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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2294

02/15/2012 Authored by Abeler, Huntley and Hamilton
The bill was read for the first time and referred to the Committee on Health and Human Services Finance
03/26/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Ways and Means
03/28/2012 Adoption of Report: Pass as Amended and Read Second Time
03/29/2012 Fiscal Calendar, Amended
Read Third Time as Amended
Passed by the House as Amended and transmitted to the Senate to include Floor Amendments
04/24/2012 Read Third Time as Amended by Conference and repassed by the House
Read Third Time as Amended by Conference and repassed by the Senate

A bill for an act

1.1 relating to state government; making adjustments to health and human services
1.2 appropriations; making changes to provisions related to health care, the
1.3 Department of Health, children and family services, continuing care, background
1.4 studies, chemical dependency, and child support; requiring reporting of potential
1.5 welfare fraud; providing for data sharing; requiring eligibility determinations;
1.6 providing rulemaking authority; providing penalties; encouraging the University
1.7 of Minnesota to request funding for rural primary care training; requiring studies
1.8 and reports; providing appointments; appropriating money; amending Minnesota
1.9 Statutes 2010, sections 62A.047; 62J.496, subdivision 2; 62Q.80; 72A.201,
1.10 subdivision 8; 144.292, subdivision 6; 144.298, subdivision 2; 144.5509;
1.11 144A.073, by adding a subdivision; 144A.351; 144D.04, subdivision 2; 145.906;
1.12 245.697, subdivision 1; 245A.03, by adding a subdivision; 245A.11, subdivisions
1.13 2a, 7, 7a; 245B.07, subdivision 1; 245C.04, subdivision 6; 245C.05, subdivision
1.14 7; 252.27, subdivision 2a; 254A.19, by adding a subdivision; 256.01, by adding
1.15 subdivisions; 256.975, subdivision 7; 256.9831, subdivision 2; 256B.056,
1.16 subdivision 1a; 256B.0625, subdivision 28a, by adding subdivisions; 256B.0659,
1.17 by adding a subdivision; 256B.0751, by adding a subdivision; 256B.0911, by
1.18 adding subdivisions; 256B.092, subdivisions 1b, 7; 256B.0943, subdivision 9;
1.19 256B.431, subdivision 17e, by adding a subdivision; 256B.434, subdivision
1.20 10; 256B.441, by adding a subdivision; 256B.48, by adding a subdivision;
1.21 256B.69, subdivision 9, by adding subdivisions; 256D.06, subdivision 1b;
1.22 256D.44, subdivision 5; 256E.37, subdivision 1; 256I.05, subdivision 1e;
1.23 256J.26, subdivision 1, by adding a subdivision; 256J.575, subdivisions 1, 2, 5,
1.24 6, 8; 256L.07, subdivision 3; 518A.40, subdivision 4; 626.556, by adding a
1.25 subdivision; Minnesota Statutes 2011 Supplement, sections 62E.14, subdivision
1.26 4g; 119B.13, subdivision 7; 144.1222, subdivision 5; 245A.03, subdivision 7;
1.27 256.987, subdivisions 1, 2, by adding subdivisions; 256B.056, subdivision 3;
1.28 256B.057, subdivision 9; 256B.0625, subdivision 38; 256B.0631, subdivision
1.29 1; 256B.0659, subdivision 11; 256B.0911, subdivisions 3a, 3c; 256B.0915,
1.30 subdivisions 3e, 3h; 256B.097, subdivision 3; 256B.49, subdivisions 14, 15, 23;
1.31 256B.5012, subdivision 13; 256B.69, subdivision 5a; 256B.76, subdivision 4;
1.32 256E.35, subdivisions 5, 6; 256I.05, subdivision 1a; 256L.03, subdivision 5;
1.33 256L.031, subdivisions 2, 3, 6; 256L.12, subdivision 9; Laws 2010, chapter 374,
1.34 section 1; Laws 2011, First Special Session chapter 9, article 7, sections 52; 54;
1.35 article 10, sections 3, subdivisions 1, 3, 4; 8, subdivision 8; proposing coding
1.36 for new law in Minnesota Statutes, chapters 144; 145; 256B; 626; repealing
1.37 Minnesota Statutes 2010, sections 62M.09, subdivision 9; 62Q.64; 144A.073,
1.38

2.1 subdivision 9; 256B.48, subdivision 6; Minnesota Rules, parts 4640.0800,
2.2 subpart 4; 4685.2000.

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

2.4 **ARTICLE 1**

2.5 **HEALTH CARE**

2.6 Section 1. Minnesota Statutes 2011 Supplement, section 62E.14, subdivision 4g, is
2.7 amended to read:

2.8 Subd. 4g. **Waiver of preexisting conditions for persons covered by healthy**
2.9 **Minnesota contribution program.** A person may enroll in the comprehensive plan with
2.10 a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for
2.11 the healthy Minnesota contribution program, and has been denied coverage as described
2.12 under section 256L.031, subdivision 6. The six-month durational residency requirement
2.13 specified in section 62E.02, subdivision 13, does not apply to individuals enrolled in the
2.14 healthy Minnesota contribution program.

2.15 Sec. 2. Minnesota Statutes 2010, section 72A.201, subdivision 8, is amended to read:

2.16 Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or
2.17 self-insured, or self-insurance administrator constitute unfair settlement practices:

2.18 (1) denying a claim or any element of a claim on the grounds of a specific policy
2.19 provision, condition, or exclusion, without informing the insured of the policy provision,
2.20 condition, or exclusion on which the denial is based;

2.21 (2) denying a claim without having made a reasonable investigation of the claim;

2.22 (3) denying a liability claim because the insured has requested that the claim be
2.23 denied;

2.24 (4) denying a liability claim because the insured has failed or refused to report the
2.25 claim, unless an independent evaluation of available information indicates there is no
2.26 liability;

2.27 (5) denying a claim without including the following information:

2.28 (i) the basis for the denial;

2.29 (ii) the name, address, and telephone number of the insurer's claim service office
2.30 or the claim representative of the insurer to whom the insured or claimant may take any
2.31 questions or complaints about the denial;

2.32 (iii) the claim number and the policy number of the insured; and

3.1 (iv) if the denied claim is a fire claim, the insured's right to file with the Department
3.2 of Commerce a complaint regarding the denial, and the address and telephone number
3.3 of the Department of Commerce;

3.4 (6) denying a claim because the insured or claimant failed to exhibit the damaged
3.5 property unless:

3.6 (i) the insurer, within a reasonable time period, made a written demand upon the
3.7 insured or claimant to exhibit the property; and

3.8 (ii) the demand was reasonable under the circumstances in which it was made;

3.9 (7) denying a claim by an insured or claimant based on the evaluation of a chemical
3.10 dependency claim reviewer selected by the insurer unless the reviewer meets the
3.11 qualifications specified under subdivision 8a. An insurer that selects chemical dependency
3.12 reviewers to conduct claim evaluations must annually file with the commissioner of
3.13 commerce a report containing the specific evaluation standards and criteria used in these
3.14 evaluations. The report must be filed at the same time its annual statement is submitted
3.15 under section 60A.13. ~~The report must also include the number of evaluations performed~~
3.16 ~~on behalf of the insurer during the reporting period, the types of evaluations performed,~~
3.17 ~~the results, the number of appeals of denials based on these evaluations, the results of~~
3.18 ~~these appeals, and the number of complaints filed in a court of competent jurisdiction.~~

3.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

3.20 Sec. 3. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
3.21 subdivision to read:

3.22 **Subd. 18c. Nonemergency Medical Transportation Advisory Committee.**

3.23 (a) The Nonemergency Medical Transportation Advisory Committee shall advise the
3.24 commissioner on the administration of nonemergency medical transportation covered
3.25 under medical assistance. The advisory committee shall meet at least quarterly and may
3.26 meet more frequently as required by the commissioner. The advisory committee shall
3.27 annually elect a chair from among its members, who shall work with the commissioner or
3.28 the commissioner's designee to establish the agenda for each meeting. The commissioner,
3.29 or the commissioner's designee, shall attend all advisory committee meetings.

3.30 (b) The Nonemergency Medical Transportation Advisory Committee shall advise
3.31 and make recommendations to the commissioner on:

3.32 (1) the development of, and periodic updates to, a policy manual for nonemergency
3.33 medical transportation services;

3.34 (2) policies and a funding source for reimbursing no-load miles;

4.1 (3) policies to prevent waste, fraud, and abuse, and to improve the efficiency of the
4.2 nonemergency medical transportation system;

4.3 (4) other issues identified in the 2011 evaluation report by the Office of the
4.4 Legislative Auditor on medical nonemergency transportation; and

4.5 (5) other aspects of the nonemergency medical transportation system, as requested
4.6 by the commissioner.

4.7 (c) The Nonemergency Medical Transportation Advisory Committee shall
4.8 coordinate its activities with the Minnesota Council on Transportation Access established
4.9 under section 174.285. The chair of the advisory committee, or the chair's designee, shall
4.10 attend all meetings of the Minnesota Council on Transportation Access.

4.11 (d) The Nonemergency Medical Transportation Advisory Committee shall expire
4.12 December 1, 2014.

4.13 Sec. 4. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
4.14 subdivision to read:

4.15 Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical
4.16 Transportation Advisory Committee consists of:

4.17 (1) two voting members who represent counties, at least one of whom must represent
4.18 a county or counties other than Anoka, Carver, Chisago, Dakota, Hennepin, Isanti,
4.19 Ramsey, Scott, Sherburne, Washington, and Wright;

4.20 (2) four voting members who represent medical assistance recipients, including
4.21 persons with physical and developmental disabilities, persons with mental illness, seniors,
4.22 children, and low-income individuals;

4.23 (3) four voting members who represent providers that deliver nonemergency medical
4.24 transportation services to medical assistance enrollees;

4.25 (4) two voting members of the house of representatives, one from the majority
4.26 party and one from the minority party, appointed by the speaker of the house, and two
4.27 voting members from the senate, one from the majority party and one from the minority
4.28 party, appointed by the Subcommittee on Committees of the Committee on Rules and
4.29 Administration;

4.30 (5) one voting member who represents demonstration providers as defined in section
4.31 256B.69, subdivision 2;

4.32 (6) one voting member who represents an organization that contracts with state or
4.33 local governments to coordinate transportation services for medical assistance enrollees;
4.34 and

5.1 (7) the commissioner of transportation or the commissioner's designee, who shall
5.2 serve as a voting member.

5.3 (b) Members of the advisory committee shall not be employed by the Department of
5.4 Human Services. Members of the advisory committee shall receive no compensation.

5.5 Sec. 5. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
5.6 subdivision to read:

5.7 Subd. 18e. **Single administrative structure and delivery system.** (a) The
5.8 commissioner shall implement a single administrative structure and delivery system for
5.9 nonemergency medical transportation, beginning July 1, 2013. The single administrative
5.10 structure and delivery system must:

5.11 (1) eliminate the distinction between access transportation services and special
5.12 transportation services;

5.13 (2) enable all medical assistance recipients to follow the same process to obtain
5.14 nonemergency medical transportation, regardless of their level of need;

5.15 (3) provide a single oversight framework for all providers of nonemergency medical
5.16 transportation; and

5.17 (4) provide flexibility in service delivery, recognizing that clients fall along a
5.18 continuum of needs and resources.

5.19 (b) The commissioner shall present to the legislature, by January 15, 2013, any draft
5.20 legislation necessary to implement the single administrative structure and delivery system
5.21 for nonemergency medical transportation.

5.22 (c) In developing the single administrative structure and delivery system and
5.23 the draft legislation, the commissioner shall consult with the Nonemergency Medical
5.24 Transportation Advisory Committee.

5.25 Sec. 6. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
5.26 subdivision to read:

5.27 Subd. 18f. **Enrollee assessment process.** (a) The commissioner, in consultation
5.28 with the Nonemergency Medical Transportation Advisory Committee, shall develop and
5.29 implement, by July 1, 2013, a comprehensive, statewide, standard assessment process
5.30 for medical assistance enrollees seeking nonemergency medical transportation services.
5.31 The assessment process must identify a client's level of needs, abilities, and resources,
5.32 and match the client with the mode of transportation in the client's service area that best
5.33 meets those needs.

5.34 (b) The assessment process must:

6.1 (1) address mental health diagnoses when determining the most appropriate mode of
6.2 transportation;

6.3 (2) base decisions on clearly defined criteria that are available to clients, providers,
6.4 and counties;

6.5 (3) be standardized across the state and be aligned with other similar existing
6.6 processes;

6.7 (4) allow for extended periods of eligibility for certain types of nonemergency
6.8 transportation, when a client's condition is unlikely to change; and

6.9 (5) increase the use of public transportation when appropriate and cost-effective,
6.10 including offering monthly bus passes to clients.

6.11 Sec. 7. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
6.12 subdivision to read:

6.13 Subd. 18g. **Use of standardized measures.** The commissioner, in consultation
6.14 with the Nonemergency Medical Transportation Advisory Committee, shall establish
6.15 performance measures to assess the cost-effectiveness and quality of nonemergency
6.16 medical transportation. At a minimum, performance measures should include the number
6.17 of unique participants served by type of transportation provider, number of trips provided
6.18 by type of transportation provider, and cost per trip by type of transportation provider. The
6.19 commissioner must also consider the measures identified in the January 2012 Department
6.20 of Human Services report to the legislature on nonemergency medical transportation.
6.21 Beginning in calendar year 2013, the commissioner shall collect, audit, and analyze
6.22 performance data on nonemergency medical transportation annually and report this
6.23 information on the agency's Web site. The commissioner shall periodically supplement
6.24 this information with the results of consumer surveys of the quality of services, and shall
6.25 make these survey findings available to the public on the agency Web site.

6.26 Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 28a, is amended to
6.27 read:

6.28 Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers
6.29 services performed by a licensed physician assistant if the service is otherwise covered
6.30 under this chapter as a physician service and if the service is within the scope of practice
6.31 of a licensed physician assistant as defined in section 147A.09.

6.32 (b) Licensed physician assistants, who are supervised by a physician certified by
6.33 the American Board of Psychiatry and Neurology or eligible for board certification in
6.34 psychiatry, may bill for medication management and evaluation and management services

7.1 provided to medical assistance enrollees in inpatient hospital settings, consistent with
7.2 their authorized scope of practice, as defined in section 147A.09, with the exception of
7.3 performing psychotherapy, diagnostic assessments, or providing clinical supervision.

7.4 Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 38,
7.5 is amended to read:

7.6 Subd. 38. **Payments for mental health services.** Payments for mental
7.7 health services covered under the medical assistance program that are provided by
7.8 masters-prepared mental health professionals shall be 80 percent of the rate paid to
7.9 doctoral-prepared professionals. Payments for mental health services covered under
7.10 the medical assistance program that are provided by masters-prepared mental health
7.11 professionals employed by community mental health centers shall be 100 percent of the
7.12 rate paid to doctoral-prepared professionals. Payments for mental health services covered
7.13 under the medical assistance program that are provided by physician assistants shall be
7.14 80.4 percent of the base rate paid to psychiatrists.

7.15 Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 1,
7.16 is amended to read:

7.17 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
7.18 assistance benefit plan shall include the following cost-sharing for all recipients, effective
7.19 for services provided on or after September 1, 2011:

7.20 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
7.21 of this subdivision, a visit means an episode of service which is required because of
7.22 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
7.23 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
7.24 midwife, advanced practice nurse, audiologist, optician, or optometrist;

7.25 (2) \$3 for eyeglasses;

7.26 (3) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
7.27 this co-payment shall be increased to \$20 upon federal approval;

7.28 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
7.29 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
7.30 shall apply to antipsychotic drugs when used for the treatment of mental illness;

7.31 (5) effective January 1, 2012, a family deductible equal to the maximum amount
7.32 allowed under Code of Federal Regulations, title 42, part 447.54; and

7.33 (6) for individuals identified by the commissioner with income at or below 100
7.34 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five

8.1 percent of family income. For purposes of this paragraph, family income is the total
8.2 earned and unearned income of the individual and the individual's spouse, if the spouse is
8.3 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

8.4 (b) Recipients of medical assistance are responsible for all co-payments and
8.5 deductibles in this subdivision.

8.6 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
8.7 process under sections 256B.69 and 256B.692, may allow managed care plans and
8.8 county-based purchasing plans to waive the family deductible under paragraph (a),
8.9 clause (5). The value of the family deductible shall not be included in the capitation
8.10 payment to managed care plans and county-based purchasing plans. Managed care plans
8.11 and county-based purchasing plans shall certify annually to the commissioner the dollar
8.12 value of the family deductible.

8.13 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
8.14 the family deductible described under paragraph (a), clause (5), from individuals and
8.15 allow long-term care and waived service providers to assume responsibility for payment.

8.16 **EFFECTIVE DATE.** Paragraph (c) is effective January 1, 2012. Paragraph (d)
8.17 is effective July 1, 2012.

8.18 Sec. 11. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
8.19 subdivision to read:

8.20 **Subd. 9. Pediatric care coordination.** The commissioner shall implement a
8.21 pediatric care coordination service for children with high-cost medical or high-cost
8.22 psychiatric conditions who are at risk of recurrent hospitalization or emergency room use
8.23 for acute, chronic, or psychiatric illness, who receive medical assistance services. Care
8.24 coordination services must be targeted to children not already receiving care coordination
8.25 through another service and may include but are not limited to the provision of health
8.26 care home services to children admitted to hospitals that do not currently provide care
8.27 coordination. Care coordination services must be provided by care coordinators who
8.28 are directly linked to provider teams in the care delivery setting, but who may be part
8.29 of a community care team shared by multiple primary care providers or practices. For
8.30 purposes of this subdivision, the commissioner shall, to the extent possible, use the
8.31 existing health care home certification and payment structure established under this
8.32 section and section 256B.0753.

8.33 Sec. 12. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a,
8.34 is amended to read:

9.1 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
9.2 and section 256L.12 shall be entered into or renewed on a calendar year basis beginning
9.3 January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to
9.4 renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December
9.5 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may
9.6 issue separate contracts with requirements specific to services to medical assistance
9.7 recipients age 65 and older.

9.8 (b) A prepaid health plan providing covered health services for eligible persons
9.9 pursuant to chapters 256B and 256L is responsible for complying with the terms of its
9.10 contract with the commissioner. Requirements applicable to managed care programs
9.11 under chapters 256B and 256L established after the effective date of a contract with the
9.12 commissioner take effect when the contract is next issued or renewed.

9.13 (c) Effective for services rendered on or after January 1, 2003, the commissioner
9.14 shall withhold five percent of managed care plan payments under this section and
9.15 county-based purchasing plan payments under section 256B.692 for the prepaid medical
9.16 assistance program pending completion of performance targets. Each performance target
9.17 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
9.18 of a performance target based on a federal or state law or rule. Criteria for assessment
9.19 of each performance target must be outlined in writing prior to the contract effective
9.20 date. Clinical or utilization performance targets and their related criteria must consider
9.21 evidence-based research and reasonable interventions when available or applicable to the
9.22 populations served, and must be developed with input from external clinical experts
9.23 and stakeholders, including managed care plans, county-based purchasing plans, and
9.24 providers. The managed care or county-based purchasing plan must demonstrate,
9.25 to the commissioner's satisfaction, that the data submitted regarding attainment of
9.26 the performance target is accurate. The commissioner shall periodically change the
9.27 administrative measures used as performance targets in order to improve plan performance
9.28 across a broader range of administrative services. The performance targets must include
9.29 measurement of plan efforts to contain spending on health care services and administrative
9.30 activities. The commissioner may adopt plan-specific performance targets that take into
9.31 account factors affecting only one plan, including characteristics of the plan's enrollee
9.32 population. The withheld funds must be returned no sooner than July of the following
9.33 year if performance targets in the contract are achieved. The commissioner may exclude
9.34 special demonstration projects under subdivision 23.

9.35 (d) Effective for services rendered on or after January 1, 2009, through December
9.36 31, 2009, the commissioner shall withhold three percent of managed care plan payments

10.1 under this section and county-based purchasing plan payments under section 256B.692
10.2 for the prepaid medical assistance program. The withheld funds must be returned no
10.3 sooner than July 1 and no later than July 31 of the following year. The commissioner may
10.4 exclude special demonstration projects under subdivision 23.

10.5 (e) Effective for services provided on or after January 1, 2010, the commissioner
10.6 shall require that managed care plans use the assessment and authorization processes,
10.7 forms, timelines, standards, documentation, and data reporting requirements, protocols,
10.8 billing processes, and policies consistent with medical assistance fee-for-service or the
10.9 Department of Human Services contract requirements consistent with medical assistance
10.10 fee-for-service or the Department of Human Services contract requirements for all
10.11 personal care assistance services under section 256B.0659.

10.12 (f) Effective for services rendered on or after January 1, 2010, through December
10.13 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments
10.14 under this section and county-based purchasing plan payments under section 256B.692
10.15 for the prepaid medical assistance program. The withheld funds must be returned no
10.16 sooner than July 1 and no later than July 31 of the following year. The commissioner may
10.17 exclude special demonstration projects under subdivision 23.

10.18 (g) Effective for services rendered on or after January 1, 2011, through December
10.19 31, 2011, the commissioner shall include as part of the performance targets described
10.20 in paragraph (c) a reduction in the health plan's emergency room utilization rate for
10.21 state health care program enrollees by a measurable rate of five percent from the plan's
10.22 utilization rate for state health care program enrollees for the previous calendar year.
10.23 Effective for services rendered on or after January 1, 2012, the commissioner shall include
10.24 as part of the performance targets described in paragraph (c) a reduction in the health
10.25 plan's emergency department utilization rate for medical assistance and MinnesotaCare
10.26 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
10.27 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
10.28 year, the managed care plan or county-based purchasing plan must achieve a qualifying
10.29 reduction of no less than ten percent of the plan's emergency department utilization
10.30 rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees
10.31 in programs described in subdivisions 23 and 28, compared to the previous ~~calendar~~
10.32 measurement year until the final performance target is reached. When measuring
10.33 performance, the commissioner must consider the difference in health risk in a managed
10.34 care or county-based purchasing plan's membership in the baseline year compared to the
10.35 measurement year, and work with the managed care or county-based purchasing plan to
10.36 account for differences that they agree are significant.

11.1 The withheld funds must be returned no sooner than July 1 and no later than July 31
11.2 of the following calendar year if the managed care plan or county-based purchasing plan
11.3 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
11.4 was achieved. The commissioner shall structure the withhold so that the commissioner
11.5 returns a portion of the withheld funds in amounts commensurate with achieved reductions
11.6 in utilization less than the target amount.

11.7 The withhold described in this paragraph shall continue for each consecutive
11.8 contract period until the plan's emergency room utilization rate for state health care
11.9 program enrollees is reduced by 25 percent of the plan's emergency room utilization
11.10 rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009.
11.11 Hospitals shall cooperate with the health plans in meeting this performance target and
11.12 shall accept payment withholds that may be returned to the hospitals if the performance
11.13 target is achieved.

11.14 (h) Effective for services rendered on or after January 1, 2012, the commissioner
11.15 shall include as part of the performance targets described in paragraph (c) a reduction in the
11.16 plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees,
11.17 as determined by the commissioner. To earn the return of the withhold each year, the
11.18 managed care plan or county-based purchasing plan must achieve a qualifying reduction
11.19 of no less than five percent of the plan's hospital admission rate for medical assistance
11.20 and MinnesotaCare enrollees, excluding Medicare enrollees in programs described in
11.21 subdivisions 23 and 28, compared to the previous calendar year until the final performance
11.22 target is reached. When measuring performance, the commissioner must consider the
11.23 difference in health risk in a managed care or county-based purchasing plan's membership
11.24 in the baseline year compared to the measurement year, and work with the managed care
11.25 or county-based purchasing plan to account for differences that they agree are significant.

11.26 The withheld funds must be returned no sooner than July 1 and no later than July
11.27 31 of the following calendar year if the managed care plan or county-based purchasing
11.28 plan demonstrates to the satisfaction of the commissioner that this reduction in the
11.29 hospitalization rate was achieved. The commissioner shall structure the withhold so that
11.30 the commissioner returns a portion of the withheld funds in amounts commensurate with
11.31 achieved reductions in utilization less than the targeted amount.

11.32 The withhold described in this paragraph shall continue until there is a 25 percent
11.33 reduction in the hospital admission rate compared to the hospital admission rates in
11.34 calendar year 2011, as determined by the commissioner. The hospital admissions in this
11.35 performance target do not include the admissions applicable to the subsequent hospital
11.36 admission performance target under paragraph (i). Hospitals shall cooperate with the

12.1 plans in meeting this performance target and shall accept payment withholds that may be
12.2 returned to the hospitals if the performance target is achieved.

12.3 (i) Effective for services rendered on or after January 1, 2012, the commissioner
12.4 shall include as part of the performance targets described in paragraph (c) a reduction in
12.5 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days
12.6 of a previous hospitalization of a patient regardless of the reason, for medical assistance
12.7 and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of
12.8 the withhold each year, the managed care plan or county-based purchasing plan must
12.9 achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance
12.10 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
12.11 subdivisions 23 and 28, of no less than five percent compared to the previous calendar
12.12 year until the final performance target is reached.

12.13 The withheld funds must be returned no sooner than July 1 and no later than July
12.14 31 of the following calendar year if the managed care plan or county-based purchasing
12.15 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
12.16 the subsequent hospitalization rate was achieved. The commissioner shall structure the
12.17 withhold so that the commissioner returns a portion of the withheld funds in amounts
12.18 commensurate with achieved reductions in utilization less that the targeted amount.

12.19 The withhold described in this paragraph must continue for each consecutive
12.20 contract period until the plan's subsequent hospitalization rate for medical assistance
12.21 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
12.22 subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization
12.23 rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this
12.24 performance target and shall accept payment withholds that must be returned to the
12.25 hospitals if the performance target is achieved.

12.26 (j) Effective for services rendered on or after January 1, 2011, through December 31,
12.27 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under
12.28 this section and county-based purchasing plan payments under section 256B.692 for the
12.29 prepaid medical assistance program. The withheld funds must be returned no sooner than
12.30 July 1 and no later than July 31 of the following year. The commissioner may exclude
12.31 special demonstration projects under subdivision 23.

12.32 (k) Effective for services rendered on or after January 1, 2012, through December
12.33 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
12.34 under this section and county-based purchasing plan payments under section 256B.692
12.35 for the prepaid medical assistance program. The withheld funds must be returned no

13.1 sooner than July 1 and no later than July 31 of the following year. The commissioner may
13.2 exclude special demonstration projects under subdivision 23.

13.3 (l) Effective for services rendered on or after January 1, 2013, through December 31,
13.4 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
13.5 this section and county-based purchasing plan payments under section 256B.692 for the
13.6 prepaid medical assistance program. The withheld funds must be returned no sooner than
13.7 July 1 and no later than July 31 of the following year. The commissioner may exclude
13.8 special demonstration projects under subdivision 23.

13.9 (m) Effective for services rendered on or after January 1, 2014, the commissioner
13.10 shall withhold three percent of managed care plan payments under this section and
13.11 county-based purchasing plan payments under section 256B.692 for the prepaid medical
13.12 assistance program. The withheld funds must be returned no sooner than July 1 and
13.13 no later than July 31 of the following year. The commissioner may exclude special
13.14 demonstration projects under subdivision 23.

13.15 (n) A managed care plan or a county-based purchasing plan under section 256B.692
13.16 may include as admitted assets under section 62D.044 any amount withheld under this
13.17 section that is reasonably expected to be returned.

13.18 (o) Contracts between the commissioner and a prepaid health plan are exempt from
13.19 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
13.20 (a), and 7.

13.21 (p) The return of the withhold under paragraphs (d), (f), and (j) to (m) is not subject
13.22 to the requirements of paragraph (c).

13.23 Sec. 13. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

13.24 Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as
13.25 required by the commissioner, including data required for assessing client satisfaction,
13.26 quality of care, cost, and utilization of services for purposes of project evaluation. The
13.27 commissioner shall also develop methods of data reporting and collection in order to
13.28 provide aggregate enrollee information on encounters and outcomes to determine access
13.29 and quality assurance. Required information shall be specified before the commissioner
13.30 contracts with a demonstration provider.

13.31 (b) Aggregate nonpersonally identifiable health plan encounter data, aggregate
13.32 spending data for major categories of service as reported to the commissioners of
13.33 health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for
13.34 service authorization and service use are public data that the commissioner shall make

14.1 available and use in public reports. The commissioner shall require each health plan and
14.2 county-based purchasing plan to provide:

14.3 (1) encounter data for each service provided, using standard codes and unit of
14.4 service definitions set by the commissioner, in a form that the commissioner can report by
14.5 age, eligibility groups, and health plan; and

14.6 (2) criteria, written policies, and procedures required to be disclosed under section
14.7 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used
14.8 for each type of service for which authorization is required.

