to the federal No Child Left Behind law for a number of items including being allowed to exempt from sanctions schools that have not made yearly progress goals because a group of students with disabilities are not testing at proficient levels. Rules governing Minnesota tests – MCA- will also be amended so that school districts can exempt students with disabilities from taking them if it is consistent with the child's IEP or allow them to take an alternative test consistent with their IEP.

## Employment

**Extended and Supported Employment**
An increase of $600,000 was included for the Extended Employment Program for people with serious mental illnesses. The total budget will be $1.2 million in the first year and $1.4 million in the second year. The regular Extended Employment Program received an additional $400,000 each year of the biennium.

**State Contracts**
When awarding janitorial service contracts for the new state buildings, the commissioner of administration shall give priority to supported work vendors provided that their bid is equal to or less than other bids submitted.

**Minimum Wage**
Beginning August 1, 2005 the minimum wage will be increased to $6.15 an hour and to $5.25 for small businesses.

## Health Care

**Medical Assistance**
**New services** were added to Medical Assistance. They include:

- **Mental health telemedicine** will be covered beginning January 1, 2006 if approved by the federal government. Telemedicine is an interactive two-way video communication tool. This will be particularly helpful in rural areas.
- **Treatment foster care** services will be covered July 1, 2006 if approved by the federal government. Treatment foster care includes case management, psychotherapy, skills training, and family psychoeducation. In order to receive this a child must undergo a diagnostic assessment conducted by a psychiatrist, licensed psychologist or licensed independent clinical social worker. The treatment plan must be developed through a child-centered and family-driven process and contain culturally appropriate interventions with specific measurable goals and objectives. Providers must be a licensed child placing agency and be a county, Indian Health Services facility or a noncounty entity under contract with the county board.
- **Psychiatric consultation** will be covered beginning January 1, 2006 if approved by the federal government. This reimburses psychiatrists for consulting by phone, e-mail, fax, etc., with primary care doctors – including pediatricians. This can be provided without the patient present if he/she consents.
- **ACT teams** (called transitional youth intensive rehabilitative mental health services) will be available for youth ages 16 or 17 who have an emotional disturbance or traumatic brain injury, and have substantial disability and functional impairment in three or more areas so that self-sufficiency upon age 18 is unlikely. Standards for providers are laid out.
- **Targeted case management** services for vulnerable adults is expanded to include adults who are homeless and have been without a permanent residence for at least one year or on at least four occasions in the last three years.
- **Medication Therapy Management Care** is available for people taking four or more prescription medicines. This is provided by a pharmacist who formulates a medication treatment plan, monitors the patient's response, resolves or prevents problems with the medication, communicates with the health care providers, educates the patient about the medication to increase adherence, etc. The department will convene an advisory committee to develop and implement this new service.

**Personal Care Assistant Services**: Changes were made to the personal care assistant services. Physicians will have to use a form approved by the commissioner to document the diagnosis and why the person needs PCA services and he or she will need to do this annually. PCA providers will have to keep better records detailing the services provided, arrival and departure times, etc. PCA hours not used within a six-month period cannot be carried over and flexible use of hours within a six-month period of time must be approved by the department.

**Emergency Rooms**: Medical Assistance will not cover visits to or services provided in the hospital emergency room that are not for emergency and emergency poststabilization care or urgent care. So, if you are on MA do not go the hospital for routine medical care or for a prescription simply because you do not have a regular doctor. MA won't pay for it and you will be billed for that care.

**Dental Services**: The $500 limit on dental services was removed effective January 1, 2006. This was a huge problem for people who take medication that creates dry mouth or affects one's gums. There will also be a two-year pilot project to provide oral health care services.

**Medications:** Effective January 1, 2006 MA will not cover drugs covered under the Medicare Prescription Drug Program. MA will also no longer cover drugs to treat impotence and erectile dysfunction.

Prior authorization will automatically be granted for 60 days for brand name drugs prescribed for the treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the drug was part of the recipient's course of treatment at the time the generically equivalent drug became available. NAMI worked on this language to ensure that people had time to discuss the change with their doctor.