14.9 (c) Each demonstration provider shall report to the commissioner on the extent to
14.10 which providers employed by or under contract with the demonstration provider use
14.11 patient-centered decision-making tools or procedures designed to engage patients early
14.12 in the decision-making process and the steps taken by the demonstration provider to
14.13 encourage their use.

14.14 Sec. 14. Minnesota Statutes 2010, section 256B.69, is amended by adding a
14.15 subdivision to read:

14.16 Subd. 9d. **Financial audit.** (a) The legislative auditor shall contract with an audit
14.17 firm to conduct a biennial independent third-party financial audit of the information
14.18 required to be provided by managed care plans and county-based purchasing plans under
14.19 subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally
14.20 accepted government auditing standards issued by the United States Government
14.21 Accountability Office. The contract with the audit firm shall be designed and administered
14.22 so as to render the independent third-party audit eligible for a federal subsidy, if available.
14.23 The contract shall require the audit to include a determination of compliance with
14.24 the federal Medicaid rate certification process. The contract shall require the audit to
14.25 determine if the administrative expenses and investment income reported by the managed
14.26 care plans and county-based purchasing plans are compliant with state and federal law.

14.27 (b) For purposes of this subdivision, "independent third-party" means an audit firm
14.28 that is independent in accordance with government auditing standards issued by the United
14.29 States Government Accountability Office and licensed in accordance with chapter 326A.
14.30 An audit firm under contract to provide services in accordance with this subdivision must
14.31 not have provided services to a managed care plan or county-based purchasing plan during
14.32 the period for which the audit is being conducted.

14.33 (c) The commissioner shall require in the request for bids and resulting contracts
14.34 with managed care plans and county-based purchasing plans under this section and section
14.35 256B.692, that each managed care plan and county-based purchasing plan submit to

15.1 and fully cooperate with the independent third-party financial audit of the information
15.2 required under subdivision 9c, paragraph (b). Each contract with a managed care plan
15.3 or county-based purchasing plan under this section or section 256B.692, must provide
15.4 the commissioner and the audit firm contracting with the legislative auditor access to all
15.5 data required to complete the audit. For purposes of this subdivision, the contracting
15.6 audit firm shall have the same investigative power as the legislative auditor under section
15.7 3.978, subdivision 2.

15.8 (d) Each managed care plan and county-based purchasing plan providing services
15.9 under this section shall provide to the commissioner biweekly encounter data and claims
15.10 data for state public health care programs and shall participate in a quality assurance
15.11 program that verifies the timeliness, completeness, accuracy, and consistency of the data
15.12 provided. The commissioner shall develop written protocols for the quality assurance
15.13 program and shall make the protocols publicly available. The commissioner shall contract
15.14 for an independent third-party audit to evaluate the quality assurance protocols as to
15.15 the capacity of the protocols to ensure complete and accurate data and to evaluate the
15.16 commissioner's implementation of the protocols. The audit firm under contract to provide
15.17 this evaluation must meet the requirements in paragraph (b).

15.18 (e) Upon completion of the audit under paragraph (a) and receipt by the legislative
15.19 auditor, the legislative auditor shall provide copies of the audit report to the commissioner,
15.20 the state auditor, the attorney general, and the chairs and ranking minority members of the
15.21 health and human services finance committees of the legislature. Upon completion of the
15.22 evaluation under paragraph (d), the commissioner shall provide copies of the report to
15.23 the legislative auditor and the chairs and ranking minority members of the health finance
15.24 committees of the legislature.

15.25 (f) Any actuary under contract with the commissioner to provide actuarial services
15.26 must meet the independence requirements under the professional code for fellows in the
15.27 Society of Actuaries and must not have provided actuarial services to a managed care plan
15.28 or county-based purchasing plan that is under contract with the commissioner pursuant to
15.29 this section and section 256B.692 during the period in which the actuarial services are
15.30 being provided. An actuary or actuarial firm meeting the requirements of this paragraph
15.31 must certify and attest to the rates paid to the managed care plans and county-based
15.32 purchasing plans under this section and section 256B.692, and the certification and
15.33 attestation must be auditable.

15.34 (g) Nothing in this subdivision shall allow the release of information that is
15.35 nonpublic data pursuant to section 13.02.

16.1 **EFFECTIVE DATE.** This section is effective the day following final enactment
16.2 and applies to the managed care and county-based purchasing plan contracts that are
16.3 effective January 1, 2014, and biennially thereafter.

16.4 Sec. 15. Minnesota Statutes 2010, section 256B.69, is amended by adding a
16.5 subdivision to read:

16.6 Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner
16.7 shall require managed care and county-based purchasing plans, as a condition of contract,
16.8 to implement strategies to reduce the incidence of low birth weight in geographic areas
16.9 identified by the commissioner as having a higher than average incidence of low birth
16.10 weight. The strategies must coordinate health care with social services and the local
16.11 public health system. Each plan shall develop and report to the commissioner outcome
16.12 measures related to reducing the incidence of low birth weight. The commissioner shall
16.13 consider the outcomes reported when considering plan participation in the competitive
16.14 bidding program established under subdivision 33.

16.15 Sec. 16. Minnesota Statutes 2010, section 256B.69, is amended by adding a
16.16 subdivision to read:

16.17 Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or
16.18 after January 1, 2014, the commissioner may utilize a competitive price bidding program
16.19 for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare
16.20 in the seven-county metropolitan area. The program must allow a minimum of two
16.21 managed care plans to serve the metropolitan area.

16.22 (b) In designing the competitive bid program, the commissioner shall consider, and
16.23 incorporate where appropriate, the procedures and criteria used in the competitive bidding
16.24 pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96.
16.25 The pilot program operating in Hennepin County under the authority of section 256B.0756
16.26 shall continue to be exempt from competitive bid.

16.27 (c) The commissioner shall use past performance data as a factor in selecting vendors
16.28 and shall consider this information, along with competitive bid and other information, in
16.29 determining whether to contract with a managed care plan under this subdivision. Where
16.30 possible, the assessment of past performance in serving persons on public programs shall
16.31 be based on encounter data submitted to the commissioner. The commissioner shall
16.32 evaluate past performance based on both the health outcomes of care and success rates
16.33 in securing participation in recommended preventive and early diagnostic care. Data
16.34 provided by managed care plans must be provided in a uniform manner as specified by

17.1 the commissioner and must include only data on medical assistance and MinnesotaCare
17.2 enrollees. The data submitted must include health outcome measures on reducing the
17.3 incidence of low birth weight established by the managed care plan under subdivision 32.

17.4 Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.76, subdivision 4, is
17.5 amended to read:

17.6 Subd. 4. **Critical access dental providers.** (a) Effective for dental services
17.7 rendered on or after January 1, 2002, the commissioner shall increase reimbursements
17.8 to dentists and dental clinics deemed by the commissioner to be critical access dental
17.9 providers. For dental services rendered on or after July 1, 2007, the commissioner shall
17.10 increase reimbursement by 30 percent above the reimbursement rate that would otherwise
17.11 be paid to the critical access dental provider. The commissioner shall pay the managed
17.12 care plans and county-based purchasing plans in amounts sufficient to reflect increased
17.13 reimbursements to critical access dental providers as approved by the commissioner.

17.14 (b) The commissioner shall designate the following dentists and dental clinics as
17.15 critical access dental providers:

17.16 (1) nonprofit community clinics that:

17.17 (i) have nonprofit status in accordance with chapter 317A;

17.18 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
17.19 501(c)(3);

17.20 (iii) are established to provide oral health services to patients who are low income,
17.21 uninsured, have special needs, and are underserved;

17.22 (iv) have professional staff familiar with the cultural background of the clinic's
17.23 patients;

17.24 (v) charge for services on a sliding fee scale designed to provide assistance to
17.25 low-income patients based on current poverty income guidelines and family size;

17.26 (vi) do not restrict access or services because of a patient's financial limitations
17.27 or public assistance status; and

17.28 (vii) have free care available as needed;

17.29 (2) federally qualified health centers, rural health clinics, and public health clinics;

17.30 (3) county owned and operated hospital-based dental clinics;

17.31 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
17.32 accordance with chapter 317A with more than 10,000 patient encounters per year with
17.33 patients who are uninsured or covered by medical assistance, general assistance medical
17.34 care, or MinnesotaCare; and

18.1 (5) a dental clinic owned and operated by the University of Minnesota or the
18.2 Minnesota State Colleges and Universities system.

18.3 (c) The commissioner may designate a dentist or dental clinic as a critical access
18.4 dental provider if the dentist or dental clinic is willing to provide care to patients covered
18.5 by medical assistance, general assistance medical care, or MinnesotaCare at a level which
18.6 significantly increases access to dental care in the service area.

18.7 (d) ~~Notwithstanding paragraph (a), critical access payments must not be made for~~
18.8 ~~dental services provided from April 1, 2010, through June 30, 2010.~~ A designated critical
18.9 access clinic shall receive the reimbursement rate specified in paragraph (a) for dental
18.10 services provided off-site at a private dental office if the following requirements are met:

18.11 (1) the designated critical access dental clinic is located within a health professional
18.12 shortage area as defined under the Code of Federal Regulations, title 42, part 5, and
18.13 the United States Code, title 42, section 254E, and is located outside the seven-county
18.14 metropolitan area;

18.15 (2) the designated critical access dental clinic is not able to provide the service
18.16 and refers the patient to the off-site dentist;

18.17 (3) the service, if provided at the critical access dental clinic, would be reimbursed
18.18 at the critical access reimbursement rate;

18.19 (4) the dentist and allied dental professionals providing the services off-site are
18.20 licensed and in good standing under chapter 150A;

18.21 (5) the dentist providing the services is enrolled as a medical assistance provider;

18.22 (6) the critical access dental clinic submits the claim for services provided off-site
18.23 and receives the payment for the services; and

18.24 (7) the critical access dental clinic maintains dental records for each claim submitted
18.25 under this paragraph, including the name of the dentist, the off-site location, and the
18.26 license number of the dentist and allied dental professionals providing the services.

18.27 **EFFECTIVE DATE.** This section is effective July 1, 2012, or upon federal
18.28 approval, whichever is later.

18.29 Sec. 18. Minnesota Statutes 2011 Supplement, section 256L.03, subdivision 5, is
18.30 amended to read:

18.31 Subd. 5. **Cost-sharing.** (a) Except as provided in paragraphs (b) and (c), the
18.32 MinnesotaCare benefit plan shall include the following cost-sharing requirements for all
18.33 enrollees:

18.34 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
18.35 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual;

19.1 (2) \$3 per prescription for adult enrollees;

19.2 (3) \$25 for eyeglasses for adult enrollees;

19.3 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
19.4 episode of service which is required because of a recipient's symptoms, diagnosis, or
19.5 established illness, and which is delivered in an ambulatory setting by a physician or
19.6 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
19.7 audiologist, optician, or optometrist;

19.8 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
19.9 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

19.10 (6) a family deductible equal to the maximum amount allowed under Code of
19.11 Federal Regulations, title 42, part 447.54.

19.12 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
19.13 children under the age of 21.

19.14 (c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

19.15 (d) Paragraph (a), clause (4), does not apply to mental health services.

19.16 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal
19.17 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,
19.18 and who are not pregnant shall be financially responsible for the coinsurance amount, if
19.19 applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

19.20 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
19.21 or changes from one prepaid health plan to another during a calendar year, any charges
19.22 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket
19.23 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
19.24 prior to enrollment, or prior to the change in health plans, shall be disregarded.

19.25 (g) MinnesotaCare reimbursements to fee-for-service providers and payments to
19.26 managed care plans or county-based purchasing plans shall not be increased as a result of
19.27 the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

19.28 (h) The commissioner, through the contracting process under section 256L.12,
19.29 may allow managed care plans and county-based purchasing plans to waive the family
19.30 deductible under paragraph (a), clause (6). The value of the family deductible shall not be
19.31 included in the capitation payment to managed care plans and county-based purchasing
19.32 plans. Managed care plans and county-based purchasing plans shall certify annually to the
19.33 commissioner the dollar value of the family deductible.

19.34 **EFFECTIVE DATE.** This section is effective January 1, 2012.

20.1 Sec. 19. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 2,
20.2 is amended to read:

20.3 Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee
20.4 may use up to the monthly defined contribution to pay premiums for coverage under
20.5 a health plan as defined in section 62A.011, subdivision 3, or as provided in section
20.6 256L.031, subdivision 6.

20.7 (b) An enrollee must select a health plan within ~~three~~ four calendar months of
20.8 approval of MinnesotaCare eligibility. If a health plan is not selected and purchased
20.9 within this time period, the enrollee must reapply and must meet all eligibility criteria.
20.10 The commissioner may determine criteria under which an enrollee has more than four
20.11 calendar months to select a health plan.

20.12 (c) ~~A health plan~~ Coverage purchased under this section must:

20.13 (1) ~~provide coverage for~~ include mental health and chemical dependency treatment
20.14 services; and

20.15 (2) comply with the coverage limitations specified in section 256L.03, subdivision
20.16 1, the second paragraph.

20.17 Sec. 20. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 3,
20.18 is amended to read:

20.19 Subd. 3. **Determination of defined contribution amount.** (a) The commissioner
20.20 shall determine the defined contribution sliding scale using the base contribution specified
20.21 in ~~paragraph (b)~~ this paragraph for the specified age ranges. The commissioner shall use a
20.22 sliding scale for defined contributions that provides:

20.23 (1) persons with household incomes equal to 200 percent of the federal poverty
20.24 guidelines with a defined contribution of 93 percent of the base contribution;

20.25 (2) persons with household incomes equal to 250 percent of the federal poverty
20.26 guidelines with a defined contribution of 80 percent of the base contribution; and

20.27 (3) persons with household incomes in evenly spaced increments between the
20.28 percentages of the federal poverty guideline or income level specified in clauses (1) and
20.29 (2) with a base contribution that is a percentage interpolated from the defined contribution
20.30 percentages specified in clauses (1) and (2).

20.31	19-29	\$125
20.32	30-34	\$135
20.33	35-39	\$140
20.34	40-44	\$175
20.35	45-49	\$215
20.36	50-54	\$295

21.1	55-59	\$345
21.2	60+	\$360

21.3 (b) The commissioner shall multiply the defined contribution amounts developed
 21.4 under paragraph (a) by 1.20 for enrollees ~~who are denied coverage under an individual~~
 21.5 ~~health plan by a health plan company and~~ who purchase coverage through the Minnesota
 21.6 Comprehensive Health Association.

21.7 Sec. 21. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 6,
 21.8 is amended to read:

21.9 Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning
 21.10 July 1, 2012, MinnesotaCare enrollees ~~who are denied coverage in the individual~~
 21.11 ~~health market by a health plan company in accordance with section 62A.65~~ are eligible
 21.12 for coverage through a health plan offered by the Minnesota Comprehensive Health
 21.13 Association ~~and~~ may enroll in MCHA in accordance with section 62E.14. Any difference
 21.14 between the revenue and actual covered losses to MCHA related to the implementation of
 21.15 this section are appropriated annually to the commissioner of human services from the
 21.16 health care access fund and shall be paid to MCHA.

21.17 Sec. 22. Minnesota Statutes 2010, section 256L.07, subdivision 3, is amended to read:

21.18 Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the
 21.19 MinnesotaCare program must have no health coverage while enrolled or for at least four
 21.20 months prior to application and renewal. Children enrolled in the original children's health
 21.21 plan and children in families with income equal to or less than 150 percent of the federal
 21.22 poverty guidelines, who have other health insurance, are eligible if the coverage:

21.23 (1) lacks two or more of the following:

21.24 (i) basic hospital insurance;

21.25 (ii) medical-surgical insurance;

21.26 (iii) prescription drug coverage;

21.27 (iv) dental coverage; or

21.28 (v) vision coverage;

21.29 (2) requires a deductible of \$100 or more per person per year; or

21.30 (3) lacks coverage because the child has exceeded the maximum coverage for a
 21.31 particular diagnosis or the policy excludes a particular diagnosis.

21.32 The commissioner may change this eligibility criterion for sliding scale premiums
 21.33 in order to remain within the limits of available appropriations. The requirement of no
 21.34 health coverage does not apply to newborns.

22.1 (b) Coverage purchased as provided under section 256L.031, subdivision 2, medical
22.2 assistance, ~~general assistance medical care,~~ and the Civilian Health and Medical Program
22.3 of the Uniformed Service, CHAMPUS, or other coverage provided under United States
22.4 Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health
22.5 coverage for purposes of the four-month requirement described in this subdivision.

22.6 (c) For purposes of this subdivision, an applicant or enrollee who is entitled to
22.7 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
22.8 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to
22.9 have health coverage. An applicant or enrollee who is entitled to premium-free Medicare
22.10 Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility
22.11 for MinnesotaCare.

22.12 (d) Applicants who were recipients of medical assistance ~~or general assistance~~
22.13 ~~medical care~~ within one month of application must meet the provisions of this subdivision
22.14 and subdivision 2.

22.15 (e) Cost-effective health insurance that was paid for by medical assistance is not
22.16 considered health coverage for purposes of the four-month requirement under this
22.17 section, except if the insurance continued after medical assistance no longer considered it
22.18 cost-effective or after medical assistance closed.

22.19 Sec. 23. Minnesota Statutes 2011 Supplement, section 256L.12, subdivision 9, is
22.20 amended to read:

22.21 Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective,
22.22 per capita, where possible. The commissioner may allow health plans to arrange for
22.23 inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with
22.24 an independent actuary to determine appropriate rates.

22.25 (b) For services rendered on or after January 1, 2004, the commissioner shall
22.26 withhold five percent of managed care plan payments and county-based purchasing
22.27 plan payments under this section pending completion of performance targets. Each
22.28 performance target must be quantifiable, objective, measurable, and reasonably attainable,
22.29 except in the case of a performance target based on a federal or state law or rule. Criteria
22.30 for assessment of each performance target must be outlined in writing prior to the contract
22.31 effective date. Clinical or utilization performance targets and their related criteria must
22.32 consider evidence-based research and reasonable interventions, when available or
22.33 applicable to the populations served, and must be developed with input from external
22.34 clinical experts and stakeholders, including managed care plans, county-based purchasing
22.35 plans, and providers. The managed care plan must demonstrate, to the commissioner's

23.1 satisfaction, that the data submitted regarding attainment of the performance target is
23.2 accurate. The commissioner shall periodically change the administrative measures used
23.3 as performance targets in order to improve plan performance across a broader range of
23.4 administrative services. The performance targets must include measurement of plan
23.5 efforts to contain spending on health care services and administrative activities. The
23.6 commissioner may adopt plan-specific performance targets that take into account factors
23.7 affecting only one plan, such as characteristics of the plan's enrollee population. The
23.8 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
23.9 following calendar year if performance targets in the contract are achieved.

23.10 (c) For services rendered on or after January 1, 2011, the commissioner shall
23.11 withhold an additional three percent of managed care plan or county-based purchasing
23.12 plan payments under this section. The withheld funds must be returned no sooner than
23.13 July 1 and no later than July 31 of the following calendar year. The return of the withhold
23.14 under this paragraph is not subject to the requirements of paragraph (b).

23.15 (d) Effective for services rendered on or after January 1, 2011, through December
23.16 31, 2011, the commissioner shall include as part of the performance targets described in
23.17 paragraph (b) a reduction in the plan's emergency room utilization rate for state health care
23.18 program enrollees by a measurable rate of five percent from the plan's utilization rate for
23.19 the previous calendar year. Effective for services rendered on or after January 1, 2012,
23.20 the commissioner shall include as part of the performance targets described in paragraph
23.21 (b) a reduction in the health plan's emergency department utilization rate for medical
23.22 assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012,
23.23 the reductions shall be based on the health plan's utilization in 2009. To earn the return of
23.24 the withhold each subsequent year, the managed care plan or county-based purchasing
23.25 plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization
23.26 rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in
23.27 programs described in section 256B.69, subdivisions 23 and 28, compared to the previous
23.28 calendar measurement year, until the final performance target is reached. When measuring
23.29 performance, the commissioner must consider the difference in health risk in a managed
23.30 care or county-based purchasing plan's membership in the baseline year compared to the
23.31 measurement year, and work with the managed care or county-based purchasing plan to
23.32 account for differences that they agree are significant.

23.33 The withheld funds must be returned no sooner than July 1 and no later than July 31
23.34 of the following calendar year if the managed care plan or county-based purchasing plan
23.35 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
23.36 was achieved. The commissioner shall structure the withhold so that the commissioner

24.1 returns a portion of the withheld funds in amounts commensurate with achieved reductions
24.2 in utilization less than the targeted amount.

24.3 The withhold described in this paragraph shall continue for each consecutive
24.4 contract period until the plan's emergency room utilization rate for state health care
24.5 program enrollees is reduced by 25 percent of the plan's emergency room utilization
24.6 rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009.
24.7 Hospitals shall cooperate with the health plans in meeting this performance target and
24.8 shall accept payment withholds that may be returned to the hospitals if the performance
24.9 target is achieved.

24.10 (e) Effective for services rendered on or after January 1, 2012, the commissioner
24.11 shall include as part of the performance targets described in paragraph (b) a reduction
24.12 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare
24.13 enrollees, as determined by the commissioner. To earn the return of the withhold
24.14 each year, the managed care plan or county-based purchasing plan must achieve a
24.15 qualifying reduction of no less than five percent of the plan's hospital admission rate
24.16 for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees
24.17 in programs described in section 256B.69, subdivisions 23 and 28, compared to the
24.18 previous calendar year, until the final performance target is reached. When measuring
24.19 performance, the commissioner must consider the difference in health risk in a managed
24.20 care or county-based purchasing plan's membership in the baseline year compared to the
24.21 measurement year, and work with the managed care or county-based purchasing plan to
24.22 account for differences that they agree are significant.

24.23 The withheld funds must be returned no sooner than July 1 and no later than July
24.24 31 of the following calendar year if the managed care plan or county-based purchasing
24.25 plan demonstrates to the satisfaction of the commissioner that this reduction in the
24.26 hospitalization rate was achieved. The commissioner shall structure the withhold so that
24.27 the commissioner returns a portion of the withheld funds in amounts commensurate with
24.28 achieved reductions in utilization less than the targeted amount.

24.29 The withhold described in this paragraph shall continue until there is a 25 percent
24.30 reduction in the hospitals admission rate compared to the hospital admission rate for
24.31 calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the
24.32 plans in meeting this performance target and shall accept payment withholds that may be
24.33 returned to the hospitals if the performance target is achieved. The hospital admissions
24.34 in this performance target do not include the admissions applicable to the subsequent
24.35 hospital admission performance target under paragraph (f).

25.1 (f) Effective for services provided on or after January 1, 2012, the commissioner
25.2 shall include as part of the performance targets described in paragraph (b) a reduction
25.3 in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a
25.4 previous hospitalization of a patient regardless of the reason, for medical assistance and
25.5 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the
25.6 withhold each year, the managed care plan or county-based purchasing plan must achieve
25.7 a qualifying reduction of the subsequent hospital admissions rate for medical assistance
25.8 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
25.9 section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the
25.10 previous calendar year until the final performance target is reached.

25.11 The withheld funds must be returned no sooner than July 1 and no later than July 31
25.12 of the following calendar year if the managed care plan or county-based purchasing plan
25.13 demonstrates to the satisfaction of the commissioner that a reduction in the subsequent
25.14 hospitalization rate was achieved. The commissioner shall structure the withhold so that
25.15 the commissioner returns a portion of the withheld funds in amounts commensurate with
25.16 achieved reductions in utilization less than the targeted amount.

25.17 The withhold described in this paragraph must continue for each consecutive
25.18 contract period until the plan's subsequent hospitalization rate for medical assistance and
25.19 MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization
25.20 rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this
25.21 performance target and shall accept payment withholds that must be returned to the
25.22 hospitals if the performance target is achieved.

25.23 (g) A managed care plan or a county-based purchasing plan under section 256B.692
25.24 may include as admitted assets under section 62D.044 any amount withheld under this
25.25 section that is reasonably expected to be returned.

25.26 Sec. 24. **NONEMERGENCY MEDICAL TRANSPORTATION SERVICES**
25.27 **REQUEST FOR INFORMATION.**

25.28 (a) The commissioner of human services shall issue a request for information
25.29 from vendors about potential solutions for the management of nonemergency medical
25.30 transportation (NEMT) services provided to recipients of Minnesota health care programs.
25.31 The request for information must require vendors to submit responses by November 1,
25.32 2012. The request for information shall seek information from vendors, including but not
25.33 limited to, the following aspects:

25.34 (1) administration of the NEMT program within a single administrative structure,
25.35 that may include a statewide or regionalized solution;

26.1 (2) oversight of transportation services;
26.2 (3) a process for assessing an individual's level of need;
26.3 (4) methods that promote the appropriate use of public transportation; and
26.4 (5) an electronic system that assists providers in managing services to clients and is
26.5 consistent with the recommendations in the 2011 evaluation report by the Office of the
26.6 Legislative Auditor on NEMT, related to the use of data to inform decision-making and
26.7 reduce waste and fraud.

26.8 (b) The commissioner shall provide the information obtained from the request for
26.9 information to the chairs and ranking minority members of the legislative committees with
26.10 jurisdiction over health and human services policy and financing by November 15, 2012.

26.11 Sec. 25. **PHYSICIAN ASSISTANTS AND OUTPATIENT MENTAL HEALTH.**

26.12 The commissioner of human services shall convene a group of interested
26.13 stakeholders to assist the commissioner in developing recommendations on how to
26.14 improve access to, and the quality of, outpatient mental health services for medical
26.15 assistance enrollees through the use of physician assistants. The commissioner shall report
26.16 these recommendations to the chairs and ranking minority members of the legislative
26.17 committees with jurisdiction over health care policy and financing by January 15, 2013.

26.18 Sec. 26. **HEALTH SERVICES ADVISORY COUNCIL.**

26.19 The Health Services Advisory Council shall review currently available literature
26.20 regarding the efficacy of various treatments for autism spectrum disorder, including
26.21 an evaluation of age-based variation in the appropriateness of existing medical and
26.22 behavioral interventions. The council shall recommend to the commissioner of human
26.23 services authorization criteria for services based on existing evidence. The council may
26.24 recommend coverage with ongoing collection of outcomes evidence in circumstances
26.25 where evidence is currently unavailable, or where the strength of the evidence is low. The
26.26 council shall make this recommendation by December 31, 2012.

26.27 Sec. 27. **REPORTING REQUIREMENTS.**

26.28 Subdivision 1. **Evidence-based childbirth program.** The commissioner of human
26.29 services may discontinue the evidence-based childbirth program and shall discontinue all
26.30 affiliated reporting requirements established under Minnesota Statutes, section 256B.0625,
26.31 subdivision 3g, once the commissioner determines that hospitals representing at least 90
26.32 percent of births covered by medical assistance or MinnesotaCare have approved policies
26.33 and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

27.1 Subd. 2. **Provider networks.** The commissioner of health, the commissioner of
 27.2 commerce, and the commissioner of human services shall merge reporting requirements
 27.3 for health maintenance organizations and county-based purchasing plans related to
 27.4 Minnesota Department of Health oversight of network adequacy under Minnesota
 27.5 Statutes, section 62D.124, and the provider network list reported to the Department of
 27.6 Human Services under Minnesota Rules, part 4685.2100. The commissioners shall work
 27.7 with health maintenance organizations and county-based purchasing plans to ensure that
 27.8 the report merger is done in a manner that simplifies health maintenance organization and
 27.9 county-based purchasing plan reporting processes.

27.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

27.11 Sec. 28. **EMERGENCY MEDICAL ASSISTANCE STUDY.**

27.12 (a) The commissioner of human services shall develop a plan to provide coordinated
 27.13 and cost-effective health care and coverage for individuals who meet eligibility standards
 27.14 for emergency medical assistance and who are ineligible for other state public programs.
 27.15 The commissioner shall consult with relevant stakeholders in the development of the plan.
 27.16 The commissioner shall consider the following elements:

27.17 (1) strategies to provide individuals with the most appropriate care in the appropriate
 27.18 setting, utilizing higher quality and lower cost providers;

27.19 (2) payment mechanisms to encourage providers to manage the care of these
 27.20 populations, and to produce lower cost of care and better patient outcomes;

27.21 (3) ensure coverage and payment options that address the unique needs of those
 27.22 needing episodic care, chronic care, and long-term care services;

27.23 (4) strategies for coordinating health care and nonhealth care services, and
 27.24 integrating with existing coverage; and

27.25 (5) other issues and strategies to ensure cost-effective and coordinated delivery
 27.26 of coverage and services.

27.27 (b) The commissioner shall submit the plan to the chairs and ranking minority
 27.28 members of the legislative committees with jurisdiction over health and human services
 27.29 policy and financing by January 15, 2013.

27.30 Sec. 29. **EMERGENCY MEDICAL CONDITION COVERAGE EXCEPTIONS.**

27.31 (a) Notwithstanding Minnesota Statutes, section 256B.06, subdivision 4, paragraph
 27.32 (h), clause (2), the following services are covered as emergency medical conditions under
 27.33 Minnesota Statutes, section 256B.06, subdivision 4, paragraph (f):

27.34 (1) dialysis services provided in a hospital or free-standing dialysis facility; and

28.1 (2) surgery and the administration of chemotherapy, radiation, and related services
28.2 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
28.3 and requires surgery, chemotherapy, or radiation treatment.

28.4 (b) Coverage under paragraph (a) is effective May 1, 2012, until June 30, 2013.

28.5 Sec. 30. **COST-SHARING REQUIREMENTS STUDY.**

28.6 The commissioner of human services, in consultation with managed care
28.7 plans, county-based purchasing plans, and other relevant stakeholders, shall develop
28.8 recommendations to implement a revised cost-sharing structure for state public health
28.9 care programs that ensures application of meaningful cost-sharing requirements within
28.10 the limits of title 42, Code of Federal Regulations, section 447.54, for enrollees in these
28.11 programs. The commissioner shall report to the chairs and ranking minority members of
28.12 the legislative committees with jurisdiction over these issues by January 15, 2013, with
28.13 draft legislation to implement these recommendations effective January 1, 2014.

28.14 Sec. 31. **STUDY OF MANAGED CARE.**

28.15 (a) The commissioner of human services must contract with an independent
28.16 vendor with demonstrated expertise in evaluating Medicaid managed care programs to
28.17 evaluate the value of managed care for state public health care programs provided under
28.18 Minnesota Statutes, sections 256B.69, 256B.692, and 256L.12. Determination of the
28.19 value of managed care must include consideration of the following, as compared to a
28.20 fee-for-service program:

28.21 (1) the satisfaction of state public health care program recipients and providers;

28.22 (2) the ability to measure and improve health outcomes of recipients;

28.23 (3) the access to health services for recipients;

28.24 (4) the availability of additional services such as care coordination, case
28.25 management, disease management, transportation, and after-hours nurse lines;

28.26 (5) actual and potential cost savings to the state;

28.27 (6) the level of alignment with state and federal health reform policies, including a
28.28 health benefit exchange for individuals not enrolled in state public health care programs;
28.29 and

28.30 (7) the ability to use different provider payment models that provide incentives for
28.31 cost-effective health care.

28.32 (b) The evaluation described in paragraph (a) must also consider the need to continue
28.33 the requirement for health maintenance organizations to participate in the medical
28.34 assistance and MinnesotaCare programs as a condition of licensure under Minnesota

29.1 Statutes, section 62D.04, subdivision 5, and under Minnesota Statutes, section 256B.0644,
29.2 in terms of continued stability and access to services for enrollees of these programs.

29.3 (c) A preliminary report of the evaluation must be submitted to the chairs and
29.4 ranking minority members of the health and human services legislative committees by
29.5 February 15, 2013, and the final report must be submitted by July 1, 2013.

29.6 Sec. 32. **REPEALER.**

29.7 Subdivision 1. **Summary of complaints and grievances.** (a) Minnesota Rules, part
29.8 4685.2000, is repealed effective the day following final enactment.

29.9 Subd. 2. **Medical necessity denials and appeals.** Minnesota Statutes 2010, section
29.10 62M.09, subdivision 9, is repealed effective the day following final enactment.

29.11 Subd. 3. **Salary reports.** Minnesota Statutes 2010, section 62Q.64, is repealed
29.12 effective the day following final enactment.

29.13 **ARTICLE 2**

29.14 **DEPARTMENT OF HEALTH**

29.15 Section 1. Minnesota Statutes 2010, section 62Q.80, is amended to read:

29.16 **62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.**

29.17 Subdivision 1. **Scope.** (a) Any community-based health care initiative may develop
29.18 and operate community-based health care coverage programs that offer to eligible
29.19 individuals and their dependents the option of purchasing through their employer health
29.20 care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A,
29.21 62A, 62C, 62D, 62M, 62N, 62Q, 62T, or 62U, or any other law or rule that applies to
29.22 entities licensed under these chapters.

29.23 (b) Each initiative shall establish health outcomes to be achieved through the
29.24 programs and performance measurements in order to determine whether these outcomes
29.25 have been met. The outcomes must include, but are not limited to:

29.26 (1) a reduction in uncompensated care provided by providers participating in the
29.27 community-based health network;

29.28 (2) an increase in the delivery of preventive health care services; and

29.29 (3) health improvement for enrollees with chronic health conditions through the
29.30 management of these conditions.

29.31 In establishing performance measurements, the initiative shall use measures that are
29.32 consistent with measures published by nonprofit Minnesota or national organizations that
29.33 produce and disseminate health care quality measures.

30.1 (c) Any program established under this section shall not constitute a financial
30.2 liability for the state, in that any financial risk involved in the operation or termination
30.3 of the program shall be borne by the community-based initiative and the participating
30.4 health care providers.

30.5 ~~Subd. 1a. **Demonstration project.** The commissioner of health and the~~
30.6 ~~commissioner of human services shall award demonstration project grants to~~
30.7 ~~community-based health care initiatives to develop and operate community-based health~~
30.8 ~~care coverage programs in Minnesota. The demonstration projects shall extend for five~~
30.9 ~~years and must comply with the requirements of this section.~~

30.10 Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

30.11 (a) "Community-based" means located in or primarily relating to the community,
30.12 as determined by the board of a community-based health initiative that is served by the
30.13 community-based health care coverage program.

30.14 (b) "Community-based health care coverage program" or "program" means a
30.15 program administered by a community-based health initiative that provides health care
30.16 services through provider members of a community-based health network or combination
30.17 of networks to eligible individuals and their dependents who are enrolled in the program.

30.18 (c) "Community-based health initiative" or "initiative" means a nonprofit corporation
30.19 that is governed by a board that has at least 80 percent of its members residing in the
30.20 community and includes representatives of the participating network providers and
30.21 employers, or a county-based purchasing organization as defined in section 256B.692.

30.22 (d) "Community-based health network" means a contract-based network of health
30.23 care providers organized by the community-based health initiative to provide or support
30.24 the delivery of health care services to enrollees of the community-based health care
30.25 coverage program on a risk-sharing or nonrisk-sharing basis.

30.26 (e) "Dependent" means an eligible employee's spouse or unmarried child who is
30.27 under the age of 19 years.

30.28 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health
30.29 care coverage program, a community-based health initiative, defined in subdivision
30.30 2, paragraph (c), ~~and receiving funds from the Department of Health,~~ shall submit to
30.31 the commissioner of health for approval the community-based health care coverage
30.32 program developed by the initiative. ~~Each community-based health initiative as defined~~
30.33 ~~in subdivision 2, paragraph (c), and receiving State Health Access Program (SHAP)~~
30.34 ~~grant funding shall submit to the commissioner of human services for approval prior~~
30.35 ~~to its operation the community-based health care coverage programs developed by the~~
30.36 ~~initiatives.~~ The ~~commissioners~~ commissioner shall ensure that each program meets

31.1 ~~the federal grant requirements and any~~ requirements described in this section and is
31.2 actuarially sound based on a review of appropriate records and methods utilized by the
31.3 community-based health initiative in establishing premium rates for the community-based
31.4 health care coverage programs.

31.5 (b) Prior to approval, the commissioner shall also ensure that:

31.6 (1) the benefits offered comply with subdivision 8 and that there are adequate
31.7 numbers of health care providers participating in the community-based health network to
31.8 deliver the benefits offered under the program;

31.9 (2) the activities of the program are limited to activities that are exempt under this
31.10 section or otherwise from regulation by the commissioner of commerce;

31.11 (3) the complaint resolution process meets the requirements of subdivision 10; and

31.12 (4) the data privacy policies and procedures comply with state and federal law.

31.13 Subd. 4. **Establishment.** The initiative shall establish and operate upon approval
31.14 by the ~~commissioners~~ commissioner of health and ~~human services~~ community-based
31.15 health care coverage programs. The operational structure established by the initiative
31.16 shall include, but is not limited to:

31.17 (1) establishing a process for enrolling eligible individuals and their dependents;

31.18 (2) collecting and coordinating premiums from enrollees and employers of enrollees;

31.19 (3) providing payment to participating providers;

31.20 (4) establishing a benefit set according to subdivision 8 and establishing premium
31.21 rates and cost-sharing requirements;

31.22 (5) creating incentives to encourage primary care and wellness services; and

31.23 (6) initiating disease management services, as appropriate.

31.24 Subd. 5. **Qualifying employees.** To be eligible for the community-based health
31.25 care coverage program, an individual must:

31.26 (1) reside in or work within the designated community-based geographic area
31.27 served by the program;

31.28 (2) be employed by a qualifying employer, be an employee's dependent, or be
31.29 self-employed on a full-time basis;

31.30 (3) not be enrolled in or have currently available health coverage, except for
31.31 catastrophic health care coverage; and

31.32 (4) not be eligible for or enrolled in medical assistance or general assistance medical
31.33 care, and not be enrolled in MinnesotaCare or Medicare.

31.34 Subd. 6. **Qualifying employers.** (a) To qualify for participation in the
31.35 community-based health care coverage program, an employer must:

32.1 (1) employ at least one but no more than 50 employees at the time of initial
32.2 enrollment in the program;

32.3 (2) pay its employees a median wage that equals 350 percent of the federal poverty
32.4 guidelines or less for an individual; and

32.5 (3) not have offered employer-subsidized health coverage to its employees for
32.6 at least 12 months prior to the initial enrollment in the program. For purposes of this
32.7 section, "employer-subsidized health coverage" means health care coverage for which the
32.8 employer pays at least 50 percent of the cost of coverage for the employee.

32.9 (b) To participate in the program, a qualifying employer agrees to:

32.10 (1) offer health care coverage through the program to all eligible employees and
32.11 their dependents regardless of health status;

32.12 (2) participate in the program for an initial term of at least one year;

32.13 (3) pay a percentage of the premium established by the initiative for the employee;
32.14 and

32.15 (4) provide the initiative with any employee information deemed necessary by the
32.16 initiative to determine eligibility and premium payments.

32.17 Subd. 7. **Participating providers.** Any health care provider participating in the
32.18 community-based health network must accept as payment in full the payment rate
32.19 established by the initiatives and may not charge to or collect from an enrollee any amount
32.20 in excess of this amount for any service covered under the program.

32.21 Subd. 8. **Coverage.** (a) The initiatives shall establish the health care benefits offered
32.22 through the community-based health care coverage programs. The benefits established
32.23 shall include, at a minimum:

32.24 (1) child health supervision services up to age 18, as defined under section 62A.047;
32.25 and

32.26 (2) preventive services, including:

32.27 (i) health education and wellness services;

32.28 (ii) health supervision, evaluation, and follow-up;

32.29 (iii) immunizations; and

32.30 (iv) early disease detection.

32.31 (b) Coverage of health care services offered by the program may be limited to
32.32 participating health care providers or health networks. All services covered under the
32.33 programs must be services that are offered within the scope of practice of the participating
32.34 health care providers.

33.1 (c) The initiatives may establish cost-sharing requirements. Any co-payment or
33.2 deductible provisions established may not discriminate on the basis of age, sex, race,
33.3 disability, economic status, or length of enrollment in the programs.

33.4 (d) If any of the initiatives amends or alters the benefits offered through the program
33.5 from the initial offering, that initiative must notify the ~~commissioners~~ commissioner of
33.6 health ~~and human services~~ and all enrollees of the benefit change.

33.7 Subd. 9. **Enrollee information.** (a) The initiatives must provide an individual or
33.8 family who enrolls in the program a clear and concise written statement that includes
33.9 the following information:

33.10 (1) health care services that are covered under the program;

33.11 (2) any exclusions or limitations on the health care services covered, including any
33.12 cost-sharing arrangements or prior authorization requirements;

33.13 (3) a list of where the health care services can be obtained and that all health
33.14 care services must be provided by or through a participating health care provider or
33.15 community-based health network;

33.16 (4) a description of the program's complaint resolution process, including how to
33.17 submit a complaint; how to file a complaint with the commissioner of health; and how to
33.18 obtain an external review of any adverse decisions as provided under subdivision 10;

33.19 (5) the conditions under which the program or coverage under the program may
33.20 be canceled or terminated; and

33.21 (6) a precise statement specifying that this program is not an insurance product and,
33.22 as such, is exempt from state regulation of insurance products.

33.23 (b) The ~~commissioners~~ commissioner of health ~~and human services~~ must approve a
33.24 copy of the written statement prior to the operation of the program.

33.25 Subd. 10. **Complaint resolution process.** (a) The initiatives must establish
33.26 a complaint resolution process. The process must make reasonable efforts to resolve
33.27 complaints and to inform complainants in writing of the initiative's decision within 60
33.28 days of receiving the complaint. Any decision that is adverse to the enrollee shall include
33.29 a description of the right to an external review as provided in paragraph (c) and how to
33.30 exercise this right.

33.31 (b) The initiatives must report any complaint that is not resolved within 60 days to
33.32 the commissioner of health.

33.33 (c) The initiatives must include in the complaint resolution process the ability of an
33.34 enrollee to pursue the external review process provided under section 62Q.73 with any
33.35 decision rendered under this external review process binding on the initiatives.

34.1 Subd. 11. **Data privacy.** The initiatives shall establish data privacy policies and
 34.2 procedures for the program that comply with state and federal data privacy laws.

34.3 Subd. 12. **Limitations on enrollment.** (a) The initiatives may limit enrollment in
 34.4 the program. If enrollment is limited, a waiting list must be established.

34.5 (b) The initiatives shall not restrict or deny enrollment in the program except for
 34.6 nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under
 34.7 this section.

34.8 (c) The initiatives may require a certain percentage of participation from eligible
 34.9 employees of a qualifying employer before coverage can be offered through the program.

34.10 Subd. 13. **Report.** Each initiative shall submit ~~quarterly~~ an annual status ~~reports~~
 34.11 report to the commissioner of health on January 15, ~~April 15, July 15, and October 15~~ of
 34.12 each year, with the first report due January 15, 2008. ~~Each initiative receiving funding~~
 34.13 ~~from the Department of Human Services shall submit status reports to the commissioner~~
 34.14 ~~of human services as defined in the terms of the contract with the Department of Human~~
 34.15 ~~Services.~~ Each status report shall include:

34.16 (1) the financial status of the program, including the premium rates, cost per member
 34.17 per month, claims paid out, premiums received, and administrative expenses;

34.18 (2) a description of the health care benefits offered and the services utilized;

34.19 (3) the number of employers participating, the number of employees and dependents
 34.20 covered under the program, and the number of health care providers participating;

34.21 (4) a description of the health outcomes to be achieved by the program and a status
 34.22 report on the performance measurements to be used and collected; and

34.23 (5) any other information requested by the ~~commissioners~~ commissioner of health,
 34.24 ~~human services~~, or commerce or the legislature.

34.25 ~~Subd. 14. **Sunset.** This section expires August 31, 2014.~~

34.26 Sec. 2. Minnesota Statutes 2011 Supplement, section 144.1222, subdivision 5, is
 34.27 amended to read:

34.28 Subd. 5. ~~Swimming pond exemption~~ **Exemptions.** (a) A public swimming pond
 34.29 in existence before January 1, 2008, is not a public pool for purposes of this section and
 34.30 section 157.16, and is exempt from the requirements for public swimming pools under
 34.31 Minnesota Rules, chapter 4717.

34.32 (b) A naturally treated swimming pool located in the city of Minneapolis is not
 34.33 a public pool for purposes of this section and section 157.16, and is exempt from the
 34.34 requirements for public swimming pools under Minnesota Rules, chapter 4717.

35.1 ~~(b)~~ (c) Notwithstanding ~~paragraph~~ paragraphs (a) and (b), a public swimming pond
 35.2 and a naturally treated swimming pool must meet the requirements for public pools
 35.3 described in subdivisions 1c and 1d.

35.4 ~~(e)~~ (d) For purposes of this subdivision, a "public swimming pond" means an
 35.5 artificial body of water contained within a lined, sand-bottom basin, intended for public
 35.6 swimming, relaxation, or recreational use that includes a water circulation system for
 35.7 maintaining water quality and does not include any portion of a naturally occurring lake
 35.8 or stream.

35.9 (e) For purposes of this subdivision, a "naturally treated swimming pool" means an
 35.10 artificial body of water contained in a basin, intended for public swimming, relaxation, or
 35.11 recreational use that uses a chemical free filtration system for maintaining water quality
 35.12 through natural processes, including the use of plants, beneficial bacteria, and microbes.

35.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

35.14 Sec. 3. **[144.1225] ADVANCED DIAGNOSTIC IMAGING SERVICES.**

35.15 Subdivision 1. Definition. For purposes of this section, "advanced diagnostic
 35.16 imaging services" has the meaning given in United States Code, title 42, section 1395M,
 35.17 except that it does not include x-ray, ultrasound, or fluoroscopy.

35.18 Subd. 2. Accreditation required. (a)(1) Except as otherwise provided in paragraph
 35.19 (b), advanced diagnostic imaging services eligible for reimbursement from any source,
 35.20 including, but not limited to, the individual receiving such services and any individual
 35.21 or group insurance contract, plan, or policy delivered in this state, including, but not
 35.22 limited to, private health insurance plans, workers' compensation insurance, motor vehicle
 35.23 insurance, the State Employee Group Insurance Program (SEGIP), and other state health
 35.24 care programs, shall be reimbursed only if the facility at which the service has been
 35.25 conducted and processed is accredited by one of the following entities:

35.26 (i) American College of Radiology (ACR);

35.27 (ii) Intersocietal Accreditation Commission (IAC);

35.28 (iii) the Joint Commission; or

35.29 (iv) other relevant accreditation organization designated by the secretary of the
 35.30 United States Department of Health and Human Services pursuant to United States Code,
 35.31 title 42, section 1395M.

35.32 (2) All accreditation standards recognized under this section must include, but are
 35.33 not limited to:

35.34 (i) provisions establishing qualifications of the physician;

36.1 (ii) standards for quality control and routine performance monitoring by a medical
36.2 physicist;

36.3 (iii) qualifications of the technologist, including minimum standards of supervised
36.4 clinical experience;

36.5 (iv) guidelines for personnel and patient safety; and

36.6 (v) standards for initial and ongoing quality control using clinical image review
36.7 and quantitative testing.

36.8 (b) Any facility that performs advanced diagnostic imaging services and is eligible
36.9 to receive reimbursement for such services from any source in paragraph (a)(1) must
36.10 obtain accreditation by August 1, 2013. Thereafter, all facilities that provide advanced
36.11 diagnostic imaging services in the state must obtain accreditation prior to commencing
36.12 operations and must, at all times, maintain accreditation with an accrediting organization
36.13 as provided in paragraph (a).

36.14 Subd. 3. **Reporting.** (a) Advanced diagnostic imaging facilities and providers
36.15 of advanced diagnostic imaging services must annually report to the commissioner
36.16 demonstration of accreditation as required under this section.

36.17 (b) The commissioner may promulgate any rules necessary to administer the
36.18 reporting required under paragraph (a).

36.19 Sec. 4. Minnesota Statutes 2010, section 144.292, subdivision 6, is amended to read:

36.20 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for
36.21 purposes of reviewing current medical care, the provider must not charge a fee.

36.22 (b) When a provider or its representative makes copies of patient records upon a
36.23 patient's request under this section, the provider or its representative may charge the
36.24 patient or the patient's representative no more than 75 cents per page, plus \$10 for time
36.25 spent retrieving and copying the records, unless other law or a rule or contract provide for
36.26 a lower maximum charge. This limitation does not apply to x-rays. The provider may
36.27 charge a patient no more than the actual cost of reproducing x-rays, plus no more than
36.28 \$10 for the time spent retrieving and copying the x-rays.

36.29 (c) The respective maximum charges of 75 cents per page and \$10 for time provided
36.30 in this subdivision are in effect for calendar year 1992 and may be adjusted annually each
36.31 calendar year as provided in this subdivision. The permissible maximum charges shall
36.32 change each year by an amount that reflects the change, as compared to the previous year,
36.33 in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U),
36.34 published by the Department of Labor.

37.1 (d) A provider or its representative may charge the \$10 retrieval fee, but must not
37.2 charge a per page fee to provide copies of records requested by a patient or the patient's
37.3 authorized representative if the request for copies of records is for purposes of appealing
37.4 a denial of Social Security disability income or Social Security disability benefits under
37.5 title II or title XVI of the Social Security Act; except that no fee shall be charged to a
37.6 person who is receiving public assistance, who is represented by an attorney on behalf of
37.7 a civil legal services program or a volunteer attorney program based on indigency. For
37.8 the purpose of further appeals, a patient may receive no more than two medical record
37.9 updates without charge, but only for medical record information previously not provided.
37.10 For purposes of this paragraph, a patient's authorized representative does not include units
37.11 of state government engaged in the adjudication of Social Security disability claims.

37.12 Sec. 5. Minnesota Statutes 2010, section 144.298, subdivision 2, is amended to read:

37.13 Subd. 2. **Liability of provider or other person.** A person who does any of the
37.14 following is liable to the patient for compensatory damages caused by an unauthorized
37.15 release or an intentional, unauthorized access, plus costs and reasonable attorney fees:

37.16 (1) negligently or intentionally requests or releases a health record in violation
37.17 of sections 144.291 to 144.297;

37.18 (2) forges a signature on a consent form or materially alters the consent form of
37.19 another person without the person's consent; ~~or~~

37.20 (3) obtains a consent form or the health records of another person under false
37.21 pretenses; or

37.22 (4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a
37.23 record locator service without authorization.

37.24 Sec. 6. Minnesota Statutes 2010, section 144.5509, is amended to read:

37.25 **144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.**

37.26 (a) A radiation therapy facility may be constructed only by an entity owned,
37.27 operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either
37.28 alone or in cooperation with another entity.

37.29 (b) Notwithstanding paragraph (a), there shall be a moratorium on the construction
37.30 of any radiation therapy facility located in the following counties: Hennepin, Ramsey,
37.31 Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns,
37.32 Chisago, Isanti, and Wright. This paragraph does not apply to the relocation or
37.33 reconstruction of an existing facility owned by a hospital if the relocation or reconstruction
37.34 is within one mile of the existing facility. This paragraph does not apply to a radiation

38.1 therapy facility that is being built attached to a community hospital in Wright County and
38.2 meets the following conditions prior to August 1, 2007: the capital expenditure report
38.3 required under Minnesota Statutes, section 62J.17, has been filed with the commissioner
38.4 of health; a timely construction schedule is developed, stipulating dates for beginning,
38.5 achieving various stages, and completing construction; and all zoning and building permits
38.6 applied for. Beginning January 1, 2013, this paragraph does not apply to any construction
38.7 necessary to relocate a radiation therapy machine from a community hospital-owned
38.8 radiation therapy facility located in the city of Maplewood to a community hospital
38.9 campus in the city of Woodbury within the same health system. This paragraph expires
38.10 August 1, 2014.

38.11 (c) Notwithstanding paragraph (a), after August 1, 2014, the construction of a
38.12 radiation therapy facility located in any of the following counties: Hennepin, Ramsey,
38.13 Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns,
38.14 Chisago, Isanti, and Wright, may occur only if the following requirements are met:

38.15 (1) the entity constructing the radiation therapy facility is controlled by or is under
38.16 common control with a hospital licensed under sections 144.50 to 144.56; and

38.17 (2) the new radiation therapy facility is located at least seven miles from an existing
38.18 radiation therapy facility.

38.19 (d) Any referring physician located within a county identified in paragraph (c) must
38.20 provide each patient who is in need of radiation therapy services with a list of all radiation
38.21 therapy facilities located within the counties identified in paragraph (c). Physicians
38.22 with a financial interest in any radiation therapy facility must disclose to the patient the
38.23 existence of the interest.

38.24 (e) For purposes of this section, "controlled by" or "under common control with"
38.25 means the possession, direct or indirect, of the power to direct or cause the direction of the
38.26 policies, operations, or activities of an entity, through the ownership of, or right to vote
38.27 or to direct the disposition of shares, membership interests, or ownership interests of
38.28 the entity.

38.29 (f) For purposes of this section, "financial interest in any radiation therapy facility"
38.30 means a direct or indirect ownership or investment interest in a radiation therapy facility
38.31 or a compensation arrangement with a radiation therapy facility.

38.32 (g) This section does not apply to the relocation or reconstruction of an existing
38.33 radiation therapy facility if:

38.34 (1) the relocation or reconstruction of the facility remains owned by the same entity;

38.35 (2) the relocation or reconstruction is located within one mile of the existing facility;

38.36 and

39.1 (3) the period in which the existing facility is closed and the relocated or
39.2 reconstructed facility begins providing services does not exceed 12 months.

39.3 **Sec. 7. [145.8811] MATERNAL AND CHILD HEALTH ADVISORY TASK**
39.4 **FORCE.**

39.5 Subdivision 1. **Composition of task force.** The commissioner shall establish and
39.6 appoint a Maternal and Child Health Advisory Task Force consisting of 15 members
39.7 who will provide equal representation from:

39.8 (1) professionals with expertise in maternal and child health services;

39.9 (2) representatives of community health boards as defined in section 145A.02,
39.10 subdivision 5; and

39.11 (3) consumer representatives interested in the health of mothers and children.

39.12 No members shall be employees of the Minnesota Department of Health. Section
39.13 15.059 governs the Maternal and Child Health Advisory Task Force. Notwithstanding
39.14 section 15.059, the Maternal and Child Health Advisory Task Force expires June 30, 2015.

39.15 Subd. 2. **Duties.** The advisory task force shall meet on a regular basis to perform
39.16 the following duties:

39.17 (1) review and report on the health care needs of mothers and children throughout
39.18 the state of Minnesota;

39.19 (2) review and report on the type, frequency, and impact of maternal and child health
39.20 care services provided to mothers and children under existing maternal and child health
39.21 care programs, including programs administered by the commissioner of health;

39.22 (3) establish, review, and report to the commissioner a list of program guidelines
39.23 and criteria which the advisory task force considers essential to providing an effective
39.24 maternal and child health care program to low-income populations and high-risk persons
39.25 and fulfilling the purposes defined in section 145.88;

39.26 (4) make recommendations to the commissioner for the use of other federal and state
39.27 funds available to meet maternal and child health needs;

39.28 (5) make recommendations to the commissioner of health on priorities for funding
39.29 the following maternal and child health services:

39.30 (i) prenatal, delivery, and postpartum care;

39.31 (ii) comprehensive health care for children, especially from birth through five
39.32 years of age;

39.33 (iii) adolescent health services;

39.34 (iv) family planning services;

39.35 (v) preventive dental care;

40.1 (vi) special services for chronically ill and disabled children; and
 40.2 (vii) any other services that promote the health of mothers and children; and
 40.3 (6) establish, in consultation with the commissioner and the State Community Health
 40.4 Advisory Committee established under section 145A.10, subdivision 10, paragraph (a),
 40.5 statewide outcomes that will improve the health status of mothers and children as required
 40.6 in section 145A.12, subdivision 7.

40.7 Sec. 8. Minnesota Statutes 2010, section 145.906, is amended to read:

40.8 **145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

40.9 (a) The commissioner of health shall work with health care facilities, licensed health
 40.10 and mental health care professionals, the women, infants, and children (WIC) program,
 40.11 mental health advocates, consumers, and families in the state to develop materials and
 40.12 information about postpartum depression, including treatment resources, and develop
 40.13 policies and procedures to comply with this section.

40.14 (b) Physicians, traditional midwives, and other licensed health care professionals
 40.15 providing prenatal care to women must have available to women and their families
 40.16 information about postpartum depression.

40.17 (c) Hospitals and other health care facilities in the state must provide departing new
 40.18 mothers and fathers and other family members, as appropriate, with written information
 40.19 about postpartum depression, including its symptoms, methods of coping with the illness,
 40.20 and treatment resources.

40.21 (d) Information about postpartum depression, including its symptoms, potential
 40.22 impact on families, and treatment resources, must be available at WIC sites.