**Transportation:** The commissioner will establish a task force on nonemergency transportation services. A representative from the disability community will be on the task force.

**CADI Waiver:** The CADI waiver growth is limited to 95 per month. There is an exception that allows the state to use existing funds from MH grants or other MH funding to "buy" additional slots over those limits. About 10,000 people receive CADI services 4,000 of whom had a primary diagnosis of mental illness. When current recipients leave the program, their slot can be reused for a new person. Reuse slots do not count against the growth caps.

**Contract Hospital Beds:** To move services closer to people's homes, the state contracts with community hospitals to provide extended psychiatric inpatient services. MA coverage will now be expanded to include stays longer than 45 days if needed. Prior authorization is required to exceed the 45 day limit.

**Medical Assistance for Employed Persons with Disabilities**
A small change was made. When people receive increases to their social security income, it will not be counted as income for purposes of MA-EPD until July 1 of each year.

**General Assistance Medical Care**
New services were added under GAMC as well:

- Mental health telemedicine will be covered beginning January 1, 2006. Telemedicine is an interactive two-way video communication tool. This will be helpful in rural areas in particular.
- Psychiatric consultation will be covered beginning January 1, 2006. This reimburses psychiatrists for consulting by phone, e-mail, fax, etc., with primary care doctors – including pediatricians. This can be provided without the patient present if he/she consents.

Drug coverage under GAMC will be limited to prescription drugs that are covered under Medical Assistance and are from manufacturers who have entered into a drug rebate agreement with the state.

The $500 limit on dental services was removed effective January 1, 2006. This was a huge problem for people who take medication that creates dry mouth or affects one's gums.

In order to create continuity of care, people on GAMC will be moved to MinnesotaCare unless they have applied for social security benefits.

**Minnesota Care**
The $5000 cap on services was eliminated and the limited benefit set for adults without children was expanded to include diabetic supplies and equipment and services provided by a physician ancillary, chiropractor, psychologist, and a licensed independent clinical social worker.

New services were added to MinnesotaCare:

- Mental health telemedicine will be covered beginning January 1, 2006. Telemedicine is an interactive two-way video communication tool. This will be helpful in rural areas in particular.
- Psychiatric consultation will be covered beginning January 1, 2006 under the regular benefit set – not the limited benefit set. This reimburses psychiatrists for consulting by phone, e-mail, fax, etc., with primary care doctors – including pediatricians. This can be provided without the patient present if he/she consents.

Gross income under MinnesotaCare for people who are self-employed (non-farm) will be figured out using the methodology used under MA. Students cannot access MinnesotaCare if they have access to health insurance through their postsecondary education institution.

Premiums were increased. The premiums will be based on monthly income and a surcharge of 8% is added to the current premium. For children in families with income below 150% of the federal poverty guidelines their premium under MinnesotaCare will be $4 per month. Counties will pay the premium for adults transitioning to MinnesotaCare for at least six months or longer if the county desires.

**Provider Shortages**
Several programs were passed that would make sure rural communities have access to medications, pharmacists and dentists. There is also a loan forgiveness program for doctors specializing in the area of pediatric psychiatry, dentistry and pharmacy.

**MnDHO**
The Minnesota disability health options program (managed care for people with disabilities) may be expanded upon approval by the federal government. There will also be a planning process to look at adding another managed care option for people with disabilities in another region of the state.

**Co-Payments**
The co-payments under MA and GAMC for prescriptions had a $20 per month limit. That limit was reduced to $12. Thus, people should not pay more than $12 per month for their prescription drugs. People living in group residential housing will have their personal needs allowance increased by $20 per month to help with their co-payments. NAMI tried unsuccessfully to repeal the provision that allows providers to deny services (or medication) because the individual owes them money. The $3 nonpreventive visit under GAMC was eliminated effective January 1, 2006. Co-payments were added under MinnesotaCare for nonpreventive visits ($3) and for nonemergency room visits ($6) effective January 1, 2006.