40.23 Sec. 9. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY**
 40.24 **RESPONSIBILITIES.**

40.25 Relating to the evaluations and legislative report completed pursuant to Laws
 40.26 2011, First Special Session chapter 9, article 2, section 26, the following activities must
 40.27 be completed:

40.28 (1) the commissioners of health and human services must update, revise, and
 40.29 link the contents of their Web sites related to supervised living facilities, intermediate
 40.30 care facilities for the developmentally disabled, nursing facilities, board and lodging
 40.31 establishments, and human services licensed programs so that consumers and providers
 40.32 can access consistent clear information about the regulations affecting these facilities; and

40.33 (2) the commissioner of management and budget, in consultation with the
 40.34 commissioners of health and human services, must evaluate and recommend options

41.1 for administering health and human services regulations. The evaluation and
41.2 recommendations must be submitted in a report to the chairs and ranking minority
41.3 members of the health and human services legislative committees no later than August 1,
41.4 2013, and shall at a minimum: (i) identify and evaluate the regulatory responsibilities of
41.5 the Departments of Health and Human Services to determine whether to reorganize these
41.6 regulatory responsibilities to improve how the state administers health and human services
41.7 regulatory functions, or whether there are ways to improve these regulatory activities
41.8 without reorganizing; (ii) describe and evaluate the multiple roles of the Department of
41.9 Human Services as a direct provider of care services, a regulator, and a payor for state
41.10 program services; and (iii) for long-term care regulated in both departments, evaluate and
41.11 make recommendations for reasonable client risk assessments, planning for client risk
41.12 reductions, and determining reasonable assumptions of client risks in relation to directing
41.13 health care, client health care rights, provider liabilities, and provider responsibilities to
41.14 provide minimum standards of care.

41.15 Sec. 10. **HEALTH RECORD ACCESS STUDY.**

41.16 The commissioner of health, in consultation with the Minnesota e-Health Advisory
41.17 Committee, shall study the following:

41.18 (1) the extent to which providers have audit procedures in place to monitor use of
41.19 representation of consent and unauthorized access to a patient's health records in violation
41.20 of Minnesota Statutes, sections 144.291 to 144.297;

41.21 (2) the feasibility of informing patients if an intentional, unauthorized access of
41.22 their health records occurs; and

41.23 (3) the feasibility of providing patients with a copy of a provider's audit log showing
41.24 who has accessed their health records.

41.25 The commissioner shall report study findings and any relevant patient privacy and
41.26 other recommendations to the legislature by February 15, 2013.

41.27 Sec. 11. **REPORTING PREVALENCE OF SEXUAL VIOLENCE.**

41.28 The commissioner of health must routinely report to the public and to the legislature
41.29 data on the prevalence and incidence of sexual violence in Minnesota, to the extent
41.30 federal funding is available for this purpose. The commissioner must use existing data
41.31 provided by the Centers for Disease Control and Prevention, or other source as identified
41.32 by commissioner.

41.33 **EFFECTIVE DATE.** This section is effective the day following final enactment.

42.1 Sec. 12. **LICENSED HOME CARE PROVIDERS.**

42.2 By February 1, 2013, the commissioner of health must report recommendations to
42.3 the legislature as to development of a comprehensive home care plan to increase inspection
42.4 and oversight of licensed home care providers under Minnesota Statutes, chapter 144A.

42.5 Sec. 13. **EVALUATION OF HEALTH AND COMMERCE REGULATORY**
42.6 **RESPONSIBILITIES.**

42.7 The commissioner of health, in consultation with the commissioner of commerce,
42.8 shall report to the legislature by February 15, 2013, on recommendations to maximize
42.9 administrative efficiency in the regulation of health maintenance organizations,
42.10 county-based purchasers, insurance carriers, and related entities while maintaining quality
42.11 health outcomes, regulatory stability, and price stability.

42.12 Sec. 14. **STUDY OF RADIATION THERAPY FACILITIES CAPACITY.**

42.13 (a) To the extent of available appropriations, the commissioner of health shall
42.14 conduct a study of the following: (1) current treatment capacity of the existing radiation
42.15 therapy facilities within the state; (2) the present need for radiation therapy services based
42.16 on population demographics and new cancer cases; and (3) the projected need in the next
42.17 ten years for radiation therapy services and whether the current facilities can sustain
42.18 this projected need.

42.19 (b) The commissioner may contract with a qualified entity to conduct the study. The
42.20 study shall be completed by March 15, 2013, and the results shall be submitted to the
42.21 chairs and ranking minority members of the health and human services committees of
42.22 the legislature.

42.23 Sec. 15. **MERC DISTRIBUTION.**

42.24 (a) For the distribution of funds for fiscal year 2013, as required under Minnesota
42.25 Statutes, section 62J.692, subdivision 4, the commissioner of health shall distribute
42.26 \$300,000 to Gillette Children's Specialty Healthcare before following the distribution
42.27 described under Minnesota Statutes, section 62J.692, subdivision 4, paragraph (a).

42.28 (b) This section is effective upon federal approval.

42.29 **ARTICLE 3**

42.30 **CHILDREN AND FAMILY SERVICES**

42.31 Section 1. Minnesota Statutes 2011 Supplement, section 119B.13, subdivision 7, is
42.32 amended to read:

43.1 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
43.2 must not be reimbursed for more than ten full-day absent days per child, excluding
43.3 holidays, in a fiscal year. Legal nonlicensed family child care providers must not be
43.4 reimbursed for absent days. If a child attends for part of the time authorized to be in care in
43.5 a day, but is absent for part of the time authorized to be in care in that same day, the absent
43.6 time must be reimbursed but the time must not count toward the ten absent day limit.
43.7 Child care providers must only be reimbursed for absent days if the provider has a written
43.8 policy for child absences and charges all other families in care for similar absences.

43.9 (b) Notwithstanding paragraph (a), children in families may exceed the ten absent
43.10 days limit if at least one parent is: (1) under the age of 21; (2) does not have a high school
43.11 or general equivalency diploma; and (3) is a student in a school district or another similar
43.12 program that provides or arranges for child care, parenting support, social services, career
43.13 and employment supports, and academic support to achieve high school graduation, upon
43.14 request of the program and approval of the county. If a child attends part of an authorized
43.15 day, payment to the provider must be for the full amount of care authorized for that day.

43.16 ~~(b)~~ (c) Child care providers must be reimbursed for up to ten federal or state
43.17 holidays or designated holidays per year when the provider charges all families for these
43.18 days and the holiday or designated holiday falls on a day when the child is authorized to
43.19 be in attendance. Parents may substitute other cultural or religious holidays for the ten
43.20 recognized state and federal holidays. Holidays do not count toward the ten absent day
43.21 limit.

43.22 ~~(c)~~ (d) A family or child care provider must not be assessed an overpayment for an
43.23 absent day payment unless (1) there was an error in the amount of care authorized for the
43.24 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
43.25 the family or provider did not timely report a change as required under law.

43.26 ~~(d)~~ (e) The provider and family shall receive notification of the number of absent
43.27 days used upon initial provider authorization for a family and ongoing notification of the
43.28 number of absent days used as of the date of the notification.

43.29 **EFFECTIVE DATE.** This section is effective January 1, 2013.

43.30 Sec. 2. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
43.31 to read:

43.32 **Subd. 18c. Drug convictions.** (a) The state court administrator shall provide a
43.33 report every six months by electronic means to the commissioner of human services,
43.34 including the name, address, date of birth, and, if available, driver's license or state
43.35 identification card number, date of sentence, effective date of the sentence, and county in

44.1 which the conviction occurred of each person convicted of a felony under chapter 152
44.2 during the previous six months.

44.3 (b) The commissioner shall determine whether the individuals who are the subject of
44.4 the data reported under paragraph (a) are receiving public assistance under chapter 256D
44.5 or 256J, and if the individual is receiving assistance under chapter 256D or 256J, the
44.6 commissioner shall instruct the county to proceed under section 256D.024 or 256J.26,
44.7 whichever is applicable, for this individual.

44.8 (c) The commissioner shall not retain any data received under paragraph (a) or (d)
44.9 that does not relate to an individual receiving publicly funded assistance under chapter
44.10 256D or 256J.

44.11 (d) In addition to the routine data transfer under paragraph (a), the state court
44.12 administrator shall provide a onetime report of the data fields under paragraph (a) for
44.13 individuals with a felony drug conviction under chapter 152 dated from July 1, 1997, until
44.14 the date of the data transfer. The commissioner shall perform the tasks identified under
44.15 paragraph (b) related to this data and shall retain the data according to paragraph (c).

44.16 **EFFECTIVE DATE.** This section is effective July 1, 2013.

44.17 Sec. 3. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
44.18 to read:

44.19 Subd. 18d. **Data sharing with the Department of Human Services; multiple**
44.20 **identification cards.** (a) The commissioner of public safety shall, on a monthly basis,
44.21 provide the commissioner of human services with the first, middle, and last name,
44.22 the address, date of birth, and driver's license or state identification card number of all
44.23 applicants and holders whose drivers' licenses and state identification cards have been
44.24 canceled under section 171.14, paragraph (a), clauses (2) or (3), by the commissioner of
44.25 public safety. After the initial data report has been provided by the commissioner of
44.26 public safety to the commissioner of human services under this paragraph, subsequent
44.27 reports shall only include cancellations that occurred after the end date of the cancellations
44.28 represented in the previous data report.

44.29 (b) The commissioner of human services shall compare the information provided
44.30 under paragraph (a) with the commissioner's data regarding recipients of all public
44.31 assistance programs managed by the Department of Human Services to determine whether
44.32 any individual with multiple identification cards issued by the Department of Public
44.33 Safety has illegally or improperly enrolled in any public assistance program managed by
44.34 the Department of Human Services.

45.1 (c) If the commissioner of human services determines that an applicant or recipient
45.2 has illegally or improperly enrolled in any public assistance program, the commissioner
45.3 shall provide all due process protections to the individual before terminating the individual
45.4 from the program according to applicable statute and notifying the county attorney.

45.5 **EFFECTIVE DATE.** This section is effective July 1, 2013.

45.6 Sec. 4. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
45.7 to read:

45.8 Subd. 18e. **Data sharing with the Department of Human Services; legal**
45.9 **presence date.** (a) The commissioner of public safety shall, on a monthly basis, provide
45.10 the commissioner of human services with the first, middle, and last name, address, date of
45.11 birth, and driver's license or state identification number of all applicants and holders of
45.12 drivers' licenses and state identification cards whose temporary legal presence date has
45.13 expired and as a result the driver's license or identification card has been accordingly
45.14 canceled under section 171.14 by the commissioner of public safety.

45.15 (b) The commissioner of human services shall use the information provided under
45.16 paragraph (a) to determine whether the eligibility of any recipients of public assistance
45.17 programs managed by the Department of Human Services has changed as a result of the
45.18 status change in the Department of Public Safety data.

45.19 (c) If the commissioner of human services determines that a recipient has illegally or
45.20 improperly received benefits from any public assistance program, the commissioner shall
45.21 provide all due process protections to the individual before terminating the individual from
45.22 the program according to applicable statute and notifying the county attorney.

45.23 **EFFECTIVE DATE.** This section is effective July 1, 2013.

45.24 Sec. 5. Minnesota Statutes 2010, section 256.9831, subdivision 2, is amended to read:

45.25 Subd. 2. **Financial transaction cards.** The commissioner shall take all actions
45.26 necessary to ensure that no person may obtain benefits under chapter 256 ~~or~~ 256D, or 256J
45.27 through the use of a financial transaction card, as defined in section 609.821, subdivision
45.28 1, paragraph (a), at a terminal located in or attached to a gambling establishment, liquor
45.29 store, tobacco store, or tattoo parlor.

45.30 Sec. 6. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 1, is
45.31 amended to read:

46.1 Subdivision 1. **Electronic benefit transfer (EBT) card.** Cash benefits for the
 46.2 general assistance and Minnesota supplemental aid programs under chapter 256D and
 46.3 programs under chapter 256J must be issued on ~~a separate~~ an EBT card with the name of
 46.4 the head of household printed on the card. The card must include the following statement:
 46.5 "It is unlawful to use this card to purchase tobacco products or alcoholic beverages." This
 46.6 card must be issued within 30 calendar days of an eligibility determination. During the
 46.7 initial 30 calendar days of eligibility, a recipient may have cash benefits issued on an EBT
 46.8 card without a name printed on the card. This card may be the same card on which food
 46.9 support benefits are issued and does not need to meet the requirements of this section.

46.10 Sec. 7. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 2, is
 46.11 amended to read:

46.12 Subd. 2. **Prohibited purchases.** An individual with an EBT debit cardholders in
 46.13 card issued for one of the programs listed under subdivision 1 ~~are~~ is prohibited from using
 46.14 the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in
 46.15 section 340A.101, subdivision 2. ~~It is unlawful for an EBT cardholder to purchase or~~
 46.16 ~~attempt to purchase tobacco products or alcoholic beverages with the cardholder's EBT~~
 46.17 ~~card.~~ Any unlawful use prohibited purchases made under this subdivision shall constitute
 46.18 fraud unlawful use and result in disqualification of the cardholder from the program ~~under~~
 46.19 ~~section 256.98, subdivision 8~~ as provided in subdivision 4.

46.20 Sec. 8. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a
 46.21 subdivision to read:

46.22 Subd. 3. **EBT use restricted to certain states.** EBT debit cardholders in programs
 46.23 listed under subdivision 1 are prohibited from using the cash portion of the EBT card at
 46.24 vendors and automatic teller machines located outside of Minnesota, Iowa, North Dakota,
 46.25 South Dakota, or Wisconsin. This subdivision does not apply to the food portion.

46.26 **EFFECTIVE DATE.** This section is effective March 1, 2013.

46.27 Sec. 9. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a
 46.28 subdivision to read:

46.29 Subd. 4. **Disqualification.** (a) Any person found to be guilty of purchasing tobacco
 46.30 products or alcoholic beverages with their EBT debit card by a federal or state court or
 46.31 by an administrative hearing determination, or waiver thereof, through a disqualification
 46.32 consent agreement, or as part of any approved diversion plan under section 401.065, or
 46.33 any court-ordered stay which carries with it any probationary or other conditions, in

47.1 the: (1) Minnesota family investment program and any affiliated program to include the
47.2 diversionary work program and the work participation cash benefit program under chapter
47.3 256J; (2) general assistance program under chapter 256D; or (3) Minnesota supplemental
47.4 aid program under chapter 256D, shall be disqualified from all of the listed programs.

47.5 (b) The needs of the disqualified individual shall not be taken into consideration
47.6 in determining the grant level for that assistance unit: (1) for one year after the first
47.7 offense; (2) for two years after the second offense; and (3) permanently after the third or
47.8 subsequent offense.

47.9 (c) The period of program disqualification shall begin on the date stipulated on the
47.10 advance notice of disqualification without possibility for postponement for administrative
47.11 stay or administrative hearing and shall continue through completion unless and until the
47.12 findings upon which the sanctions were imposed are reversed by a court of competent
47.13 jurisdiction. The period for which sanctions are imposed is not subject to review.

47.14 **EFFECTIVE DATE.** This section is effective June 1, 2012.

47.15 Sec. 10. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

47.16 Subd. 1b. **Earned income savings account.** In addition to the \$50 disregard
47.17 required under subdivision 1, the county agency shall disregard an additional earned
47.18 income up to a maximum of ~~\$150~~ \$500 per month for: (1) persons residing in facilities
47.19 licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to
47.20 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons
47.21 living in supervised apartments with services funded under Minnesota Rules, parts
47.22 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan;
47.23 and (3) persons residing in group residential housing, as that term is defined in section
47.24 256I.03, subdivision 3, for whom the county agency has approved a discharge plan
47.25 which includes work. The additional amount disregarded must be placed in a separate
47.26 savings account by the eligible individual, to be used upon discharge from the residential
47.27 facility into the community. For individuals residing in a chemical dependency program
47.28 licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from
47.29 the savings account require the signature of the individual and for those individuals with
47.30 an authorized representative payee, the signature of the payee. A maximum of ~~\$1,000~~
47.31 \$2,000, including interest, of the money in the savings account must be excluded from
47.32 the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in
47.33 that account in excess of ~~\$1,000~~ \$2,000 must be applied to the resident's cost of care. If
47.34 excluded money is removed from the savings account by the eligible individual at any
47.35 time before the individual is discharged from the facility into the community, the money is

48.1 income to the individual in the month of receipt and a resource in subsequent months. If
48.2 an eligible individual moves from a community facility to an inpatient hospital setting,
48.3 the separate savings account is an excluded asset for up to 18 months. During that time,
48.4 amounts that accumulate in excess of the ~~\$1,000~~ \$2,000 savings limit must be applied to
48.5 the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the
48.6 18-month period, the entire account must be applied to the patient's cost of care.

48.7 **EFFECTIVE DATE.** This section is effective October 1, 2012.

48.8 Sec. 11. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 5, is
48.9 amended to read:

48.10 Subd. 5. **Household eligibility; participation.** (a) To be eligible for state or TANF
48.11 matching funds in the family assets for independence initiative, a household must meet the
48.12 eligibility requirements of the federal Assets for Independence Act, Public Law 105-285,
48.13 in Title IV, section 408 of that act.

48.14 (b) Each participating household must sign a family asset agreement that includes
48.15 the amount of scheduled deposits into its savings account, the proposed use, and the
48.16 proposed savings goal. A participating household must agree to complete an economic
48.17 literacy training program.

48.18 Participating households may only deposit money that is derived from household
48.19 earned income or from state and federal income tax credits.

48.20 Sec. 12. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 6, is
48.21 amended to read:

48.22 Subd. 6. **Withdrawal; matching; permissible uses.** (a) To receive a match, a
48.23 participating household must transfer funds withdrawn from a family asset account to its
48.24 matching fund custodial account held by the fiscal agent, according to the family asset
48.25 agreement. The fiscal agent must determine if the match request is for a permissible use
48.26 consistent with the household's family asset agreement.

48.27 The fiscal agent must ensure the household's custodial account contains the
48.28 applicable matching funds to match the balance in the household's account, including
48.29 interest, on at least a quarterly basis and at the time of an approved withdrawal. Matches
48.30 must be provided as follows:

48.31 (1) from state grant and TANF funds, a matching contribution of \$1.50 for every
48.32 \$1 of funds withdrawn from the family asset account equal to the lesser of \$720 per
48.33 year or a \$3,000 lifetime limit; and

49.1 (2) from nonstate funds, a matching contribution of no less than \$1.50 for every \$1
49.2 of funds withdrawn from the family asset account equal to the lesser of \$720 per year or
49.3 a \$3,000 lifetime limit.

49.4 (b) Upon receipt of transferred custodial account funds, the fiscal agent must make a
49.5 direct payment to the vendor of the goods or services for the permissible use.

49.6 Sec. 13. Minnesota Statutes 2010, section 256E.37, subdivision 1, is amended to read:

49.7 Subdivision 1. **Grant authority.** The commissioner may make grants to state
49.8 agencies and political subdivisions to construct or rehabilitate facilities for early childhood
49.9 programs, crisis nurseries, or parenting time centers. The following requirements apply:

49.10 (1) The facilities must be owned by the state or a political subdivision, but may
49.11 be leased under section 16A.695 to organizations that operate the programs. The
49.12 commissioner must prescribe the terms and conditions of the leases.

49.13 (2) A grant for an individual facility must not exceed \$500,000 for each program
49.14 that is housed in the facility, up to a maximum of \$2,000,000 for a facility that houses
49.15 three programs or more. Programs include Head Start, School Readiness, Early Childhood
49.16 Family Education, licensed child care, and other early childhood intervention programs.

49.17 (3) State appropriations must be matched on a 50 percent basis with nonstate funds.
49.18 The matching requirement must apply program wide and not to individual grants.

49.19 (4) At least 80 percent of grant funds must be distributed to facilities located in
49.20 counties not included in the definition under section 473.121, subdivision 4.

49.21 Sec. 14. Minnesota Statutes 2011 Supplement, section 256I.05, subdivision 1a, is
49.22 amended to read:

49.23 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section
49.24 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37
49.25 for other services necessary to provide room and board provided by the group residence
49.26 if the residence is licensed by or registered by the Department of Health, or licensed by
49.27 the Department of Human Services to provide services in addition to room and board,
49.28 and if the provider of services is not also concurrently receiving funding for services for
49.29 a recipient under a home and community-based waiver under title XIX of the Social
49.30 Security Act; or funding from the medical assistance program under section 256B.0659,
49.31 for personal care services for residents in the setting; or residing in a setting which
49.32 receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is
49.33 available for other necessary services through a home and community-based waiver, or
49.34 personal care services under section 256B.0659, then the GRH rate is limited to the rate

50.1 set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary
50.2 service rate exceed \$426.37. The registration and licensure requirement does not apply to
50.3 establishments which are exempt from state licensure because they are located on Indian
50.4 reservations and for which the tribe has prescribed health and safety requirements. Service
50.5 payments under this section may be prohibited under rules to prevent the supplanting of
50.6 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining
50.7 the approval of the Secretary of Health and Human Services to provide home and
50.8 community-based waiver services under title XIX of the Social Security Act for residents
50.9 who are not eligible for an existing home and community-based waiver due to a primary
50.10 diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is
50.11 determined to be cost-effective.

50.12 (b) The commissioner is authorized to make cost-neutral transfers from the GRH
50.13 fund for beds under this section to other funding programs administered by the department
50.14 after consultation with the county or counties in which the affected beds are located.
50.15 The commissioner may also make cost-neutral transfers from the GRH fund to county
50.16 human service agencies for beds permanently removed from the GRH census under a plan
50.17 submitted by the county agency and approved by the commissioner. The commissioner
50.18 shall report the amount of any transfers under this provision annually to the legislature.

50.19 (c) The provisions of paragraph (b) do not apply to a facility that has its
50.20 reimbursement rate established under section 256B.431, subdivision 4, paragraph (c).

50.21 (d) Counties must not negotiate supplementary service rates with providers of group
50.22 residential housing that are licensed as board and lodging with special services and that
50.23 do not encourage a policy of sobriety on their premises and make referrals to available
50.24 community services for volunteer and employment opportunities for residents.

50.25 Sec. 15. Minnesota Statutes 2010, section 256I.05, subdivision 1e, is amended to read:

50.26 Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the
50.27 provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall
50.28 negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to
50.29 exceed \$700 per month, including any legislatively authorized inflationary adjustments,
50.30 for a group residential housing provider that:

50.31 (1) is located in Hennepin County and has had a group residential housing contract
50.32 with the county since June 1996;

50.33 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a
50.34 26-bed facility; and

51.1 (3) serves a chemically dependent clientele, providing 24 hours per day supervision
 51.2 and limiting a resident's maximum length of stay to 13 months out of a consecutive
 51.3 24-month period.

51.4 (b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a
 51.5 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700
 51.6 per month, including any legislatively authorized inflationary adjustments, of a group
 51.7 residential provider that:

51.8 (1) is located in St. Louis County and has had a group residential housing contract
 51.9 with the county since 2006;

51.10 (2) operates a 62-bed facility; and

51.11 (3) serves a chemically dependent adult male clientele, providing 24 hours per
 51.12 day supervision and limiting a resident's maximum length of stay to 13 months out of
 51.13 a consecutive 24-month period.

51.14 (c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency
 51.15 shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not
 51.16 to exceed \$700 per month, including any legislatively authorized inflationary adjustments,
 51.17 for the group residential provider described under paragraphs (a) and (b), not to exceed
 51.18 an additional 115 beds.

51.19 **EFFECTIVE DATE.** This section is effective July 1, 2013.

51.20 Sec. 16. Minnesota Statutes 2010, section 256J.26, subdivision 1, is amended to read:

51.21 Subdivision 1. **Person convicted of drug offenses.** ~~(a) Applicants or participants~~
 51.22 An individual who ~~have~~ has been convicted of a felony level drug offense committed after
 51.23 July 1, 1997, may, if otherwise eligible, receive MFIP benefits subject to the following
 51.24 conditions: during the previous ten years from the date of application or recertification is
 51.25 subject to the following:

51.26 (1) Benefits for the entire assistance unit must be paid in vendor form for shelter and
 51.27 utilities during any time the applicant is part of the assistance unit.

51.28 (2) The convicted applicant or participant shall be subject to random drug testing as
 51.29 a condition of continued eligibility and following any positive test for an illegal controlled
 51.30 substance is subject to the following sanctions:

51.31 (i) for failing a drug test the first time, the residual amount of the participant's grant
 51.32 after making vendor payments for shelter and utility costs, if any, must be reduced by an
 51.33 amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same
 51.34 size. When a sanction under this subdivision is in effect, the job counselor must attempt
 51.35 to meet with the person face-to-face. During the face-to-face meeting, the job counselor

52.1 must explain the consequences of a subsequent drug test failure and inform the participant
52.2 of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is
52.3 not possible, the county agency must send the participant a notice of adverse action as
52.4 provided in section 256J.31, subdivisions 4 and 5, and must include the information
52.5 required in the face-to-face meeting; or

52.6 (ii) for failing a drug test two times, the participant is permanently disqualified from
52.7 receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP
52.8 grant must be reduced by the amount which would have otherwise been made available to
52.9 the disqualified participant. Disqualification under this item does not make a participant
52.10 ineligible for food stamps or food support. Before a disqualification under this provision is
52.11 imposed, the job counselor must attempt to meet with the participant face-to-face. During
52.12 the face-to-face meeting, the job counselor must identify other resources that may be
52.13 available to the participant to meet the needs of the family and inform the participant of
52.14 the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is
52.15 not possible, the county agency must send the participant a notice of adverse action as
52.16 provided in section 256J.31, subdivisions 4 and 5, and must include the information
52.17 required in the face-to-face meeting.

52.18 (3) A participant who fails a drug test the first time and is under a sanction due to
52.19 other MFIP program requirements is considered to have more than one occurrence of
52.20 noncompliance and is subject to the applicable level of sanction as specified under section
52.21 256J.46, subdivision 1, paragraph (d).

52.22 (b) Applicants requesting only food stamps or food support or participants receiving
52.23 only food stamps or food support, who have been convicted of a drug offense that
52.24 occurred after July 1, 1997, may, if otherwise eligible, receive food stamps or food support
52.25 if the convicted applicant or participant is subject to random drug testing as a condition
52.26 of continued eligibility. Following a positive test for an illegal controlled substance, the
52.27 applicant is subject to the following sanctions:

52.28 (1) for failing a drug test the first time, food stamps or food support shall be reduced
52.29 by an amount equal to 30 percent of the applicable food stamp or food support allotment.
52.30 When a sanction under this clause is in effect, a job counselor must attempt to meet with
52.31 the person face-to-face. During the face-to-face meeting, a job counselor must explain
52.32 the consequences of a subsequent drug test failure and inform the participant of the right
52.33 to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible,
52.34 a county agency must send the participant a notice of adverse action as provided in
52.35 section 256J.31, subdivisions 4 and 5, and must include the information required in the
52.36 face-to-face meeting; and

53.1 (2) for failing a drug test two times, the participant is permanently disqualified from
53.2 receiving food stamps or food support. Before a disqualification under this provision is
53.3 imposed, a job counselor must attempt to meet with the participant face-to-face. During
53.4 the face-to-face meeting, the job counselor must identify other resources that may be
53.5 available to the participant to meet the needs of the family and inform the participant of
53.6 the right to appeal the disqualification under section 256J.40. If a face-to-face meeting
53.7 is not possible, a county agency must send the participant a notice of adverse action as
53.8 provided in section 256J.31, subdivisions 4 and 5, and must include the information
53.9 required in the face-to-face meeting.

53.10 ~~(e)~~ (b) For the purposes of this subdivision, "drug offense" means an offense that
53.11 occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application
53.12 or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, ~~or~~ 152.096, or
53.13 152.137. Drug offense also means a conviction in another jurisdiction of the possession,
53.14 use, or distribution of a controlled substance, or conspiracy to commit any of these
53.15 offenses, if the offense occurred ~~after July 1, 1997,~~ during the previous ten years from
53.16 the date of application or recertification and the conviction is a felony offense in that
53.17 jurisdiction, or in the case of New Jersey, a high misdemeanor.

53.18 **EFFECTIVE DATE.** This section is effective October 1, 2012, for all new MFIP
53.19 applicants who apply on or after that date and for all recertifications occurring on or
53.20 after that date.

53.21 Sec. 17. Minnesota Statutes 2010, section 256J.26, is amended by adding a subdivision
53.22 to read:

53.23 **Subd. 5. Vendor payment; uninhabitable units.** Upon discovery by the county
53.24 that a unit has been deemed uninhabitable under section 504B.131, the county shall
53.25 immediately notify the landlord to return the vendor paid rent under this section for the
53.26 month in which the discovery occurred. The county shall cease future rent payments for
53.27 the uninhabitable housing units until the landlord demonstrates the premises are fit for
53.28 the intended use. A landlord who is required to return vendor paid rent or is prohibited
53.29 from receiving future rent under this subdivision may not take an eviction action against
53.30 anyone in the assistance unit.

53.31 Sec. 18. Minnesota Statutes 2010, section 256J.575, subdivision 1, is amended to read:

53.32 Subdivision 1. **Purpose.** ~~(a) The~~ Family stabilization services serve families who
53.33 are not making significant progress within the regular employment and training services

54.1 track of the Minnesota family investment program (MFIP) due to a variety of barriers to
54.2 employment.

54.3 ~~(b) The goal of the services is to stabilize and improve the lives of families at risk~~
54.4 ~~of long-term welfare dependency or family instability due to employment barriers such~~
54.5 ~~as physical disability, mental disability, age, or providing care for a disabled household~~
54.6 ~~member. These services promote and support families to achieve the greatest possible~~
54.7 ~~degree of self-sufficiency.~~

54.8 Sec. 19. Minnesota Statutes 2010, section 256J.575, subdivision 2, is amended to read:

54.9 Subd. 2. **Definitions.** The terms used in this section have the meanings given them
54.10 in paragraphs (a) ~~to (d)~~ and (b).

54.11 ~~(a) "Case manager" means the county-designated staff person or employment~~
54.12 ~~services counselor.~~

54.13 ~~(b) "Case management" "Family stabilization services" means the services~~
54.14 ~~programs, activities, and services provided by or through the county agency or through the~~
54.15 ~~employment services agency to participating families, including. Services include, but~~
54.16 ~~are not limited to, assessment as defined in section 256J.521, subdivision 1, information,~~
54.17 ~~referrals, and assistance in the preparation and implementation of a family stabilization~~
54.18 ~~plan under subdivision 5.~~

54.19 ~~(c) (b) "Family stabilization plan" means a plan developed by a case manager~~
54.20 ~~and with the participant, which identifies the participant's most appropriate path to~~
54.21 ~~unsubsidized employment, family stability, and barrier reduction, taking into account the~~
54.22 ~~family's circumstances.~~

54.23 ~~(d) "Family stabilization services" means programs, activities, and services in this~~
54.24 ~~section that provide participants and their family members with assistance regarding,~~
54.25 ~~but not limited to:~~

54.26 ~~(1) obtaining and retaining unsubsidized employment;~~

54.27 ~~(2) family stability;~~

54.28 ~~(3) economic stability; and~~

54.29 ~~(4) barrier reduction.~~

54.30 ~~The goal of the services is to achieve the greatest degree of economic self-sufficiency~~
54.31 ~~and family well-being possible for the family under the circumstances.~~

54.32 Sec. 20. Minnesota Statutes 2010, section 256J.575, subdivision 5, is amended to read:

54.33 Subd. 5. **Case management; Family stabilization plans; coordinated services.**

54.34 (a) The county agency or employment services provider shall provide ~~family stabilization~~

55.1 ~~services to families through a case management model. A case manager shall be assigned~~
55.2 ~~to each participating family within 30 days after the family is determined to be eligible~~
55.3 ~~for family stabilization services. The case manager, with the full involvement of the~~
55.4 ~~participant, shall recommend, and the county agency shall establish and modify as~~
55.5 ~~necessary, a family stabilization plan for each participating family. Once a participant~~
55.6 ~~has been determined eligible for family stabilization services, the county agency or~~
55.7 ~~employment services provider must attempt to meet with the participant to develop a~~
55.8 ~~plan within 30 days.~~

55.9 (b) If a participant is already assigned to a county case manager or a
55.10 county-designated case manager in social services, disability services, or housing services
55.11 that case manager already assigned may be the case manager for purposes of these services.

55.12 ~~(b) The family stabilization plan must include:~~

55.13 ~~(1) each participant's plan for long-term self-sufficiency, including an employment~~
55.14 ~~goal where applicable;~~

55.15 ~~(2) an assessment of each participant's strengths and barriers, and any special~~
55.16 ~~circumstances of the participant's family that impact, or are likely to impact, the~~
55.17 ~~participant's progress towards the goals in the plan; and~~

55.18 ~~(3) an identification of the services, supports, education, training, and~~
55.19 ~~accommodations needed to reduce or overcome any barriers to enable the family to~~
55.20 ~~achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.~~

55.21 ~~(c) The case manager and the participant shall meet within 30 days of the family's~~
55.22 ~~referral to the case manager. The initial family stabilization plan must be completed within~~
55.23 ~~30 days of the first meeting with the case manager. The case manager shall establish a~~
55.24 ~~schedule for periodic review of the family stabilization plan that includes personal contact~~
55.25 ~~with the participant at least once per month. In addition, the case manager shall review~~
55.26 ~~and, if necessary, modify the plan under the following circumstances:~~

55.27 ~~(1) there is a lack of satisfactory progress in achieving the goals of the plan;~~

55.28 ~~(2) the participant has lost unsubsidized or subsidized employment;~~

55.29 ~~(3) a family member has failed or is unable to comply with a family stabilization~~
55.30 ~~plan requirement;~~

55.31 ~~(4) services, supports, or other activities required by the plan are unavailable;~~

55.32 ~~(5) changes to the plan are needed to promote the well-being of the children; or~~

55.33 ~~(6) the participant and case manager determine that the plan is no longer appropriate~~
55.34 ~~for any other reason.~~

56.1 (c) Participants determined eligible for family stabilization services must have
 56.2 access to employment and training services under sections 256J.515 to 256J.575, to the
 56.3 extent these services are available to other MFIP participants.

56.4 Sec. 21. Minnesota Statutes 2010, section 256J.575, subdivision 6, is amended to read:

56.5 Subd. 6. **Cooperation with services requirements.** ~~(a) A participant who is eligible~~
 56.6 ~~for family stabilization services under this section shall comply with paragraphs (b) to (d).~~

56.7 ~~(b) Participants shall engage in family stabilization plan services for the appropriate~~
 56.8 ~~number of hours per week that the activities are scheduled and available, based on the~~
 56.9 ~~needs of the participant and the participant's family, unless good cause exists for not~~
 56.10 ~~doing so, as defined in section 256J.57, subdivision 1. The appropriate number of hours~~
 56.11 ~~must be based on the participant's plan.~~

56.12 ~~(c) The case manager county agency or employment services agency shall review~~
 56.13 ~~the participant's progress toward the goals in the family stabilization plan every six~~
 56.14 ~~months to determine whether conditions have changed, including whether revisions to~~
 56.15 ~~the plan are needed.~~

56.16 ~~(d) A participant's requirement to comply with any or all family stabilization plan~~
 56.17 ~~requirements under this subdivision is excused when the case management services,~~
 56.18 ~~training and educational services, or family support services identified in the participant's~~
 56.19 ~~family stabilization plan are unavailable for reasons beyond the control of the participant,~~
 56.20 ~~including when money appropriated is not sufficient to provide the services.~~

56.21 Sec. 22. Minnesota Statutes 2010, section 256J.575, subdivision 8, is amended to read:

56.22 Subd. 8. **Funding.** (a) The commissioner of human services shall treat MFIP
 56.23 expenditures made to or on behalf of any minor child under this section, who is part of a
 56.24 household that meets criteria in subdivision 3, as expenditures under a separately funded
 56.25 state program. These expenditures shall not count toward the state's maintenance of effort
 56.26 requirements under the federal TANF program.

56.27 (b) A family is no longer part of a separately funded program under this section if
 56.28 the caregiver no longer meets the criteria for family stabilization services in subdivision
 56.29 3, ~~or if it is determined at recertification that a caregiver with a child under the age of six~~
 56.30 ~~is working at least 87 hours per month in paid or unpaid employment, or a caregiver~~
 56.31 ~~without a child under the age of six is working at least 130 hours per month in paid or~~
 56.32 ~~unpaid employment, whichever occurs sooner.~~

56.33 Sec. 23. **[626.5533] REPORTING POTENTIAL WELFARE FRAUD.**

57.1 Subdivision 1. **Reports required.** A peace officer must report to the head of the
57.2 officer's department every arrest where the person arrested possesses more than one
57.3 welfare electronic benefit transfer card. Each report must include all of the following:

57.4 (1) the name of the suspect;

57.5 (2) the suspect's drivers license or state identification card number, where available;

57.6 (3) the suspect's home address;

57.7 (4) the number on each card;

57.8 (5) the name on each electronic benefit card in the possession of the suspect, in cases
57.9 where the card has a name printed on it;

57.10 (6) the date of the alleged offense;

57.11 (7) the location of the alleged offense;

57.12 (8) the alleged offense; and

57.13 (9) any other information the commissioner of human services deems necessary.

57.14 Subd. 2. **Use of information collected.** The head of a local law enforcement agency
57.15 or state law enforcement department that employs peace officers licensed under section
57.16 626.843 must forward the report required under subdivision 1 to the commissioner of
57.17 human services within 30 days of receiving the report. The commissioner of human
57.18 services shall use the report to determine whether the suspect is authorized to possess any
57.19 of the electronic benefit cards found in the suspect's possession.

57.20 Subd. 3. **Reporting forms.** The commissioner of human services, in consultation
57.21 with the superintendent of the Bureau of Criminal Apprehension, shall adopt reporting
57.22 forms to be used by law enforcement agencies in making the reports required under this
57.23 section.

57.24 Sec. 24. Minnesota Statutes 2010, section 626.556, is amended by adding a subdivision
57.25 to read:

57.26 Subd. 10n. **Required referral to early intervention services.** A child under
57.27 age three who is involved in a substantiated case of maltreatment shall be referred for
57.28 screening under the Individuals with Disabilities Education Act, part C. Parents must be
57.29 informed that the evaluation and acceptance of services are voluntary. The commissioner
57.30 of human services shall monitor referral rates by county and annually report the
57.31 information to the legislature beginning March 15, 2014. Refusal to have a child screened
57.32 is not a basis for a child in need of protection or services petition under chapter 260C.

57.33 Sec. 25. Laws 2010, chapter 374, section 1, is amended to read:

58.1 Section 1. ~~LADDER OUT OF POVERTY~~ ASSET DEVELOPMENT AND
 58.2 FINANCIAL LITERACY TASK FORCE.

58.3 Subdivision 1. **Creation.** (a) The task force consists of the following members:

58.4 (1) four senators, including two members of the majority party and two members of
 58.5 the minority party, appointed by the Subcommittee on Committees of the Committee on
 58.6 Rules and Administration of the senate;

58.7 (2) four members of the house of representatives, including two members of the
 58.8 majority party, appointed by the speaker of the house, and two members of the minority
 58.9 party, appointed by the minority leader; and

58.10 (3) the commissioner of the Minnesota Department of Commerce or the
 58.11 commissioner's designee; and

58.12 ~~(4) the attorney general or the attorney general's designee.~~

58.13 (b) The task force shall ensure that representatives of the following have the
 58.14 opportunity to meet with and present views to the task force: the attorney general; credit
 58.15 unions; independent community banks; state and federal financial institutions; community
 58.16 action agencies; faith-based financial counseling agencies; faith-based social justice
 58.17 organizations; legal services organizations representing low-income persons; nonprofit
 58.18 organizations providing free tax preparation services as part of the volunteer income tax
 58.19 assistance program; relevant state and local agencies; University of Minnesota faculty
 58.20 involved in personal and family financial education; philanthropic organizations that have
 58.21 as one of their missions combating predatory lending; organizations representing older
 58.22 Minnesotans; and organizations representing the interests of women, Latinos and Latinas,
 58.23 African-Americans, Asian-Americans, American Indians, and immigrants.

58.24 Subd. 2. **Duties.** (a) At a minimum, the task force must identify specific policies,
 58.25 strategies, and actions to: reduce asset poverty and increase household financial security
 58.26 by improving opportunities for households to earn, learn, save, invest, and protect
 58.27 assets through expansion of such asset building opportunities as the Family Assets for
 58.28 Independence in Minnesota (FAIM) program and Earned Income Tax Credit (EITC)
 58.29 program.

58.30 ~~(1) increase opportunities for poor and near-poor families and individuals to acquire~~
 58.31 ~~assets and create and build wealth;~~

58.32 ~~(2) expand the utilization of Family Assets for Independence in Minnesota (FAIM)~~
 58.33 ~~or other culturally specific individual development account programs;~~

58.34 ~~(3) reduce or eliminate predatory financial practices in Minnesota through regulatory~~
 58.35 ~~actions, legislative enactments, and the development and deployment of alternative,~~
 58.36 ~~nonpredatory financial products;~~

59.1 ~~(4) provide incentives or assistance to private sector financial institutions to~~
59.2 ~~offer additional programs and services that provide alternatives to and education about~~
59.3 ~~predatory financial products;~~

59.4 ~~(5) provide financial literacy information to low-income families and individuals at~~
59.5 ~~the time the recipient has the ability, opportunity, and motivation to receive, understand,~~
59.6 ~~and act on the information provided; and~~

59.7 ~~(6) identify incentives and mechanisms to increase community engagement in~~
59.8 ~~combating poverty and helping poor and near-poor families and individuals to acquire~~
59.9 ~~assets and create and build wealth.~~

59.10 For purposes of this section, "asset poverty" means an individual's or family's
59.11 inability to meet fixed financial obligations and other financial requirements of daily living
59.12 with existing assets for a three-month period in the event of a disruption in income or
59.13 extraordinary economic emergency.

59.14 ~~(b) By June 1, 2012~~ During the 2013 and 2014 legislative sessions, the task force
59.15 must provide the legislature with written recommendations ~~and any draft legislation~~
59.16 necessary to ~~implement the recommendations to the chairs and ranking minority members~~
59.17 ~~of the legislative committees and divisions with jurisdiction over commerce and consumer~~
59.18 ~~protection~~ fulfill the duties enumerated in paragraph (a). The recommendations may
59.19 include draft legislation.

59.20 Subd. 3. **Administrative provisions.** (a) The director of the Legislative
59.21 Coordinating Commission, or a designee of the director, must convene the initial meeting
59.22 of the task force by September 15, 2010. The members of the task force must elect a chair
59.23 or cochairs from the legislative members at the initial meeting.

59.24 (b) Members of the task force serve without compensation or payment of expenses
59.25 except as provided in this paragraph. To the extent possible, meetings of the task force
59.26 shall be scheduled on dates when legislative members of the task force are able to
59.27 attend legislative meetings that would make them eligible to receive legislative per diem
59.28 payments.

59.29 (c) The task force expires June 1, 2012, ~~or upon the submission of the report required~~
59.30 ~~under subdivision 3, whichever is earlier~~ 2014.

59.31 (d) The task force may accept gifts and grants, which are accepted on behalf of the
59.32 state and constitute donations to the state. The funds must be deposited in an account in
59.33 the special revenue fund and are appropriated to the Legislative Coordinating Commission
59.34 for purposes of the task force.

59.35 (e) The Legislative Coordinating Commission shall provide fiscal services to the
59.36 task force as needed under this subdivision.

60.1 Subd. 4. **Deadline for appointments and designations.** The appointments and
 60.2 designations authorized under this section must be completed no later than August 15,
 60.3 ~~2010~~ 2012.

60.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

60.5 Sec. 26. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 60.6 1, is amended to read:

60.7 Subdivision 1. **Total Appropriation** \$ **6,259,280,000** \$ **6,212,085,000**

60.8 Appropriations by Fund			
	60.9 2012	2013	
60.10 General	5,657,737,000	5,584,471,000	
60.11 State Government			
60.12 Special Revenue	3,565,000	3,565,000	
60.13 Health Care Access	330,435,000	353,283,000	
60.14 Federal TANF	265,378,000	268,101,000	
60.15 Lottery Prize	1,665,000	1,665,000	
60.16 Special Revenue	500,000	1,000,000	

60.17 **Receipts for Systems Projects.**

60.18 Appropriations and federal receipts for
 60.19 information systems projects for MAXIS,
 60.20 PRISM, MMIS, and SSIS must be deposited
 60.21 in the state systems account authorized in
 60.22 Minnesota Statutes, section 256.014. Money
 60.23 appropriated for computer projects approved
 60.24 by the Minnesota Office of Enterprise
 60.25 Technology, funded by the legislature,
 60.26 and approved by the commissioner
 60.27 of management and budget, may be
 60.28 transferred from one project to another
 60.29 and from development to operations as the
 60.30 commissioner of human services considers
 60.31 necessary. Any unexpended balance in
 60.32 the appropriation for these projects does
 60.33 not cancel but is available for ongoing
 60.34 development and operations.

61.1 **Nonfederal Share Transfers.** The
61.2 nonfederal share of activities for which
61.3 federal administrative reimbursement is
61.4 appropriated to the commissioner may be
61.5 transferred to the special revenue fund.

61.6 **TANF Maintenance of Effort.**

61.7 (a) In order to meet the basic maintenance
61.8 of effort (MOE) requirements of the TANF
61.9 block grant specified under Code of Federal
61.10 Regulations, title 45, section 263.1, the
61.11 commissioner may only report nonfederal
61.12 money expended for allowable activities
61.13 listed in the following clauses as TANF/MOE
61.14 expenditures:

61.15 (1) MFIP cash, diversionary work program,
61.16 and food assistance benefits under Minnesota
61.17 Statutes, chapter 256J;

61.18 (2) the child care assistance programs
61.19 under Minnesota Statutes, sections 119B.03
61.20 and 119B.05, and county child care
61.21 administrative costs under Minnesota
61.22 Statutes, section 119B.15;

61.23 (3) state and county MFIP administrative
61.24 costs under Minnesota Statutes, chapters
61.25 256J and 256K;

61.26 (4) state, county, and tribal MFIP
61.27 employment services under Minnesota
61.28 Statutes, chapters 256J and 256K;

61.29 (5) expenditures made on behalf of legal
61.30 noncitizen MFIP recipients who qualify for
61.31 the MinnesotaCare program under Minnesota
61.32 Statutes, chapter 256L;

- 62.1 (6) qualifying working family credit
62.2 expenditures under Minnesota Statutes,
62.3 section 290.0671; and
- 62.4 (7) qualifying Minnesota education credit
62.5 expenditures under Minnesota Statutes,
62.6 section 290.0674.
- 62.7 (b) The commissioner shall ensure that
62.8 sufficient qualified nonfederal expenditures
62.9 are made each year to meet the state's
62.10 TANF/MOE requirements. For the activities
62.11 listed in paragraph (a), clauses (2) to
62.12 (7), the commissioner may only report
62.13 expenditures that are excluded from the
62.14 definition of assistance under Code of
62.15 Federal Regulations, title 45, section 260.31.
- 62.16 (c) For fiscal years beginning with state fiscal
62.17 year 2003, the commissioner shall assure
62.18 that the maintenance of effort used by the
62.19 commissioner of management and budget
62.20 for the February and November forecasts
62.21 required under Minnesota Statutes, section
62.22 16A.103, contains expenditures under
62.23 paragraph (a), clause (1), equal to at least 16
62.24 percent of the total required under Code of
62.25 Federal Regulations, title 45, section 263.1.
- 62.26 (d) Minnesota Statutes, section 256.011,
62.27 subdivision 3, which requires that federal
62.28 grants or aids secured or obtained under that
62.29 subdivision be used to reduce any direct
62.30 appropriations provided by law, do not apply
62.31 if the grants or aids are federal TANF funds.
- 62.32 (e) For the federal fiscal years beginning on
62.33 or after October 1, 2007, the commissioner
62.34 may not claim an amount of TANF/MOE in
62.35 excess of the 75 percent standard in Code

63.1 of Federal Regulations, title 45, section
63.2 263.1(a)(2), except:
63.3 (1) to the extent necessary to meet the 80
63.4 percent standard under Code of Federal
63.5 Regulations, title 45, section 263.1(a)(1),
63.6 if it is determined by the commissioner
63.7 that the state will not meet the TANF work
63.8 participation target rate for the current year;
63.9 (2) to provide any additional amounts
63.10 under Code of Federal Regulations, title 45,
63.11 section 264.5, that relate to replacement of
63.12 TANF funds due to the operation of TANF
63.13 penalties; and
63.14 (3) to provide any additional amounts that
63.15 may contribute to avoiding or reducing
63.16 TANF work participation penalties through
63.17 the operation of the excess MOE provisions
63.18 of Code of Federal Regulations, title 45,
63.19 section 261.43 (a)(2).
63.20 For the purposes of clauses (1) to (3),
63.21 the commissioner may supplement the
63.22 MOE claim with working family credit
63.23 expenditures or other qualified expenditures
63.24 to the extent such expenditures are otherwise
63.25 available after considering the expenditures
63.26 allowed in this subdivision.
63.27 (f) Notwithstanding any contrary provision
63.28 in this article, paragraphs (a) to (e) expire
63.29 June 30, 2015.

63.30 **Working Family Credit Expenditures**
63.31 **as TANF/MOE.** The commissioner may
63.32 claim as TANF maintenance of effort up to
63.33 \$6,707,000 per year of working family credit
63.34 expenditures for fiscal years 2012 and 2013.

64.1 **Working Family Credit Expenditures**

64.2 **to be Claimed for TANF/MOE.** The
64.3 commissioner may count the following
64.4 amounts of working family credit
64.5 expenditures as TANF/MOE:

64.6 (1) fiscal year 2012, \$23,692,000;

64.7 (2) fiscal year 2013, ~~\$44,969,000~~
64.8 \$51,978,000;

64.9 (3) fiscal year 2014, ~~\$32,579,000~~
64.10 \$43,576,000; and

64.11 (4) fiscal year 2015, ~~\$32,476,000~~
64.12 \$43,548,000.

64.13 Notwithstanding any contrary provision in
64.14 this article, this rider expires June 30, 2015.

64.15 **TANF Transfer to Federal Child Care**
64.16 **and Development Fund.** (a) The following
64.17 TANF fund amounts are appropriated
64.18 to the commissioner for purposes of
64.19 MFIP/Transition Year Child Care Assistance
64.20 under Minnesota Statutes, section 119B.05:

64.21 (1) fiscal year 2012, \$10,020,000;

64.22 (2) fiscal year 2013, ~~\$28,020,000~~
64.23 \$28,022,000;

64.24 (3) fiscal year 2014, ~~\$14,020,000~~
64.25 \$14,030,000; and

64.26 (4) fiscal year 2015, ~~\$14,020,000~~
64.27 \$14,030,000.

64.28 (b) The commissioner shall authorize the
64.29 transfer of sufficient TANF funds to the
64.30 federal child care and development fund to
64.31 meet this appropriation and shall ensure that
64.32 all transferred funds are expended according

65.1 to federal child care and development fund
65.2 regulations.

65.3 **Food Stamps Employment and Training**

65.4 **Funds.** (a) Notwithstanding Minnesota
65.5 Statutes, sections 256D.051, subdivisions 1a,
65.6 6b, and 6c, and 256J.626, federal food stamps
65.7 employment and training funds received
65.8 as reimbursement for child care assistance
65.9 program expenditures must be deposited in
65.10 the general fund. The amount of funds must
65.11 be limited to \$500,000 per year in fiscal
65.12 years 2012 through 2015, contingent upon
65.13 approval by the federal Food and Nutrition
65.14 Service.

65.15 (b) Consistent with the receipt of these
65.16 federal funds, the commissioner may
65.17 adjust the level of working family credit
65.18 expenditures claimed as TANF maintenance
65.19 of effort. Notwithstanding any contrary
65.20 provision in this article, this rider expires
65.21 June 30, 2015.

65.22 **ARRA Food Support Benefit Increases.**

65.23 The funds provided for food support benefit
65.24 increases under the Supplemental Nutrition
65.25 Assistance Program provisions of the
65.26 American Recovery and Reinvestment Act
65.27 (ARRA) of 2009 must be used for benefit
65.28 increases beginning July 1, 2009.

65.29 **Supplemental Security Interim Assistance**

65.30 **Reimbursement Funds.** \$2,800,000 of
65.31 uncommitted revenue available to the
65.32 commissioner of human services for SSI
65.33 advocacy and outreach services must be
65.34 transferred to and deposited into the general
65.35 fund by October 1, 2011.

66.1 Sec. 27. **MINNESOTA VISIBLE CHILD WORK GROUP.**

66.2 Subdivision 1. **Purpose.** The Minnesota visible child work group is established to
66.3 identify and recommend issues that should be addressed in a statewide, comprehensive
66.4 plan to improve the well-being of children who are homeless or have experienced
66.5 homelessness.

66.6 Subd. 2. **Membership.** The members of the Minnesota visible child work group
66.7 include: (1) two members of the Minnesota house of representatives appointed by
66.8 the speaker of the house, one member from the majority party and one member from
66.9 the minority party; (2) two members of the Minnesota senate appointed by the senate
66.10 Subcommittee on Committees of the Committee on Rules and Administration, one
66.11 member from the majority party and one member from the minority party; (3) three
66.12 representatives from family shelter, transitional housing, and supportive housing providers
66.13 appointed by the governor; (4) two individuals appointed by the governor who have
66.14 experienced homelessness; (5) three housing and child advocates appointed by the
66.15 governor; (6) three representatives from the business or philanthropic community; and (7)
66.16 children's cabinet members, or their designees. Work group membership should include
66.17 people from rural, suburban, and urban areas of the state.

66.18 Subd. 3. **Duties.** The work group shall: (1) recommend goals and objectives for a
66.19 comprehensive, statewide plan to improve the well-being of children who are homeless or
66.20 who have experienced homelessness; (2) recommend a definition of "child well-being";
66.21 (3) identify evidence-based interventions and best practices improving the well-being
66.22 of young children; (4) plan implementation timelines and ways to measure progress,
66.23 including measures of child well-being from birth through adolescence; (5) identify ways
66.24 to address issues of collaboration and coordination across systems, including education,
66.25 health, human services, and housing; (6) recommend the type of data and information
66.26 necessary to develop, effectively implement, and monitor a strategic plan; (7) examine and
66.27 make recommendations regarding funding to implement an effective plan; and (8) provide
66.28 recommendations for ongoing reports on the well-being of children, monitoring progress
66.29 in implementing the statewide comprehensive plan, and any other issues determined to be
66.30 relevant to achieving the goals of this section.

66.31 Subd. 4. **Work group convening and facilitation.** The work group must be
66.32 organized, scheduled, and facilitated by the staff of a nonprofit child advocacy, outreach,
66.33 research, and youth development organization focusing on a wide range of issues
66.34 affecting children who are vulnerable, and a nonprofit organization working to provide
66.35 safe, affordable, and sustainable homes for children and families in the seven-county
66.36 metropolitan area through partnerships with the public and private sector. These two

67.1 organizations will also be responsible for preparing and submitting the work group's
67.2 recommendations.

67.3 Subd. 5. **Report.** The work group shall make recommendations under subdivision
67.4 3 to the legislative committees with jurisdiction over education, housing, health, and
67.5 human services policy and finance by December 15, 2012. The recommendations must
67.6 also be submitted to the children's cabinet to provide the foundation for a statewide
67.7 visible child plan.

67.8 Subd. 6. **Expiration.** The Minnesota visible child work group expires on June
67.9 30, 2013.

67.10 Sec. 28. **UNIFORM ASSET LIMIT REQUIREMENTS.**

67.11 The commissioner of human services, in consultation with county human
67.12 services representatives, shall analyze the differences in asset limit requirements across
67.13 human services assistance programs, including group residential housing, Minnesota
67.14 supplemental aid, general assistance, Minnesota family investment program, diversionary
67.15 work program, the federal Supplemental Nutrition Assistance Program, state food
67.16 assistance programs, and child care programs. The goal of the analysis is to establish a
67.17 consistent asset limit across human services programs and minimize the administrative
67.18 burdens on counties in implementing asset tests. The commissioner shall report its
67.19 findings and conclusions to the legislative committees with jurisdiction over health and
67.20 human services policy and finance by January 15, 2013, and include draft legislation
67.21 establishing a uniform asset limit for human services assistance programs.

67.22 Sec. 29. **DIRECTIONS TO THE COMMISSIONER.**

67.23 The commissioner of human services, in consultation with the commissioner of
67.24 public safety, shall report to the chairs and ranking minority members of the legislative
67.25 committees with jurisdiction over health and human services policy and finance regarding
67.26 the implementation of Minnesota Statutes, section 256.01, subdivisions 18c, 18d, and 18e,
67.27 the number of persons affected, and fiscal impact by program by December 1, 2013.

67.28 **EFFECTIVE DATE.** This section is effective July 1, 2013.