The commissioner is instructed to seek federal waivers in order to develop a sliding scale for premiums under the Medical Assistance program for people whose income is above 175% of the federal poverty guidelines.

**Provider Payment Increases**
Most community providers received a 2.2553% annual rate increase. This includes CADI waivers, personal care services, residential programs, adult mental health integrated funds, etc. Providers are supposed to use 75% of the money to increase wages and benefits for staff. Hospitals received a 6% decrease; however, this was not applied to mental health services in hospitals.

**Small Business Exemption**
Health insurance companies can now offer health insurance plans to small businesses (fewer than 50 employees) that offer a flexible benefit plan. Flexible means that they can modify or exclude any of the mandatory benefits required under state law – such as mental health benefits. The employer must give a written list to employees of the benefits that won't be covered.

## Housing

**Homeless**
There will be a long-term care homeless supportive services fund to provide integrated services needed to stabilize housing for individuals, families and youth living in supportive housing. Long-term homelessness means people lacking a place to live continuously for one year or more

or at least four times in the past three years. Priority is given to multi-county projects. The proposals must include a number of things such as strategies to enhance housing stability, a multi-agency approach, commitment to maximize use of other resources and programs, an evaluation component and demonstrated partnerships with other agencies. $10 million is appropriated and an additional $2.2 million was appropriated for youth transitioning from foster care. Some studies state that 40% or more of the people who experience long term homelessness have a serious mental illness.

**Supportive Housing**
The bonding bill contained $12 million for permanent supportive housing for people experiencing long-term homelessness. Thus, it is for persons who have been without a permanent residence for at least 12 months or on at least four occasions in the last three years or are at significant risk of lacking a permanent residence for at least 12 months or on at least four occasions in the last three years. The housing must provide or coordinate with linkages to services necessary for residents to maintain housing stability and maximize opportunities for education and employment. It also included $350,000 for Hennepin County to build 6 units of affordable supportive housing; however, not all of the units are targeted for people experiencing long-term homelessness.

**Bridges**
The Bridges Housing Program's funding remained at $1.638 million each year of the biennium.

**Homeless Outreach**
Funds were included in the public safety bill for a metro and nonmetro entity to provide homeless outreach and create a bridge to stable housing and services for the homeless. Metro grantees will have to match the grant by 50% and nonmetro by 25%.

## Other

**MFIP/SSI**
People who are on MFIP (Minnesota's welfare program) had their monthly grants reduced by $125 for each person in the "assistance unit" who was on SSI. This was changed so that now the maximum amount that can be reduced per unit is $125. This isn't effective until it is approved by the federal government.

**Voting**
Employees who work at a residential facility can vouch for a resident living at the facility. Another voter in the precinct can only vouch for up to 15 voters, but an employee has no limit. The operator of a facility must provide to the county auditor no less than 20 days before each election a list of the names of current employees and the address of the facility.

**Suicide Prevention**
The grants through the Health Department were reduced by $1.966 million.

**Hennepin County Medical Center**
Hennepin Healthcare System (HHS) is created to take over the operation and management of the Hennepin County Medical Center. It will be a subsidiary of the county. The county will retain some control and will have two county commissioners on the corporation's board and will have power over the corporation related to its mission, budget, ability to incur debt, governance and care for people who are poor and have no health insurance. HHS cannot dissolve or reorganize without county board approval.

**Marriage and Family Therapists**
Marriage and family therapists are now included in the definition of professional services.

**Waivers from Rules or State Law**
One or more local governments can now request a waiver or exemption from a state law or rule governing local government service delivery. If the local government is not successful obtaining an exemption from any administrative rule governing the issue, they can apply to the State Auditor. This process does not apply to school districts seeking variances under another statute. The application will not be approved if granting it would violate the state or federal constitution, violate federal law, or result in loss of services to people entitled to those services.

*Please note: As more clarification of new language becomes available, this document may change. 7/18/2005*

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