67.29 Sec. 30. **REVISOR INSTRUCTION.**

67.30 The revisor of statutes shall change the term "assistance transaction card" or
67.31 similar terms to "electronic benefit transaction" or similar terms wherever they appear in
67.32 Minnesota Statutes, chapter 256. The revisor may make changes necessary to correct the
67.33 punctuation, grammar, or structure of the remaining text and preserve its meaning.

ARTICLE 4

CONTINUING CARE

68.1

68.2

68.3 Section 1. Minnesota Statutes 2010, section 62J.496, subdivision 2, is amended to read:

68.4 Subd. 2. **Eligibility.** (a) "Eligible borrower" means one of the following:

68.5 (1) federally qualified health centers;

68.6 (2) community clinics, as defined under section 145.9268;

68.7 (3) nonprofit or local unit of government hospitals licensed under sections 144.50
68.8 to 144.56;

68.9 (4) individual or small group physician practices that are focused primarily on
68.10 primary care;

68.11 (5) nursing facilities licensed under sections 144A.01 to 144A.27;

68.12 (6) local public health departments as defined in chapter 145A; and

68.13 (7) other providers of health or health care services approved by the commissioner
68.14 for which interoperable electronic health record capability would improve quality of
68.15 care, patient safety, or community health.

68.16 (b) The commissioner shall administer the loan fund to prioritize support and
68.17 assistance to:

68.18 (1) critical access hospitals;

68.19 (2) federally qualified health centers;

68.20 (3) entities that serve uninsured, underinsured, and medically underserved
68.21 individuals, regardless of whether such area is urban or rural; ~~and~~

68.22 (4) individual or small group practices that are primarily focused on primary care; ~~;~~

68.23 (5) nursing facilities certified to participate in the medical assistance program; and

68.24 (6) providers enrolled in the elderly waiver program of customized living or 24-hour

68.25 customized living of the medical assistance program, if at least half of their annual

68.26 operating revenue is paid under the medical assistance program.

68.27 (c) An eligible applicant must submit a loan application to the commissioner of
68.28 health on forms prescribed by the commissioner. The application must include, at a
68.29 minimum:

68.30 (1) the amount of the loan requested and a description of the purpose or project
68.31 for which the loan proceeds will be used;

68.32 (2) a quote from a vendor;

68.33 (3) a description of the health care entities and other groups participating in the
68.34 project;

68.35 (4) evidence of financial stability and a demonstrated ability to repay the loan; and

69.1 (5) a description of how the system to be financed interoperates or plans in the
 69.2 future to interoperate with other health care entities and provider groups located in the
 69.3 same geographical area;

69.4 (6) a plan on how the certified electronic health record technology will be maintained
 69.5 and supported over time; and

69.6 (7) any other requirements for applications included or developed pursuant to
 69.7 section 3014 of the HITECH Act.

69.8 Sec. 2. Minnesota Statutes 2010, section 144A.073, is amended by adding a
 69.9 subdivision to read:

69.10 Subd. 13. **Moratorium exception funding.** In fiscal year 2013, the commissioner
 69.11 of health may approve moratorium exception projects under this section for which the full
 69.12 annualized state share of medical assistance costs does not exceed \$1,000,000.

69.13 Sec. 3. Minnesota Statutes 2010, section 144A.351, is amended to read:

69.14 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
 69.15 **REPORT REQUIRED.**

69.16 The commissioners of health and human services, with the cooperation of counties
 69.17 and in consultation with stakeholders, including persons who need or are using long-term
 69.18 care services and supports, lead agencies, regional entities, senior, disability, and mental
 69.19 health organization representatives, service providers, and community members shall
 69.20 prepare a report to the legislature by August 15, ~~2004~~ 2013, and biennially thereafter,
 69.21 regarding the status of the full range of long-term care services and supports for the
 69.22 elderly and children and adults with disabilities and mental illnesses in Minnesota. The
 69.23 report shall address:

69.24 (1) demographics and need for long-term care services and supports in Minnesota;

69.25 (2) summary of county and regional reports on long-term care gaps, surpluses,
 69.26 imbalances, and corrective action plans;

69.27 (3) status of long-term care services and mental illnesses, housing options, and
 69.28 supports by county and region including:

69.29 (i) changes in availability of the range of long-term care services and housing
 69.30 options;

69.31 (ii) access problems, including access to the least restrictive and most integrated
 69.32 services and settings, regarding long-term care services; and

69.33 (iii) comparative measures of long-term care services availability, including serving
 69.34 people in their home areas near family, and progress changes over time; and

70.1 (4) recommendations regarding goals for the future of long-term care services and
 70.2 supports, policy and fiscal changes, and resource development and transition needs.

70.3 Sec. 4. Minnesota Statutes 2010, section 144D.04, subdivision 2, is amended to read:

70.4 Subd. 2. **Contents of contract.** A housing with services contract, which need not be
 70.5 entitled as such to comply with this section, shall include at least the following elements
 70.6 in itself or through supporting documents or attachments:

70.7 (1) the name, street address, and mailing address of the establishment;

70.8 (2) the name and mailing address of the owner or owners of the establishment and, if
 70.9 the owner or owners is not a natural person, identification of the type of business entity
 70.10 of the owner or owners;

70.11 (3) the name and mailing address of the managing agent, through management
 70.12 agreement or lease agreement, of the establishment, if different from the owner or owners;

70.13 (4) the name and address of at least one natural person who is authorized to accept
 70.14 service of process on behalf of the owner or owners and managing agent;

70.15 (5) a statement describing the registration and licensure status of the establishment
 70.16 and any provider providing health-related or supportive services under an arrangement
 70.17 with the establishment;

70.18 (6) the term of the contract;

70.19 (7) a description of the services to be provided to the resident in the base rate to be
 70.20 paid by resident, including a delineation of the portion of the base rate that constitutes rent
 70.21 and a delineation of charges for each service included in the base rate;

70.22 (8) a description of any additional services, including home care services, available
 70.23 for an additional fee from the establishment directly or through arrangements with the
 70.24 establishment, and a schedule of fees charged for these services;

70.25 (9) a description of the process through which the contract may be modified,
 70.26 amended, or terminated, including whether a move to a different room or sharing a room
 70.27 would be required in the event that the tenant can no longer pay the current rent;

70.28 (10) a description of the establishment's complaint resolution process available
 70.29 to residents including the toll-free complaint line for the Office of Ombudsman for
 70.30 Long-Term Care;

70.31 (11) the resident's designated representative, if any;

70.32 (12) the establishment's referral procedures if the contract is terminated;

70.33 (13) requirements of residency used by the establishment to determine who may
 70.34 reside or continue to reside in the housing with services establishment;

70.35 (14) billing and payment procedures and requirements;

71.1 (15) a statement regarding the ability of residents to receive services from service
71.2 providers with whom the establishment does not have an arrangement;

71.3 (16) a statement regarding the availability of public funds for payment for residence
71.4 or services in the establishment; and

71.5 (17) a statement regarding the availability of and contact information for
71.6 long-term care consultation services under section 256B.0911 in the county in which the
71.7 establishment is located.

71.8 Sec. 5. Minnesota Statutes 2010, section 245A.03, is amended by adding a subdivision
71.9 to read:

71.10 **Subd. 6a. Adult foster care homes serving people with mental illness;**
71.11 **certification.** (a) The commissioner of human services shall issue a mental health
71.12 certification for adult foster care homes licensed under this chapter and Minnesota Rules,
71.13 parts 9555.5105 to 9555.6265, that serve people with mental illness where the home is not
71.14 the primary residence of the license holder when a provider is determined to have met
71.15 the requirements under paragraph (b). This certification is voluntary for license holders.
71.16 The certification shall be printed on the license, and identified on the commissioner's
71.17 public Web site.

71.18 (b) The requirements for certification are:

71.19 (1) all staff working in the adult foster care home have received at least seven hours
71.20 of annual training covering all of the following topics:

71.21 (i) mental health diagnoses;

71.22 (ii) mental health crisis response and de-escalation techniques;

71.23 (iii) recovery from mental illness;

71.24 (iv) treatment options including evidence-based practices;

71.25 (v) medications and their side effects;

71.26 (vi) co-occurring substance abuse and health conditions; and

71.27 (vii) community resources;

71.28 (2) a mental health professional, as defined in section 245.462, subdivision 18, or
71.29 a mental health practitioner as defined in section 245.462, subdivision 17, are available
71.30 for consultation and assistance;

71.31 (3) there is a plan and protocol in place to address a mental health crisis; and

71.32 (4) each individual's Individual Placement Agreement identifies who is providing
71.33 clinical services and their contact information, and includes an individual crisis prevention
71.34 and management plan developed with the individual.

72.1 (c) License holders seeking certification under this subdivision must request this
 72.2 certification on forms provided by the commissioner and must submit the request to the
 72.3 county licensing agency in which the home is located. The county licensing agency must
 72.4 forward the request to the commissioner with a county recommendation regarding whether
 72.5 the commissioner should issue the certification.

72.6 (d) Ongoing compliance with the certification requirements under paragraph (b)
 72.7 shall be reviewed by the county licensing agency at each licensing review. When a county
 72.8 licensing agency determines that the requirements of paragraph (b) are not met, the county
 72.9 shall inform the commissioner, and the commissioner will remove the certification.

72.10 (e) A denial of the certification or the removal of the certification based on a
 72.11 determination that the requirements under paragraph (b) have not been met by the adult
 72.12 foster care license holder are not subject to appeal. A license holder that has been denied a
 72.13 certification or that has had a certification removed may again request certification when
 72.14 the license holder is in compliance with the requirements of paragraph (b).

72.15 Sec. 6. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is
 72.16 amended to read:

72.17 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
 72.18 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
 72.19 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
 72.20 9555.6265, under this chapter for a physical location that will not be the primary residence
 72.21 of the license holder for the entire period of licensure. If a license is issued during this
 72.22 moratorium, and the license holder changes the license holder's primary residence away
 72.23 from the physical location of the foster care license, the commissioner shall revoke the
 72.24 license according to section 245A.07. Exceptions to the moratorium include:

72.25 (1) foster care settings that are required to be registered under chapter 144D;

72.26 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
 72.27 and determined to be needed by the commissioner under paragraph (b);

72.28 (3) new foster care licenses determined to be needed by the commissioner under
 72.29 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or
 72.30 restructuring of state-operated services that limits the capacity of state-operated facilities;

72.31 (4) new foster care licenses determined to be needed by the commissioner under
 72.32 paragraph (b) for persons requiring hospital level care; or

72.33 (5) new foster care licenses determined to be needed by the commissioner for the
 72.34 transition of people from personal care assistance to the home and community-based
 72.35 services.

73.1 (b) The commissioner shall determine the need for newly licensed foster care homes
73.2 as defined under this subdivision. As part of the determination, the commissioner shall
73.3 consider the availability of foster care capacity in the area in which the licensee seeks to
73.4 operate, and the recommendation of the local county board. The determination by the
73.5 commissioner must be final. A determination of need is not required for a change in
73.6 ownership at the same address.

73.7 (c) Residential settings that would otherwise be subject to the moratorium established
73.8 in paragraph (a), that are in the process of receiving an adult or child foster care license as
73.9 of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult
73.10 or child foster care license. For this paragraph, all of the following conditions must be met
73.11 to be considered in the process of receiving an adult or child foster care license:

73.12 (1) participants have made decisions to move into the residential setting, including
73.13 documentation in each participant's care plan;

73.14 (2) the provider has purchased housing or has made a financial investment in the
73.15 property;

73.16 (3) the lead agency has approved the plans, including costs for the residential setting
73.17 for each individual;

73.18 (4) the completion of the licensing process, including all necessary inspections, is
73.19 the only remaining component prior to being able to provide services; and

73.20 (5) the needs of the individuals cannot be met within the existing capacity in that
73.21 county.

73.22 To qualify for the process under this paragraph, the lead agency must submit
73.23 documentation to the commissioner by August 1, 2009, that all of the above criteria are
73.24 met.

73.25 (d) The commissioner shall study the effects of the license moratorium under this
73.26 subdivision and shall report back to the legislature by January 15, 2011. This study shall
73.27 include, but is not limited to the following:

73.28 (1) the overall capacity and utilization of foster care beds where the physical location
73.29 is not the primary residence of the license holder prior to and after implementation
73.30 of the moratorium;

73.31 (2) the overall capacity and utilization of foster care beds where the physical
73.32 location is the primary residence of the license holder prior to and after implementation
73.33 of the moratorium; and

73.34 (3) the number of licensed and occupied ICF/MR beds prior to and after
73.35 implementation of the moratorium.

74.1 (e) When a foster care recipient moves out of a foster home that is not the primary
74.2 residence of the license holder according to section 256B.49, subdivision 15, paragraph
74.3 (f), the county shall immediately inform the Department of Human Services Licensing
74.4 Division, ~~and~~. The department shall ~~immediately~~ decrease the statewide licensed
74.5 capacity for the home foster care settings where the physical location is not the primary
74.6 residence of the license holder, if the voluntary changes described in paragraph (g) are
74.7 not sufficient to meet the savings required by reductions in licensed bed capacity under
74.8 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
74.9 and maintain statewide long-term care residential services capacity within budgetary
74.10 limits. Implementation of the statewide licensed capacity reduction shall begin on July 1,
74.11 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs
74.12 determination process. Under this paragraph, the commissioner has the authority to reduce
74.13 unused licensed capacity of a current foster care program to accomplish the consolidation
74.14 or closure of settings. A decreased licensed capacity according to this paragraph is not
74.15 subject to appeal under this chapter.

74.16 (f) Residential settings that would otherwise be subject to the decreased license
74.17 capacity established in paragraph (e) shall be exempt under the following circumstances:

74.18 (1) until August 1, 2013, the license holder's beds occupied by residents whose
74.19 primary diagnosis is mental illness and the license holder is:

74.20 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
74.21 health services (ARMHS) as defined in section 256B.0623;

74.22 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
74.23 9520.0870;

74.24 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
74.25 9520.0870; or

74.26 (iv) a provider of intensive residential treatment services (IRTS) licensed under
74.27 Minnesota Rules, parts 9520.0500 to 9520.0670; or

74.28 (2) the license holder is certified under the requirements in subdivision 6a.

74.29 (g) A resource need determination process, managed at the state level, using the
74.30 available reports required by section 144A.351, and other data and information shall
74.31 be used to determine where the reduced capacity required under paragraph (e) will be
74.32 implemented. The commissioner shall consult with the stakeholders described in section
74.33 144A.351, and employ a variety of methods to improve the state's capacity to meet
74.34 long-term care service needs within budgetary limits, including seeking proposals from
74.35 service providers or lead agencies to change service type, capacity, or location to improve
74.36 services, increase the independence of residents, and better meet needs identified by the

75.1 long-term care services reports and statewide data and information. By February 1 of each
75.2 year, the commissioner shall provide information and data on the overall capacity of
75.3 licensed long-term care services, actions taken under this subdivision to manage statewide
75.4 long-term care services and supports resources, and any recommendations for change to
75.5 the legislative committees with jurisdiction over health and human services budget.

75.6 Sec. 7. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

75.7 Subd. 2a. **Adult foster care license capacity.** (a) The commissioner shall issue
75.8 adult foster care licenses with a maximum licensed capacity of four beds, including
75.9 nonstaff roomers and boarders, except that the commissioner may issue a license with a
75.10 capacity of five beds, including roomers and boarders, according to paragraphs (b) to (f).

75.11 (b) An adult foster care license holder may have a maximum license capacity of five
75.12 if all persons in care are age 55 or over and do not have a serious and persistent mental
75.13 illness or a developmental disability.

75.14 (c) The commissioner may grant variances to paragraph (b) to allow a foster care
75.15 provider with a licensed capacity of five persons to admit an individual under the age of 55
75.16 if the variance complies with section 245A.04, subdivision 9, and approval of the variance
75.17 is recommended by the county in which the licensed foster care provider is located.

75.18 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
75.19 bed for emergency crisis services for a person with serious and persistent mental illness
75.20 or a developmental disability, regardless of age, if the variance complies with section
75.21 245A.04, subdivision 9, and approval of the variance is recommended by the county in
75.22 which the licensed foster care provider is located.

75.23 (e) The commissioner may grant a variance to paragraph (b) to allow for the
75.24 use of a fifth bed for respite services, as defined in section 245A.02, for persons with
75.25 disabilities, regardless of age, if the variance complies with section 245A.03, subdivision
75.26 7, and section 245A.04, subdivision 9, and approval of the variance is recommended by
75.27 the county in which the licensed foster care provider is licensed. Respite care may be
75.28 provided under the following conditions:

75.29 (1) staffing ratios cannot be reduced below the approved level for the individuals
75.30 being served in the home on a permanent basis;

75.31 (2) no more than two different individuals can be accepted for respite services in
75.32 any calendar month and the total respite days may not exceed 120 days per program in
75.33 any calendar year;

76.1 (3) the person receiving respite services must have his or her own bedroom, which
 76.2 could be used for alternative purposes when not used as a respite bedroom, and cannot be
 76.3 the room of another person who lives in the foster care home; and

76.4 (4) individuals living in the foster care home must be notified when the variance
 76.5 is approved. The provider must give 60 days' notice in writing to the residents and their
 76.6 legal representatives prior to accepting the first respite placement. Notice must be given to
 76.7 residents at least two days prior to service initiation, or as soon as the license holder is
 76.8 able if they receive notice of the need for respite less than two days prior to initiation,
 76.9 each time a respite client will be served, unless the requirement for this notice is waived
 76.10 by the resident or legal guardian.

76.11 ~~(e) If the 2009 legislature adopts a rate reduction that impacts providers of adult~~
 76.12 ~~foster care services; (f) The commissioner may issue an adult foster care license with a~~
 76.13 ~~capacity of five adults if the fifth bed does not increase the overall statewide capacity of~~
 76.14 ~~licensed adult foster care beds in homes that are not the primary residence of the license~~
 76.15 ~~holder, over the licensed capacity in such homes on July 1, 2009, as identified in a plan~~
 76.16 ~~submitted to the commissioner by the county, when the capacity is recommended by~~
 76.17 ~~the county licensing agency of the county in which the facility is located and if the~~
 76.18 ~~recommendation verifies that:~~

76.19 (1) the facility meets the physical environment requirements in the adult foster
 76.20 care licensing rule;

76.21 (2) the five-bed living arrangement is specified for each resident in the resident's:

76.22 (i) individualized plan of care;

76.23 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

76.24 (iii) individual resident placement agreement under Minnesota Rules, part
 76.25 9555.5105, subpart 19, if required;

76.26 (3) the license holder obtains written and signed informed consent from each
 76.27 resident or resident's legal representative documenting the resident's informed choice
 76.28 to remain living in the home and that the resident's refusal to consent would not have
 76.29 resulted in service termination; and

76.30 (4) the facility was licensed for adult foster care before March 1, ~~2009~~ 2011.

76.31 ~~(f)~~ (g) The commissioner shall not issue a new adult foster care license under
 76.32 paragraph ~~(e)~~ (f) after June 30, ~~2011~~ 2016. The commissioner shall allow a facility with
 76.33 an adult foster care license issued under paragraph ~~(e)~~ (f) before June 30, ~~2011~~ 2016, to
 76.34 continue with a capacity of five adults if the license holder continues to comply with the
 76.35 requirements in paragraph ~~(e)~~ (f).

77.1 Sec. 8. Minnesota Statutes 2010, section 245A.11, subdivision 7, is amended to read:

77.2 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
77.3 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts
77.4 requiring a caregiver to be present in an adult foster care home during normal sleeping
77.5 hours to allow for alternative methods of overnight supervision. The commissioner may
77.6 grant the variance if the local county licensing agency recommends the variance and the
77.7 county recommendation includes documentation verifying that:

77.8 (1) the county has approved the license holder's plan for alternative methods of
77.9 providing overnight supervision and determined the plan protects the residents' health,
77.10 safety, and rights;

77.11 (2) the license holder has obtained written and signed informed consent from
77.12 each resident or each resident's legal representative documenting the resident's or legal
77.13 representative's agreement with the alternative method of overnight supervision; and

77.14 (3) the alternative method of providing overnight supervision, which may include
77.15 the use of technology, is specified for each resident in the resident's: (i) individualized
77.16 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
77.17 required; or (iii) individual resident placement agreement under Minnesota Rules, part
77.18 9555.5105, subpart 19, if required.

77.19 (b) To be eligible for a variance under paragraph (a), the adult foster care license
77.20 holder must not have had a ~~licensing action~~ conditional license issued under section
77.21 245A.06₂ or any other licensing sanction issued under section 245A.07 during the prior 24
77.22 months based on failure to provide adequate supervision, health care services, or resident
77.23 safety in the adult foster care home.

77.24 (c) A license holder requesting a variance under this subdivision to utilize
77.25 technology as a component of a plan for alternative overnight supervision may request
77.26 the commissioner's review in the absence of a county recommendation. Upon receipt of
77.27 such a request from a license holder, the commissioner shall review the variance request
77.28 with the county.

77.29 Sec. 9. Minnesota Statutes 2010, section 245A.11, subdivision 7a, is amended to read:

77.30 Subd. 7a. **Alternate overnight supervision technology; adult foster care license.**
77.31 (a) The commissioner may grant an applicant or license holder an adult foster care license
77.32 for a residence that does not have a caregiver in the residence during normal sleeping
77.33 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses
77.34 monitoring technology to alert the license holder when an incident occurs that may
77.35 jeopardize the health, safety, or rights of a foster care recipient. The applicant or license

78.1 holder must comply with all other requirements under Minnesota Rules, parts 9555.5105
78.2 to 9555.6265, and the requirements under this subdivision. The license printed by the
78.3 commissioner must state in bold and large font:

78.4 (1) that the facility is under electronic monitoring; and

78.5 (2) the telephone number of the county's common entry point for making reports of
78.6 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

78.7 (b) Applications for a license under this section must be submitted directly to
78.8 the Department of Human Services licensing division. The licensing division must
78.9 immediately notify the host county and lead county contract agency and the host county
78.10 licensing agency. The licensing division must collaborate with the county licensing
78.11 agency in the review of the application and the licensing of the program.

78.12 (c) Before a license is issued by the commissioner, and for the duration of the
78.13 license, the applicant or license holder must establish, maintain, and document the
78.14 implementation of written policies and procedures addressing the requirements in
78.15 paragraphs (d) through (f).

78.16 (d) The applicant or license holder must have policies and procedures that:

78.17 (1) establish characteristics of target populations that will be admitted into the home,
78.18 and characteristics of populations that will not be accepted into the home;

78.19 (2) explain the discharge process when a foster care recipient requires overnight
78.20 supervision or other services that cannot be provided by the license holder due to the
78.21 limited hours that the license holder is on site;

78.22 (3) describe the types of events to which the program will respond with a physical
78.23 presence when those events occur in the home during time when staff are not on site, and
78.24 how the license holder's response plan meets the requirements in paragraph (e), clause
78.25 (1) or (2);

78.26 (4) establish a process for documenting a review of the implementation and
78.27 effectiveness of the response protocol for the response required under paragraph (e),
78.28 clause (1) or (2). The documentation must include:

78.29 (i) a description of the triggering incident;

78.30 (ii) the date and time of the triggering incident;

78.31 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

78.32 (iv) whether the response met the resident's needs;

78.33 (v) whether the existing policies and response protocols were followed; and

78.34 (vi) whether the existing policies and protocols are adequate or need modification.

78.35 When no physical presence response is completed for a three-month period, the
78.36 license holder's written policies and procedures must require a physical presence response

79.1 drill to be conducted for which the effectiveness of the response protocol under paragraph
79.2 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

79.3 (5) establish that emergency and nonemergency phone numbers are posted in a
79.4 prominent location in a common area of the home where they can be easily observed by a
79.5 person responding to an incident who is not otherwise affiliated with the home.

79.6 (e) The license holder must document and include in the license application which
79.7 response alternative under clause (1) or (2) is in place for responding to situations that
79.8 present a serious risk to the health, safety, or rights of people receiving foster care services
79.9 in the home:

79.10 (1) response alternative (1) requires only the technology to provide an electronic
79.11 notification or alert to the license holder that an event is underway that requires a response.
79.12 Under this alternative, no more than ten minutes will pass before the license holder will be
79.13 physically present on site to respond to the situation; or

79.14 (2) response alternative (2) requires the electronic notification and alert system
79.15 under alternative (1), but more than ten minutes may pass before the license holder is
79.16 present on site to respond to the situation. Under alternative (2), all of the following
79.17 conditions are met:

79.18 (i) the license holder has a written description of the interactive technological
79.19 applications that will assist the license holder in communicating with and assessing the
79.20 needs related to the care, health, and safety of the foster care recipients. This interactive
79.21 technology must permit the license holder to remotely assess the well being of the foster
79.22 care recipient without requiring the initiation of the foster care recipient. Requiring the
79.23 foster care recipient to initiate a telephone call does not meet this requirement;

79.24 (ii) the license holder documents how the remote license holder is qualified and
79.25 capable of meeting the needs of the foster care recipients and assessing foster care
79.26 recipients' needs under item (i) during the absence of the license holder on site;

79.27 (iii) the license holder maintains written procedures to dispatch emergency response
79.28 personnel to the site in the event of an identified emergency; and

79.29 (iv) each foster care recipient's individualized plan of care, individual service plan
79.30 under section 256B.092, subdivision 1b, if required, or individual resident placement
79.31 agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the
79.32 maximum response time, which may be greater than ten minutes, for the license holder
79.33 to be on site for that foster care recipient.

79.34 (f) ~~Each foster care recipient's placement agreement, individual~~
79.35 ~~service agreements, and plans applicable to the foster care recipient agreement, and plan~~
79.36 must clearly state that the adult foster care license category is a program without the

80.1 presence of a caregiver in the residence during normal sleeping hours; the protocols in
80.2 place for responding to situations that present a serious risk to the health, safety, or rights
80.3 of foster care recipients under paragraph (e), clause (1) or (2); and a signed informed
80.4 consent from each foster care recipient or the person's legal representative documenting
80.5 the person's or legal representative's agreement with placement in the program. If
80.6 electronic monitoring technology is used in the home, the informed consent form must
80.7 also explain the following:

80.8 (1) how any electronic monitoring is incorporated into the alternative supervision
80.9 system;

80.10 (2) the backup system for any electronic monitoring in times of electrical outages or
80.11 other equipment malfunctions;

80.12 (3) how the ~~license holder is~~ caregivers are trained on the use of the technology;

80.13 (4) the event types and license holder response times established under paragraph (e);

80.14 (5) how the license holder protects the foster care recipient's privacy related to
80.15 electronic monitoring and related to any electronically recorded data generated by the
80.16 monitoring system. A foster care recipient may not be removed from a program under
80.17 this subdivision for failure to consent to electronic monitoring. The consent form must
80.18 explain where and how the electronically recorded data is stored, with whom it will be
80.19 shared, and how long it is retained; and

80.20 (6) the risks and benefits of the alternative overnight supervision system.

80.21 The written explanations under clauses (1) to (6) may be accomplished through
80.22 cross-references to other policies and procedures as long as they are explained to the
80.23 person giving consent, and the person giving consent is offered a copy.

80.24 (g) Nothing in this section requires the applicant or license holder to develop or
80.25 maintain separate or duplicative policies, procedures, documentation, consent forms, or
80.26 individual plans that may be required for other licensing standards, if the requirements of
80.27 this section are incorporated into those documents.

80.28 (h) The commissioner may grant variances to the requirements of this section
80.29 according to section 245A.04, subdivision 9.

80.30 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
80.31 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
80.32 contractors affiliated with the license holder.

80.33 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
80.34 remotely determine what action the license holder needs to take to protect the well-being
80.35 of the foster care recipient.

81.1 (k) The commissioner shall evaluate license applications using the requirements
81.2 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
81.3 including a checklist of criteria needed for approval.

81.4 (l) To be eligible for a license under paragraph (a), the adult foster care license holder
81.5 must not have had a conditional license issued under section 245A.06 or any licensing
81.6 sanction under section 245A.07 during the prior 24 months based on failure to provide
81.7 adequate supervision, health care services, or resident safety in the adult foster care home.

81.8 (m) The commissioner shall review an application for an alternative overnight
81.9 supervision license within 60 days of receipt of the application. When the commissioner
81.10 receives an application that is incomplete because the applicant failed to submit required
81.11 documents or that is substantially deficient because the documents submitted do not meet
81.12 licensing requirements, the commissioner shall provide the applicant written notice
81.13 that the application is incomplete or substantially deficient. In the written notice to the
81.14 applicant, the commissioner shall identify documents that are missing or deficient and
81.15 give the applicant 45 days to resubmit a second application that is substantially complete.
81.16 An applicant's failure to submit a substantially complete application after receiving
81.17 notice from the commissioner is a basis for license denial under section 245A.05. The
81.18 commissioner shall complete subsequent review within 30 days.

81.19 (n) Once the application is considered complete under paragraph (m), the
81.20 commissioner will approve or deny an application for an alternative overnight supervision
81.21 license within 60 days.

81.22 (o) For the purposes of this subdivision, "supervision" means:

81.23 (1) oversight by a caregiver as specified in the individual resident's place agreement
81.24 and awareness of the resident's needs and activities; and

81.25 (2) the presence of a caregiver in a residence during normal sleeping hours, unless a
81.26 determination has been made and documented in the individual's support plan that the
81.27 individual does not require the presence of a caregiver during normal sleeping hours.

81.28 Sec. 10. Minnesota Statutes 2010, section 245B.07, subdivision 1, is amended to read:

81.29 Subdivision 1. **Consumer data file.** The license holder must maintain the following
81.30 information for each consumer:

81.31 (1) identifying information that includes date of birth, medications, legal
81.32 representative, history, medical, and other individual-specific information, and names and
81.33 telephone numbers of contacts;

81.34 (2) consumer health information, including individual medication administration
81.35 and monitoring information;

82.1 (3) the consumer's individual service plan. When a consumer's case manager does
 82.2 not provide a current individual service plan, the license holder shall make a written
 82.3 request to the case manager to provide a copy of the individual service plan and inform
 82.4 the consumer or the consumer's legal representative of the right to an individual service
 82.5 plan and the right to appeal under section 256.045. In the event the case manager fails
 82.6 to provide an individual service plan after a written request from the license holder, the
 82.7 license holder shall not be sanctioned or penalized financially for not having a current
 82.8 individual service plan in the consumer's data file;

82.9 (4) copies of assessments, analyses, summaries, and recommendations;

82.10 (5) progress review reports;

82.11 (6) incidents involving the consumer;

82.12 (7) reports required under section 245B.05, subdivision 7;

82.13 (8) discharge summary, when applicable;

82.14 (9) record of other license holders serving the consumer that includes a contact
 82.15 person and telephone numbers, services being provided, services that require coordination
 82.16 between two license holders, and name of staff responsible for coordination;

82.17 (10) information about verbal aggression directed at the consumer by another
 82.18 consumer; and

82.19 (11) information about self-abuse.

82.20 Sec. 11. Minnesota Statutes 2010, section 245C.04, subdivision 6, is amended to read:

82.21 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
 82.22 **seniors and individuals with disabilities.** (a) Providers required to initiate background
 82.23 studies under section 256B.4912 must initiate a study before the individual begins in a
 82.24 position allowing direct contact with persons served by the provider.

82.25 (b) ~~The commissioner shall conduct~~ Except as provided in paragraph (c), the
 82.26 providers must initiate a background study annually of an individual required to be studied
 82.27 under section 245C.03, subdivision 6.

82.28 (c) After an initial background study under this subdivision is initiated on an
 82.29 individual by a provider of both services licensed by the commissioner and the unlicensed
 82.30 services under this subdivision, a repeat annual background study is not required if:

82.31 (1) the provider maintains compliance with the requirements of section 245C.07,
 82.32 paragraph (a), regarding one individual with one address and telephone number as the
 82.33 person to receive sensitive background study information for the multiple programs that
 82.34 depend on the same background study, and that the individual who is designated to receive
 82.35 the sensitive background information is capable of determining, upon the request of the

83.1 commissioner, whether a background study subject is providing direct contact services
83.2 in one or more of the provider's programs or services and, if so, at which location or
83.3 locations; and

83.4 (2) the individual who is the subject of the background study provides direct
83.5 contact services under the provider's licensed program for at least 40 hours per year so
83.6 the individual will be recognized by a probation officer or corrections agent to prompt
83.7 a report to the commissioner regarding criminal convictions as required under section
83.8 245C.05, subdivision 7.

83.9 Sec. 12. Minnesota Statutes 2010, section 245C.05, subdivision 7, is amended to read:

83.10 Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or
83.11 corrections agent shall notify the commissioner of an individual's conviction if the
83.12 individual ~~is~~:

83.13 (1) has been affiliated with a program or facility regulated by the Department of
83.14 Human Services or Department of Health, a facility serving children or youth licensed by
83.15 the Department of Corrections, or any type of home care agency or provider of personal
83.16 care assistance services within the preceding year; and

83.17 (2) has been convicted of a crime constituting a disqualification under section
83.18 245C.14.

83.19 (b) For the purpose of this subdivision, "conviction" has the meaning given it
83.20 in section 609.02, subdivision 5.

83.21 (c) The commissioner, in consultation with the commissioner of corrections, shall
83.22 develop forms and information necessary to implement this subdivision and shall provide
83.23 the forms and information to the commissioner of corrections for distribution to local
83.24 probation officers and corrections agents.

83.25 (d) The commissioner shall inform individuals subject to a background study that
83.26 criminal convictions for disqualifying crimes will be reported to the commissioner by the
83.27 corrections system.

83.28 (e) A probation officer, corrections agent, or corrections agency is not civilly or
83.29 criminally liable for disclosing or failing to disclose the information required by this
83.30 subdivision.

83.31 (f) Upon receipt of disqualifying information, the commissioner shall provide the
83.32 notice required under section 245C.17, as appropriate, to agencies on record as having
83.33 initiated a background study or making a request for documentation of the background
83.34 study status of the individual.

83.35 (g) This subdivision does not apply to family child care programs.

84.1 Sec. 13. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

84.2 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
84.3 child, including a child determined eligible for medical assistance without consideration of
84.4 parental income, must contribute to the cost of services used by making monthly payments
84.5 on a sliding scale based on income, unless the child is married or has been married,
84.6 parental rights have been terminated, or the child's adoption is subsidized according to
84.7 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
84.8 is a partial or full payment for medical services provided for diagnostic, therapeutic,
84.9 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
84.10 defined in United States Code, title 26, section 213, needed by the child with a chronic
84.11 illness or disability.

84.12 (b) For households with adjusted gross income equal to or greater than 100 percent
84.13 of federal poverty guidelines, the parental contribution shall be computed by applying the
84.14 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

84.15 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
84.16 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
84.17 contribution is \$4 per month;

84.18 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
84.19 poverty guidelines and less than or equal to 545 percent of federal poverty guidelines,
84.20 the parental contribution shall be determined using a sliding fee scale established by the
84.21 commissioner of human services which begins at one percent of adjusted gross income
84.22 at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted
84.23 gross income for those with adjusted gross income up to 545 percent of federal poverty
84.24 guidelines;

84.25 (3) if the adjusted gross income is greater than 545 percent of federal poverty
84.26 guidelines and less than 675 percent of federal poverty guidelines, the parental
84.27 contribution shall be 7.5 percent of adjusted gross income;

84.28 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
84.29 poverty guidelines and less than 975 percent of federal poverty guidelines, the parental
84.30 contribution shall be determined using a sliding fee scale established by the commissioner
84.31 of human services which begins at 7.5 percent of adjusted gross income at 675 percent of
84.32 federal poverty guidelines and increases to ten percent of adjusted gross income for those
84.33 with adjusted gross income up to 975 percent of federal poverty guidelines; and

84.34 (5) if the adjusted gross income is equal to or greater than 975 percent of federal
84.35 poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross
84.36 income.

85.1 If the child lives with the parent, the annual adjusted gross income is reduced by
85.2 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
85.3 specified in section 256B.35, the parent is responsible for the personal needs allowance
85.4 specified under that section in addition to the parental contribution determined under this
85.5 section. The parental contribution is reduced by any amount required to be paid directly to
85.6 the child pursuant to a court order, but only if actually paid.

85.7 (c) The household size to be used in determining the amount of contribution under
85.8 paragraph (b) includes natural and adoptive parents and their dependents, including the
85.9 child receiving services. Adjustments in the contribution amount due to annual changes
85.10 in the federal poverty guidelines shall be implemented on the first day of July following
85.11 publication of the changes.

85.12 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
85.13 natural or adoptive parents determined according to the previous year's federal tax form,
85.14 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
85.15 have been used to purchase a home shall not be counted as income.

85.16 (e) The contribution shall be explained in writing to the parents at the time eligibility
85.17 for services is being determined. The contribution shall be made on a monthly basis
85.18 effective with the first month in which the child receives services. Annually upon
85.19 redetermination or at termination of eligibility, if the contribution exceeded the cost of
85.20 services provided, the local agency or the state shall reimburse that excess amount to
85.21 the parents, either by direct reimbursement if the parent is no longer required to pay a
85.22 contribution, or by a reduction in or waiver of parental fees until the excess amount is
85.23 exhausted. All reimbursements must include a notice that the amount reimbursed may be
85.24 taxable income if the parent paid for the parent's fees through an employer's health care
85.25 flexible spending account under the Internal Revenue Code, section 125, and that the
85.26 parent is responsible for paying the taxes owed on the amount reimbursed.

85.27 (f) The monthly contribution amount must be reviewed at least every 12 months;
85.28 when there is a change in household size; and when there is a loss of or gain in income
85.29 from one month to another in excess of ten percent. The local agency shall mail a written
85.30 notice 30 days in advance of the effective date of a change in the contribution amount.
85.31 A decrease in the contribution amount is effective in the month that the parent verifies a
85.32 reduction in income or change in household size.

85.33 (g) Parents of a minor child who do not live with each other shall each pay the
85.34 contribution required under paragraph (a). An amount equal to the annual court-ordered
85.35 child support payment actually paid on behalf of the child receiving services shall be

86.1 deducted from the adjusted gross income of the parent making the payment prior to
86.2 calculating the parental contribution under paragraph (b).

86.3 (h) The contribution under paragraph (b) shall be increased by an additional five
86.4 percent if the local agency determines that insurance coverage is available but not
86.5 obtained for the child. For purposes of this section, "available" means the insurance is a
86.6 benefit of employment for a family member at an annual cost of no more than five percent
86.7 of the family's annual income. For purposes of this section, "insurance" means health
86.8 and accident insurance coverage, enrollment in a nonprofit health service plan, health
86.9 maintenance organization, self-insured plan, or preferred provider organization.

86.10 Parents who have more than one child receiving services shall not be required
86.11 to pay more than the amount for the child with the highest expenditures. There shall
86.12 be no resource contribution from the parents. The parent shall not be required to pay
86.13 a contribution in excess of the cost of the services provided to the child, not counting
86.14 payments made to school districts for education-related services. Notice of an increase in
86.15 fee payment must be given at least 30 days before the increased fee is due.

86.16 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
86.17 in the 12 months prior to July 1:

86.18 (1) the parent applied for insurance for the child;

86.19 (2) the insurer denied insurance;

86.20 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
86.21 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
86.22 commerce, or litigated the complaint or appeal; and

86.23 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

86.24 For purposes of this section, "insurance" has the meaning given in paragraph (h).

86.25 A parent who has requested a reduction in the contribution amount under this
86.26 paragraph shall submit proof in the form and manner prescribed by the commissioner or
86.27 county agency, including, but not limited to, the insurer's denial of insurance, the written
86.28 letter or complaint of the parents, court documents, and the written response of the insurer
86.29 approving insurance. The determinations of the commissioner or county agency under this
86.30 paragraph are not rules subject to chapter 14.

86.31 (j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, ~~2013~~
86.32 2015, the parental contribution shall be computed by applying the following contribution
86.33 schedule to the adjusted gross income of the natural or adoptive parents:

86.34 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
86.35 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
86.36 contribution is \$4 per month;

87.1 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
87.2 poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,
87.3 the parental contribution shall be determined using a sliding fee scale established by the
87.4 commissioner of human services which begins at one percent of adjusted gross income
87.5 at 175 percent of federal poverty guidelines and increases to eight percent of adjusted
87.6 gross income for those with adjusted gross income up to 525 percent of federal poverty
87.7 guidelines;

87.8 (3) if the adjusted gross income is greater than 525 percent of federal poverty
87.9 guidelines and less than 675 percent of federal poverty guidelines, the parental
87.10 contribution shall be 9.5 percent of adjusted gross income;

87.11 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
87.12 poverty guidelines and less than 900 percent of federal poverty guidelines, the parental
87.13 contribution shall be determined using a sliding fee scale established by the commissioner
87.14 of human services which begins at 9.5 percent of adjusted gross income at 675 percent of
87.15 federal poverty guidelines and increases to 12 percent of adjusted gross income for those
87.16 with adjusted gross income up to 900 percent of federal poverty guidelines; and

87.17 (5) if the adjusted gross income is equal to or greater than 900 percent of federal
87.18 poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross
87.19 income. If the child lives with the parent, the annual adjusted gross income is reduced by
87.20 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
87.21 specified in section 256B.35, the parent is responsible for the personal needs allowance
87.22 specified under that section in addition to the parental contribution determined under this
87.23 section. The parental contribution is reduced by any amount required to be paid directly to
87.24 the child pursuant to a court order, but only if actually paid.

87.25 Sec. 14. Minnesota Statutes 2010, section 256.975, subdivision 7, is amended to read:

87.26 Subd. 7. **Consumer information and assistance and long-term care options**
87.27 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
87.28 statewide service to aid older Minnesotans and their families in making informed choices
87.29 about long-term care options and health care benefits. Language services to persons with
87.30 limited English language skills may be made available. The service, known as Senior
87.31 LinkAge Line, must be available during business hours through a statewide toll-free
87.32 number and must also be available through the Internet.

87.33 (b) The service must provide long-term care options counseling by assisting older
87.34 adults, caregivers, and providers in accessing information and options counseling about

88.1 choices in long-term care services that are purchased through private providers or available
88.2 through public options. The service must:

88.3 (1) develop a comprehensive database that includes detailed listings in both
88.4 consumer- and provider-oriented formats;

88.5 (2) make the database accessible on the Internet and through other telecommunication
88.6 and media-related tools;

88.7 (3) link callers to interactive long-term care screening tools and make these tools
88.8 available through the Internet by integrating the tools with the database;

88.9 (4) develop community education materials with a focus on planning for long-term
88.10 care and evaluating independent living, housing, and service options;

88.11 (5) conduct an outreach campaign to assist older adults and their caregivers in
88.12 finding information on the Internet and through other means of communication;

88.13 (6) implement a messaging system for overflow callers and respond to these callers
88.14 by the next business day;

88.15 (7) link callers with county human services and other providers to receive more
88.16 in-depth assistance and consultation related to long-term care options;

88.17 (8) link callers with quality profiles for nursing facilities and other providers
88.18 developed by the commissioner of health;

88.19 (9) incorporate information about the availability of housing options, as well as
88.20 registered housing with services and consumer rights within the MinnesotaHelp.info
88.21 network long-term care database to facilitate consumer comparison of services and costs
88.22 among housing with services establishments and with other in-home services and to
88.23 support financial self-sufficiency as long as possible. Housing with services establishments
88.24 and their arranged home care providers shall provide information that will facilitate price
88.25 comparisons, including delineation of charges for rent and for services available. The
88.26 commissioners of health and human services shall align the data elements required by
88.27 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
88.28 consumers standardized information and ease of comparison of long-term care options.
88.29 The commissioner of human services shall provide the data to the Minnesota Board on
88.30 Aging for inclusion in the MinnesotaHelp.info network long-term care database;

88.31 (10) provide long-term care options counseling. Long-term care options counselors
88.32 shall:

88.33 (i) for individuals not eligible for case management under a public program or public
88.34 funding source, provide interactive decision support under which consumers, family
88.35 members, or other helpers are supported in their deliberations to determine appropriate

89.1 long-term care choices in the context of the consumer's needs, preferences, values, and
89.2 individual circumstances, including implementing a community support plan;

89.3 (ii) provide Web-based educational information and collateral written materials to
89.4 familiarize consumers, family members, or other helpers with the long-term care basics,
89.5 issues to be considered, and the range of options available in the community;

89.6 (iii) provide long-term care futures planning, which means providing assistance to
89.7 individuals who anticipate having long-term care needs to develop a plan for the more
89.8 distant future; and

89.9 (iv) provide expertise in benefits and financing options for long-term care, including
89.10 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
89.11 private pay options, and ways to access low or no-cost services or benefits through
89.12 volunteer-based or charitable programs; ~~and~~

89.13 (11) using risk management and support planning protocols, provide long-term care
89.14 options counseling to current residents of nursing homes deemed appropriate for discharge
89.15 by the commissioner. In order to meet this requirement, the commissioner shall provide
89.16 designated Senior LinkAge Line contact centers with a list of nursing home residents
89.17 appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall
89.18 provide these residents, if they indicate a preference to receive long-term care options
89.19 counseling, with initial assessment, review of risk factors, independent living support
89.20 consultation, or referral to:

89.21 (i) long-term care consultation services under section 256B.0911;

89.22 (ii) designated care coordinators of contracted entities under section 256B.035 for
89.23 persons who are enrolled in a managed care plan; or

89.24 (iii) the long-term care consultation team for those who are appropriate for relocation
89.25 service coordination due to high-risk factors or psychological or physical disability; and

89.26 (12) develop referral protocols and processes that will assist certified health care
89.27 homes and hospitals to identify at-risk older adults and determine when to refer these
89.28 individuals to the Senior LinkAge Line for long-term care options counseling under this
89.29 section. The commissioner is directed to work with the commissioner of health to develop
89.30 protocols that would comply with the health care home designation criteria and protocols
89.31 available at the time of hospital discharge. The commissioner shall keep a record of the
89.32 number of people who choose long-term care options counseling as a result of this section.

89.33 Sec. 15. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to
89.34 read:

90.1 Subd. 1a. **Income and assets generally.** Unless specifically required by state
90.2 law or rule or federal law or regulation, the methodologies used in counting income
90.3 and assets to determine eligibility for medical assistance for persons whose eligibility
90.4 category is based on blindness, disability, or age of 65 or more years, the methodologies
90.5 for the supplemental security income program shall be used, except as provided under
90.6 subdivision 3, paragraph (a), clause (6). Increases in benefits under title II of the Social
90.7 Security Act shall not be counted as income for purposes of this subdivision until July 1 of
90.8 each year. Effective upon federal approval, for children eligible under section 256B.055,
90.9 subdivision 12, or for home and community-based waiver services whose eligibility
90.10 for medical assistance is determined without regard to parental income, child support
90.11 payments, including any payments made by an obligor in satisfaction of or in addition
90.12 to a temporary or permanent order for child support, and Social Security payments are
90.13 not counted as income. For families and children, which includes all other eligibility
90.14 categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as
90.15 required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996
90.16 (PRWORA), Public Law 104-193, shall be used, except that effective October 1, 2003, the
90.17 earned income disregards and deductions are limited to those in subdivision 1c. For these
90.18 purposes, a "methodology" does not include an asset or income standard, or accounting
90.19 method, or method of determining effective dates.

90.20 **EFFECTIVE DATE.** This section is effective April 1, 2012.

90.21 Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3,
90.22 is amended to read:

90.23 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
90.24 medical assistance, a person must not individually own more than \$3,000 in assets, or if a
90.25 member of a household with two family members, husband and wife, or parent and child,
90.26 the household must not own more than \$6,000 in assets, plus \$200 for each additional
90.27 legal dependent. In addition to these maximum amounts, an eligible individual or family
90.28 may accrue interest on these amounts, but they must be reduced to the maximum at the
90.29 time of an eligibility redetermination. The accumulation of the clothing and personal
90.30 needs allowance according to section 256B.35 must also be reduced to the maximum at
90.31 the time of the eligibility redetermination. The value of assets that are not considered in
90.32 determining eligibility for medical assistance is the value of those assets excluded under
90.33 the supplemental security income program for aged, blind, and disabled persons, with
90.34 the following exceptions:

90.35 (1) household goods and personal effects are not considered;

91.1 (2) capital and operating assets of a trade or business that the local agency determines
 91.2 are necessary to the person's ability to earn an income are not considered;

91.3 (3) motor vehicles are excluded to the same extent excluded by the supplemental
 91.4 security income program;

91.5 (4) assets designated as burial expenses are excluded to the same extent excluded by
 91.6 the supplemental security income program. Burial expenses funded by annuity contracts
 91.7 or life insurance policies must irrevocably designate the individual's estate as contingent
 91.8 beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

91.9 (5) for a person who no longer qualifies as an employed person with a disability due
 91.10 to loss of earnings, assets allowed while eligible for medical assistance under section
 91.11 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
 91.12 of ineligibility as an employed person with a disability, to the extent that the person's total
 91.13 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph
 91.14 (d); ~~and~~

91.15 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
 91.16 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
 91.17 before the person's 65th birthday, the assets owned by the person and the person's spouse
 91.18 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
 91.19 when determining eligibility for medical assistance under section 256B.055, subdivision
 91.20 7. The income of a spouse of a person enrolled in medical assistance under section
 91.21 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
 91.22 65th birthday must be disregarded when determining eligibility for medical assistance
 91.23 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
 91.24 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
 91.25 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
 91.26 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

91.27 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
 91.28 15.

91.29 **EFFECTIVE DATE.** This section is effective April 1, 2012.

91.30 Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9,
 91.31 is amended to read:

91.32 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
 91.33 for a person who is employed and who:

91.34 (1) but for excess earnings or assets, meets the definition of disabled under the
 91.35 Supplemental Security Income program;

92.1 (2) ~~is at least 16 but less than 65 years of age;~~

92.2 ~~(3)~~ meets the asset limits in paragraph (d); and

92.3 ~~(4)~~ (3) pays a premium and other obligations under paragraph (e).

92.4 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
92.5 for medical assistance under this subdivision, a person must have more than \$65 of earned
92.6 income. Earned income must have Medicare, Social Security, and applicable state and
92.7 federal taxes withheld. The person must document earned income tax withholding. Any
92.8 spousal income or assets shall be disregarded for purposes of eligibility and premium
92.9 determinations.

92.10 (c) After the month of enrollment, a person enrolled in medical assistance under
92.11 this subdivision who:

92.12 (1) is temporarily unable to work and without receipt of earned income due to a
92.13 medical condition, as verified by a physician; or

92.14 (2) loses employment for reasons not attributable to the enrollee, and is without
92.15 receipt of earned income may retain eligibility for up to four consecutive months after the
92.16 month of job loss. To receive a four-month extension, enrollees must verify the medical
92.17 condition or provide notification of job loss. All other eligibility requirements must be met
92.18 and the enrollee must pay all calculated premium costs for continued eligibility.

92.19 (d) For purposes of determining eligibility under this subdivision, a person's assets
92.20 must not exceed \$20,000, excluding:

92.21 (1) all assets excluded under section 256B.056;

92.22 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
92.23 Keogh plans, and pension plans;

92.24 (3) medical expense accounts set up through the person's employer; and

92.25 (4) spousal assets, including spouse's share of jointly held assets.

92.26 (e) All enrollees must pay a premium to be eligible for medical assistance under this
92.27 subdivision, except as provided under section 256.01, subdivision 18b.

92.28 (1) An enrollee must pay the greater of a \$65 premium or the premium calculated
92.29 based on the person's gross earned and unearned income and the applicable family size
92.30 using a sliding fee scale established by the commissioner, which begins at one percent of
92.31 income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of
92.32 income for those with incomes at or above 300 percent of the federal poverty guidelines.

92.33 (2) Annual adjustments in the premium schedule based upon changes in the federal
92.34 poverty guidelines shall be effective for premiums due in July of each year.

93.1 (3) All enrollees who receive unearned income must pay five percent of unearned
93.2 income in addition to the premium amount, except as provided under section 256.01,
93.3 subdivision 18b.

93.4 (4) Increases in benefits under title II of the Social Security Act shall not be counted
93.5 as income for purposes of this subdivision until July 1 of each year.

93.6 (f) A person's eligibility and premium shall be determined by the local county
93.7 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
93.8 the commissioner.

93.9 (g) Any required premium shall be determined at application and redetermined at
93.10 the enrollee's six-month income review or when a change in income or household size is
93.11 reported. Enrollees must report any change in income or household size within ten days
93.12 of when the change occurs. A decreased premium resulting from a reported change in
93.13 income or household size shall be effective the first day of the next available billing month
93.14 after the change is reported. Except for changes occurring from annual cost-of-living
93.15 increases, a change resulting in an increased premium shall not affect the premium amount
93.16 until the next six-month review.

93.17 (h) Premium payment is due upon notification from the commissioner of the
93.18 premium amount required. Premiums may be paid in installments at the discretion of
93.19 the commissioner.

93.20 (i) Nonpayment of the premium shall result in denial or termination of medical
93.21 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
93.22 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
93.23 D, are met. Except when an installment agreement is accepted by the commissioner,
93.24 all persons disenrolled for nonpayment of a premium must pay any past due premiums
93.25 as well as current premiums due prior to being reenrolled. Nonpayment shall include
93.26 payment with a returned, refused, or dishonored instrument. The commissioner may
93.27 require a guaranteed form of payment as the only means to replace a returned, refused,
93.28 or dishonored instrument.

93.29 (j) The commissioner shall notify enrollees annually beginning at least 24 months
93.30 before the person's 65th birthday of the medical assistance eligibility rules affecting
93.31 income, assets, and treatment of a spouse's income and assets that will be applied upon
93.32 reaching age 65.

93.33 (k) For enrollees whose income does not exceed 200 percent of the federal poverty
93.34 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
93.35 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
93.36 paragraph (a).

94.1 **EFFECTIVE DATE.** This section is effective April 1, 2012.

94.2 Sec. 18. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 11,
94.3 is amended to read:

94.4 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
94.5 must meet the following requirements:

94.6 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
94.7 of age with these additional requirements:

94.8 (i) supervision by a qualified professional every 60 days; and

94.9 (ii) employment by only one personal care assistance provider agency responsible
94.10 for compliance with current labor laws;

94.11 (2) be employed by a personal care assistance provider agency;

94.12 (3) enroll with the department as a personal care assistant after clearing a background
94.13 study. Except as provided in subdivision 11a, before a personal care assistant provides
94.14 services, the personal care assistance provider agency must initiate a background study on
94.15 the personal care assistant under chapter 245C, and the personal care assistance provider
94.16 agency must have received a notice from the commissioner that the personal care assistant
94.17 is:

94.18 (i) not disqualified under section 245C.14; or

94.19 (ii) is disqualified, but the personal care assistant has received a set aside of the
94.20 disqualification under section 245C.22;

94.21 (4) be able to effectively communicate with the recipient and personal care
94.22 assistance provider agency;

94.23 (5) be able to provide covered personal care assistance services according to the
94.24 recipient's personal care assistance care plan, respond appropriately to recipient needs,
94.25 and report changes in the recipient's condition to the supervising qualified professional
94.26 or physician;

94.27 (6) not be a consumer of personal care assistance services;

94.28 (7) maintain daily written records including, but not limited to, time sheets under
94.29 subdivision 12;

94.30 (8) effective January 1, 2010, complete standardized training as determined
94.31 by the commissioner before completing enrollment. The training must be available
94.32 in languages other than English and to those who need accommodations due to
94.33 disabilities. Personal care assistant training must include successful completion of the
94.34 following training components: basic first aid, vulnerable adult, child maltreatment,
94.35 OSHA universal precautions, basic roles and responsibilities of personal care assistants

95.1 including information about assistance with lifting and transfers for recipients, emergency
95.2 preparedness, orientation to positive behavioral practices, fraud issues, and completion of
95.3 time sheets. Upon completion of the training components, the personal care assistant must
95.4 demonstrate the competency to provide assistance to recipients;

95.5 (9) complete training and orientation on the needs of the recipient within the first
95.6 seven days after the services begin; and

95.7 (10) be limited to providing and being paid for up to 275 hours per month, except
95.8 that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,
95.9 2011, of personal care assistance services regardless of the number of recipients being
95.10 served or the number of personal care assistance provider agencies enrolled with. The
95.11 number of hours worked per day shall not be disallowed by the department unless in
95.12 violation of the law.

95.13 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
95.14 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

95.15 (c) Persons who do not qualify as a personal care assistant include parents and
95.16 stepparents of minors, spouses, paid legal guardians, family foster care providers, except
95.17 as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential
95.18 setting. When the personal care assistant is a relative of the recipient, the commissioner
95.19 shall pay 80 percent of the provider rate. This rate reduction is effective July 1, 2013. For
95.20 purposes of this section, relative means the parent or adoptive parent of an adult child, a
95.21 sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

95.22 Sec. 19. Minnesota Statutes 2010, section 256B.0659, is amended by adding a
95.23 subdivision to read:

95.24 Subd. 31. **Commissioner's access.** When the commissioner is investigating a
95.25 possible overpayment of Medicaid funds, the commissioner must be given immediate
95.26 access without prior notice to the office during regular business hours and to
95.27 documentation and records related to services provided and submission of claims for
95.28 services provided. Denying the commissioner access to records is cause for immediate
95.29 suspension of payment and/or terminating the personal care provider organization's
95.30 enrollment according to section 256B.064.

95.31 Sec. 20. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a,
95.32 is amended to read:

95.33 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
95.34 services planning, or other assistance intended to support community-based living,

96.1 including persons who need assessment in order to determine waiver or alternative care
96.2 program eligibility, must be visited by a long-term care consultation team within 15
96.3 calendar days after the date on which an assessment was requested or recommended. After
96.4 January 1, 2011, these requirements also apply to personal care assistance services, private
96.5 duty nursing, and home health agency services, on timelines established in subdivision 5.
96.6 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

96.7 (b) The county may utilize a team of either the social worker or public health nurse,
96.8 or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the
96.9 assessment in a face-to-face interview. The consultation team members must confer
96.10 regarding the most appropriate care for each individual screened or assessed.

96.11 (c) The assessment must be comprehensive and include a person-centered
96.12 assessment of the health, psychological, functional, environmental, and social needs of
96.13 referred individuals and provide information necessary to develop a support plan that
96.14 meets the consumers needs, using an assessment form provided by the commissioner.

96.15 (d) The assessment must be conducted in a face-to-face interview with the person
96.16 being assessed and the person's legal representative, as required by legally executed
96.17 documents, and other individuals as requested by the person, who can provide information
96.18 on the needs, strengths, and preferences of the person necessary to develop a support plan
96.19 that ensures the person's health and safety, but who is not a provider of service or has any
96.20 financial interest in the provision of services. For persons who are to be assessed for
96.21 elderly waiver customized living services under section 256B.0915, with the permission
96.22 of the person being assessed or the person's designated or legal representative, the client's
96.23 current or proposed provider of services may submit a copy of the provider's nursing
96.24 assessment or written report outlining their recommendations regarding the client's care
96.25 needs. The person conducting the assessment will notify the provider of the date by which
96.26 this information is to be submitted. This information shall be provided to the person
96.27 conducting the assessment prior to the assessment.

96.28 (e) The person, or the person's legal representative, must be provided with written
96.29 recommendations for community-based services, including consumer-directed options,
96.30 or institutional care that include documentation that the most cost-effective alternatives
96.31 available were offered to the individual, and alternatives to residential settings, including,
96.32 but not limited to, foster care settings that are not the primary residence of the license
96.33 holder. For purposes of this requirement, "cost-effective alternatives" means community
96.34 services and living arrangements that cost the same as or less than institutional care.

96.35 (f) If the person chooses to use community-based services, the person or the person's
96.36 legal representative must be provided with a written community support plan, regardless

97.1 of whether the individual is eligible for Minnesota health care programs. A person may
97.2 request assistance in identifying community supports without participating in a complete
97.3 assessment. Upon a request for assistance identifying community support, the person must
97.4 be transferred or referred to the services available under sections 256.975, subdivision 7,
97.5 and 256.01, subdivision 24, for telephone assistance and follow up.

97.6 (g) The person has the right to make the final decision between institutional
97.7 placement and community placement after the recommendations have been provided,
97.8 except as provided in subdivision 4a, paragraph (c).

97.9 (h) The team must give the person receiving assessment or support planning, or
97.10 the person's legal representative, materials, and forms supplied by the commissioner
97.11 containing the following information:

97.12 (1) the need for and purpose of preadmission screening if the person selects nursing
97.13 facility placement;

97.14 (2) the role of the long-term care consultation assessment and support planning in
97.15 waiver and alternative care program eligibility determination;

97.16 (3) information about Minnesota health care programs;

97.17 (4) the person's freedom to accept or reject the recommendations of the team;

97.18 (5) the person's right to confidentiality under the Minnesota Government Data
97.19 Practices Act, chapter 13;

97.20 (6) the long-term care consultant's decision regarding the person's need for
97.21 institutional level of care as determined under criteria established in section 144.0724,
97.22 subdivision 11, or 256B.092; and

97.23 (7) the person's right to appeal the decision regarding the need for nursing facility
97.24 level of care or the county's final decisions regarding public programs eligibility according
97.25 to section 256.045, subdivision 3.

97.26 (i) Face-to-face assessment completed as part of eligibility determination for
97.27 the alternative care, elderly waiver, community alternatives for disabled individuals,
97.28 community alternative care, and traumatic brain injury waiver programs under sections
97.29 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
97.30 than 60 calendar days after the date of assessment. The effective eligibility start date
97.31 for these programs can never be prior to the date of assessment. If an assessment was
97.32 completed more than 60 days before the effective waiver or alternative care program
97.33 eligibility start date, assessment and support plan information must be updated in a
97.34 face-to-face visit and documented in the department's Medicaid Management Information
97.35 System (MMIS). The effective date of program eligibility in this case cannot be prior to
97.36 the date the updated assessment is completed.

98.1 Sec. 21. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3c,
98.2 is amended to read:

98.3 Subd. 3c. **Consultation for housing with services.** (a) The purpose of long-term
98.4 care consultation for registered housing with services is to support persons with current or
98.5 anticipated long-term care needs in making informed choices among options that include
98.6 the most cost-effective and least restrictive settings. Prospective residents maintain the
98.7 right to choose housing with services or assisted living if that option is their preference.

98.8 (b) Registered housing with services establishments shall inform all prospective
98.9 residents or the prospective resident's designated or legal representative of the availability
98.10 of long-term care consultation and the need to receive and verify the consultation prior
98.11 to signing a lease or contract. Long-term care consultation for registered housing with
98.12 services is provided as determined by the commissioner of human services. The service
98.13 is delivered under a partnership between lead agencies as defined in subdivision 1a,
98.14 paragraph (d), and the Area Agencies on Aging, and is a point of entry to a combination
98.15 of telephone-based long-term care options counseling provided by Senior LinkAge Line
98.16 and in-person long-term care consultation provided by lead agencies. The point of entry
98.17 service must be provided within five working days of the request of the prospective
98.18 resident as follows:

98.19 (1) the consultation shall be conducted with the prospective resident, or in the
98.20 alternative, the resident's designated or legal representative, if:

98.21 (i) the resident verbally requests; or

98.22 (ii) the registered housing with services provider has documentation of the
98.23 designated or legal representative's authority to enter into a lease or contract on behalf of
98.24 the prospective resident and accepts the documentation in good faith;

98.25 (2) the consultation shall be performed in a manner that provides objective and
98.26 complete information;

98.27 ~~(2)~~ (3) the consultation must include a review of the prospective resident's reasons
98.28 for considering housing with services, the prospective resident's personal goals, a
98.29 discussion of the prospective resident's immediate and projected long-term care needs,
98.30 and alternative community services or housing with services settings that may meet the
98.31 prospective resident's needs;

98.32 ~~(3)~~ (4) the prospective resident shall be informed of the availability of a face-to-face
98.33 visit at no charge to the prospective resident to assist the prospective resident in assessment
98.34 and planning to meet the prospective resident's long-term care needs; and

98.35 ~~(4)~~ (5) verification of counseling shall be generated and provided to the prospective
98.36 resident by Senior LinkAge Line upon completion of the telephone-based counseling.

99.1 (c) Housing with services establishments registered under chapter 144D shall:

99.2 (1) inform all prospective residents or the prospective resident's designated or legal
 99.3 representative of the availability of and contact information for consultation services
 99.4 under this subdivision;

99.5 (2) ~~except for individuals seeking lease-only arrangements in subsidized housing~~
 99.6 ~~settings,~~ receive a copy of the verification of counseling prior to executing a lease or
 99.7 service contract with the prospective resident, and prior to executing a service contract
 99.8 with individuals who have previously entered into lease-only arrangements; and

99.9 (3) retain a copy of the verification of counseling as part of the resident's file.

99.10 (d) Emergency admissions to registered housing with services establishments prior
 99.11 to consultation under paragraph (b) are permitted according to policies established by
 99.12 the commissioner.

99.13 Sec. 22. Minnesota Statutes 2010, section 256B.0911, is amended by adding a
 99.14 subdivision to read:

99.15 Subd. 3d. **Exemptions.** Individuals shall be exempt from the requirements outlined
 99.16 in subdivision 3c in the following circumstances:

99.17 (1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

99.18 (2) the individual has previously received a long-term care consultation assessment
 99.19 under this section. In this instance, the assessor who completes the long-term care
 99.20 consultation will issue a verification code and provide it to the individual;

99.21 (3) the individual is receiving or is being evaluated for hospice services from a
 99.22 hospice provider licensed under sections 144A.75 to 144A.755; or

99.23 (4) the individual has used financial planning services and created a long-term care
 99.24 plan as defined by the commissioner in the 12 months prior to signing a lease or contract
 99.25 with a registered housing with services establishment.

99.26 Sec. 23. Minnesota Statutes 2010, section 256B.0911, is amended by adding a
 99.27 subdivision to read:

99.28 Subd. 3e. **Consultation at hospital discharge.** (a) Hospitals shall refer all
 99.29 individuals described in paragraph (b) prior to discharge from an inpatient hospital stay
 99.30 to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make
 99.31 these referrals using referral protocols and processes developed under section 256.975,
 99.32 subdivision 7. The purpose of the counseling is to support persons with current or
 99.33 anticipated long-term care needs in making informed choices among options that include
 99.34 the most cost-effective and least restrictive setting.

100.1 (b) The individuals who shall be referred under paragraph (a) include older adults
100.2 who are at risk of nursing home placement. Protocols for identifying at-risk individuals
100.3 shall be developed under section 256.975, subdivision 7, paragraph (b), clause (12).

100.4 (c) Counseling provided under this subdivision shall meet the requirements for the
100.5 consultation required under section 256B.0911, subdivision 3c.

100.6 **EFFECTIVE DATE.** This section is effective October 1, 2012.

100.7 Sec. 24. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3e,
100.8 is amended to read:

100.9 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
100.10 services shall be a monthly rate authorized by the lead agency within the parameters
100.11 established by the commissioner. The payment agreement must delineate the amount of
100.12 each component service included in the recipient's customized living service plan. The
100.13 lead agency, with input from the provider of customized living services, shall ensure that
100.14 there is a documented need within the parameters established by the commissioner for all
100.15 component customized living services authorized.

100.16 (b) The payment rate must be based on the amount of component services to be
100.17 provided utilizing component rates established by the commissioner. Counties and tribes
100.18 shall use tools issued by the commissioner to develop and document customized living
100.19 service plans and rates.

100.20 (c) Component service rates must not exceed payment rates for comparable elderly
100.21 waiver or medical assistance services and must reflect economies of scale. Customized
100.22 living services must not include rent or raw food costs.

100.23 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
100.24 individualized monthly authorized payment for the customized living service plan shall
100.25 not exceed 50 percent of the greater of either the statewide or any of the geographic
100.26 groups' weighted average monthly nursing facility rate of the case mix resident class
100.27 to which the elderly waiver eligible client would be assigned under Minnesota Rules,
100.28 parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described
100.29 in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the
100.30 resident assessment system as described in section 256B.438 for nursing home rate
100.31 determination is implemented. Effective on July 1 of the state fiscal year in which
100.32 the resident assessment system as described in section 256B.438 for nursing home
100.33 rate determination is implemented and July 1 of each subsequent state fiscal year, the
100.34 individualized monthly authorized payment for the services described in this clause shall
100.35 not exceed the limit which was in effect on June 30 of the previous state fiscal year

101.1 updated annually based on legislatively adopted changes to all service rate maximums for
101.2 home and community-based service providers.

101.3 (e) Effective July 1, 2011, the individualized monthly payment for the customized
101.4 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
101.5 monthly authorized payment limit for customized living for individuals classified as case
101.6 mix A, reduced by 25 percent. This rate limit must be applied to all new participants
101.7 enrolled in the program on or after July 1, 2011, who meet the criteria described in
101.8 subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who
101.9 meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

101.10 (f) Customized living services are delivered by a provider licensed by the
101.11 Department of Health as a class A or class F home care provider and provided in a
101.12 building that is registered as a housing with services establishment under chapter 144D.
101.13 Licensed home care providers are subject to section 256B.0651, subdivision 14.

101.14 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
101.15 family for additional units of any allowable component service beyond those available
101.16 under the service rate limits described in paragraph (d), nor for additional units of any
101.17 allowable component service beyond those approved in the service plan by the lead agency.

101.18 Sec. 25. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3h,
101.19 is amended to read:

101.20 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
101.21 payment rate for 24-hour customized living services is a monthly rate authorized by the
101.22 lead agency within the parameters established by the commissioner of human services.
101.23 The payment agreement must delineate the amount of each component service included
101.24 in each recipient's customized living service plan. The lead agency, with input from
101.25 the provider of customized living services, shall ensure that there is a documented need
101.26 within the parameters established by the commissioner for all component customized
101.27 living services authorized. The lead agency shall not authorize 24-hour customized living
101.28 services unless there is a documented need for 24-hour supervision.

101.29 (b) For purposes of this section, "24-hour supervision" means that the recipient
101.30 requires assistance due to needs related to one or more of the following:

101.31 (1) intermittent assistance with toileting, positioning, or transferring;

101.32 (2) cognitive or behavioral issues;

101.33 (3) a medical condition that requires clinical monitoring; or

101.34 (4) for all new participants enrolled in the program on or after July 1, 2011, and
101.35 all other participants at their first reassessment after July 1, 2011, dependency in at

102.1 least three of the following activities of daily living as determined by assessment under
102.2 section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency
102.3 score in eating is three or greater; and needs medication management and at least 50
102.4 hours of service per month. The lead agency shall ensure that the frequency and mode
102.5 of supervision of the recipient and the qualifications of staff providing supervision are
102.6 described and meet the needs of the recipient.

102.7 (c) The payment rate for 24-hour customized living services must be based on the
102.8 amount of component services to be provided utilizing component rates established by the
102.9 commissioner. Counties and tribes will use tools issued by the commissioner to develop
102.10 and document customized living plans and authorize rates.

102.11 (d) Component service rates must not exceed payment rates for comparable elderly
102.12 waiver or medical assistance services and must reflect economies of scale.

102.13 (e) The individually authorized 24-hour customized living payments, in combination
102.14 with the payment for other elderly waiver services, including case management, must not
102.15 exceed the recipient's community budget cap specified in subdivision 3a. Customized
102.16 living services must not include rent or raw food costs.

102.17 (f) The individually authorized 24-hour customized living payment rates shall not
102.18 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
102.19 living services in effect and in the Medicaid management information systems on March
102.20 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
102.21 to 9549.0059, to which elderly waiver service clients are assigned. When there are
102.22 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
102.23 shall multiply the calculated service payment rate maximum for the A classification by
102.24 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
102.25 9549.0059, to determine the applicable payment rate maximum. Service payment rate
102.26 maximums shall be updated annually based on legislatively adopted changes to all service
102.27 rates for home and community-based service providers.

102.28 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
102.29 may establish alternative payment rate systems for 24-hour customized living services in
102.30 housing with services establishments which are freestanding buildings with a capacity of
102.31 16 or fewer, by applying a single hourly rate for covered component services provided
102.32 in either:

102.33 (1) licensed corporate adult foster homes; or

102.34 (2) specialized dementia care units which meet the requirements of section 144D.065
102.35 and in which:

102.36 (i) each resident is offered the option of having their own apartment; or

103.1 (ii) the units are licensed as board and lodge establishments with maximum capacity
 103.2 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
 103.3 subparts 1, 2, 3, and 4, item A.

103.4 (h) 24-hour customized living services are delivered by a provider licensed by
 103.5 the Department of Health as a class A or class F home care provider and provided in a
 103.6 building that is registered as a housing with services establishment under chapter 144D.
 103.7 Licensed home care providers are subject to section 256B.0651, subdivision 14.

103.8 ~~(h)~~ (i) A provider may not bill or otherwise charge an elderly waiver participant
 103.9 or their family for additional units of any allowable component service beyond those
 103.10 available under the service rate limits described in paragraph (e), nor for additional
 103.11 units of any allowable component service beyond those approved in the service plan
 103.12 by the lead agency.

103.13 Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
 103.14 read:

103.15 Subd. 1b. **Individual service plan.** (a) The individual service plan must:

103.16 (1) include the results of the assessment information on the person's need for service,
 103.17 including identification of service needs that will be or that are met by the person's
 103.18 relatives, friends, and others, as well as community services used by the general public;

103.19 (2) identify the person's preferences for services as stated by the person, the person's
 103.20 legal guardian or conservator, or the parent if the person is a minor;

103.21 (3) identify long- and short-range goals for the person;

103.22 (4) identify specific services and the amount and frequency of the services to be
 103.23 provided to the person based on assessed needs, preferences, and available resources.

103.24 The individual service plan shall also specify other services the person needs that are
 103.25 not available;

103.26 (5) identify the need for an individual program plan to be developed by the provider
 103.27 according to the respective state and federal licensing and certification standards, and
 103.28 additional assessments to be completed or arranged by the provider after service initiation;

103.29 (6) identify provider responsibilities to implement and make recommendations for
 103.30 modification to the individual service plan;

103.31 (7) include notice of the right to request a conciliation conference or a hearing
 103.32 under section 256.045;

103.33 (8) be agreed upon and signed by the person, the person's legal guardian
 103.34 or conservator, or the parent if the person is a minor, and the authorized county
 103.35 representative; and

104.1 (9) be reviewed by a health professional if the person has overriding medical needs
104.2 that impact the delivery of services.

104.3 (b) Service planning formats developed for interagency planning such as transition,
104.4 vocational, and individual family service plans may be substituted for service planning
104.5 formats developed by county agencies.

104.6 (c) Approved, written, and signed changes to a consumer's services that meet the
104.7 criteria in this subdivision shall be an addendum to that consumer's individual service plan.

104.8 Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

104.9 Subd. 7. **Screening teams.** (a) For persons with developmental disabilities,
104.10 screening teams shall be established which shall evaluate the need for the level of care
104.11 provided by residential-based habilitation services, residential services, training and
104.12 habilitation services, and nursing facility services. The evaluation shall address whether
104.13 home and community-based services are appropriate for persons who are at risk of
104.14 placement in an intermediate care facility for persons with developmental disabilities, or
104.15 for whom there is reasonable indication that they might require this level of care. The
104.16 screening team shall make an evaluation of need within 60 working days of a request for
104.17 service by a person with a developmental disability, and within five working days of
104.18 an emergency admission of a person to an intermediate care facility for persons with
104.19 developmental disabilities.

104.20 (b) The screening team shall consist of the case manager for persons with
104.21 developmental disabilities, the person, the person's legal guardian or conservator, or the
104.22 parent if the person is a minor, and a qualified developmental disability professional, as
104.23 defined in the Code of Federal Regulations, title 42, section 483.430, as amended through
104.24 June 3, 1988. The case manager may also act as the qualified developmental disability
104.25 professional if the case manager meets the federal definition.

104.26 (c) County social service agencies may contract with a public or private agency
104.27 or individual who is not a service provider for the person for the public guardianship
104.28 representation required by the screening or individual service planning process. The
104.29 contract shall be limited to public guardianship representation for the screening and
104.30 individual service planning activities. The contract shall require compliance with the
104.31 commissioner's instructions and may be for paid or voluntary services.

104.32 (d) For persons determined to have overriding health care needs and are
104.33 seeking admission to a nursing facility or an ICF/MR, or seeking access to home and
104.34 community-based waived services, a registered nurse must be designated as either the
104.35 case manager or the qualified developmental disability professional.

105.1 (e) For persons under the jurisdiction of a correctional agency, the case manager
105.2 must consult with the corrections administrator regarding additional health, safety, and
105.3 supervision needs.

105.4 (f) The case manager, with the concurrence of the person, the person's legal guardian
105.5 or conservator, or the parent if the person is a minor, may invite other individuals to
105.6 attend meetings of the screening team. With the permission of the person being screened
105.7 or the person's designated legal representative, the person's current provider of services
105.8 may submit a written report outlining their recommendations regarding the person's care
105.9 needs prepared by a direct service employee with at least 20 hours of service to that client.
105.10 The screening team must notify the provider of the date by which this information is to
105.11 be submitted. This information must be provided to the screening team and the person
105.12 or the person's legal representative and must be considered prior to the finalization of
105.13 the screening.

105.14 (g) No member of the screening team shall have any direct or indirect service
105.15 provider interest in the case.

105.16 (h) Nothing in this section shall be construed as requiring the screening team
105.17 meeting to be separate from the service planning meeting.

105.18 Sec. 28. Minnesota Statutes 2011 Supplement, section 256B.097, subdivision 3,
105.19 is amended to read:

105.20 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
105.21 Council which must define regional quality councils, and carry out a community-based,
105.22 person-directed quality review component, and a comprehensive system for effective
105.23 incident reporting, investigation, analysis, and follow-up.

105.24 (b) By August 1, 2011, the commissioner of human services shall appoint the
105.25 members of the initial State Quality Council. Members shall include representatives
105.26 from the following groups:

105.27 (1) disability service recipients and their family members;

105.28 (2) during the first two years of the State Quality Council, there must be at least three
105.29 members from the Region 10 stakeholders. As regional quality councils are formed under
105.30 subdivision 4, each regional quality council shall appoint one member;

105.31 (3) disability service providers;

105.32 (4) disability advocacy groups; and

105.33 (5) county human services agencies and staff from the Department of Human
105.34 Services and Ombudsman for Mental Health and Developmental Disabilities.

106.1 (c) Members of the council who do not receive a salary or wages from an employer
106.2 for time spent on council duties may receive a per diem payment when performing council
106.3 duties and functions.

106.4 (d) The State Quality Council shall:

106.5 (1) assist the Department of Human Services in fulfilling federally mandated
106.6 obligations by monitoring disability service quality and quality assurance and
106.7 improvement practices in Minnesota; ~~and~~

106.8 (2) establish state quality improvement priorities with methods for achieving results
106.9 and provide an annual report to the legislative committees with jurisdiction over policy
106.10 and funding of disability services on the outcomes, improvement priorities, and activities
106.11 undertaken by the commission during the previous state fiscal year;

106.12 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
106.13 with disabilities from optimizing choice of community-based services; and

106.14 (4) recommend to the chairs and ranking minority members of the legislative
106.15 committees with jurisdiction over human services and civil law by January 15, 2013,
106.16 statutory and rule changes related to the findings under clause (3) that promote
106.17 individualized service and housing choices balanced with appropriate individualized
106.18 protection.

106.19 (e) The State Quality Council, in partnership with the commissioner, shall:

106.20 (1) approve and direct implementation of the community-based, person-directed
106.21 system established in this section;

106.22 (2) recommend an appropriate method of funding this system, and determine the
106.23 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

106.24 (3) approve measurable outcomes in the areas of health and safety, consumer
106.25 evaluation, education and training, providers, and systems;

106.26 (4) establish variable licensure periods not to exceed three years based on outcomes
106.27 achieved; and

106.28 (5) in cooperation with the Quality Assurance Commission, design a transition plan
106.29 for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

106.30 (f) The State Quality Council shall notify the commissioner of human services that a
106.31 facility, program, or service has been reviewed by quality assurance team members under
106.32 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

106.33 (g) The State Quality Council, in partnership with the commissioner, shall establish
106.34 an ongoing review process for the system. The review shall take into account the
106.35 comprehensive nature of the system which is designed to evaluate the broad spectrum of

107.1 licensed and unlicensed entities that provide services to persons with disabilities. The
107.2 review shall address efficiencies and effectiveness of the system.

107.3 (h) The State Quality Council may recommend to the commissioner certain
107.4 variances from the standards governing licensure of programs for persons with disabilities
107.5 in order to improve the quality of services so long as the recommended variances do
107.6 not adversely affect the health or safety of persons being served or compromise the
107.7 qualifications of staff to provide services.

107.8 (i) The safety standards, rights, or procedural protections referenced under
107.9 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
107.10 recommendations to the commissioner or to the legislature in the report required under
107.11 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
107.12 procedural protections referenced under subdivision 2, paragraph (c).

107.13 (j) The State Quality Council may hire staff to perform the duties assigned in this
107.14 subdivision.

107.15 Sec. 29. Minnesota Statutes 2010, section 256B.431, subdivision 17e, is amended to
107.16 read:

107.17 Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.**
107.18 Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2),
107.19 for a total replacement, as defined in subdivision 17d, authorized under section
107.20 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation,
107.21 renovation, upgrading, or conversion completed on or after July 1, 2001, or any
107.22 building project eligible for reimbursement under section 256B.434, subdivision 4f, the
107.23 replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed
107.24 rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating
107.25 the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part
107.26 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be
107.27 adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1,
107.28 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph
107.29 (a), beginning October 1, 2012.

107.30 Sec. 30. Minnesota Statutes 2010, section 256B.431, is amended by adding a
107.31 subdivision to read:

107.32 Subd. 45. **Rate adjustments for some moratorium exception projects.**
107.33 Notwithstanding any other law to the contrary, money available for moratorium exception
107.34 projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the

108.1 incremental rate increases resulting from this section for any nursing facility with a
108.2 moratorium exception project approved under section 144A.073, and completed after
108.3 August 30, 2010, where the replacement-costs-new limits under subdivision 17e were
108.4 higher at any time after project approval than at the time of project completion. The
108.5 commissioner shall calculate the property rate increase for these facilities using the highest
108.6 set of limits; however, any rate increase under this section shall not be effective until on
108.7 or after the effective date of this section, contingent upon federal approval. No property
108.8 rate decrease shall result from this section.

108.9 **EFFECTIVE DATE.** This section is effective upon federal approval.

108.10 Sec. 31. Minnesota Statutes 2010, section 256B.434, subdivision 10, is amended to
108.11 read:

108.12 Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that
108.13 has entered into a contract under this section is not required to file a cost report, as defined
108.14 in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the
108.15 basis for the calculation of the contract payment rate for the first rate year of the alternative
108.16 payment demonstration project contract; and (2) a facility under contract is not subject
108.17 to audits of historical costs or revenues, or paybacks or retroactive adjustments based on
108.18 these costs or revenues, except audits, paybacks, or adjustments relating to the cost report
108.19 that is the basis for calculation of the first rate year under the contract.

108.20 (b) A facility that is under contract with the commissioner under this section is
108.21 not subject to the moratorium on licensure or certification of new nursing home beds in
108.22 section 144A.071, unless the project results in a net increase in bed capacity or involves
108.23 relocation of beds from one site to another. Contract payment rates must not be adjusted
108.24 to reflect any additional costs that a nursing facility incurs as a result of a construction
108.25 project undertaken under this paragraph. In addition, as a condition of entering into a
108.26 contract under this section, a nursing facility must agree that any future medical assistance
108.27 payments for nursing facility services will not reflect any additional costs attributable to
108.28 the sale of a nursing facility under this section and to construction undertaken under
108.29 this paragraph that otherwise would not be authorized under the moratorium in section
108.30 144A.073. Nothing in this section prevents a nursing facility participating in the
108.31 alternative payment demonstration project under this section from seeking approval of
108.32 an exception to the moratorium through the process established in section 144A.073,
108.33 and if approved the facility's rates shall be adjusted to reflect the cost of the project.
108.34 Nothing in this section prevents a nursing facility participating in the alternative payment
108.35 demonstration project from seeking legislative approval of an exception to the moratorium

109.1 under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the
109.2 cost of the project.

109.3 ~~(e) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e),~~
109.4 ~~and pursuant to any terms and conditions contained in the facility's contract, a nursing~~
109.5 ~~facility that is under contract with the commissioner under this section is in compliance~~
109.6 ~~with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.~~

109.7 ~~(d)~~ (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing
109.8 administration has not approved a required waiver, or the Centers for Medicare and
109.9 Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval,
109.10 the commissioner shall require a cost report for the rate year.

109.11 ~~(e)~~ (d) A facility that is under contract with the commissioner under this section
109.12 shall be allowed to change therapy arrangements from an unrelated vendor to a related
109.13 vendor during the term of the contract. The commissioner may develop reasonable
109.14 requirements designed to prevent an increase in therapy utilization for residents enrolled
109.15 in the medical assistance program.

109.16 ~~(f)~~ (e) Nursing facilities participating in the alternative payment system
109.17 demonstration project must either participate in the alternative payment system quality
109.18 improvement program established by the commissioner or submit information on their
109.19 own quality improvement process to the commissioner for approval. Nursing facilities
109.20 that have had their own quality improvement process approved by the commissioner
109.21 must report results for at least one key area of quality improvement annually to the
109.22 commissioner.

109.23 Sec. 32. Minnesota Statutes 2010, section 256B.441, is amended by adding a
109.24 subdivision to read:

109.25 Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation
109.26 with the commissioner of health, may designate certain nursing facilities as critical access
109.27 nursing facilities. The designation shall be granted on a competitive basis, within the
109.28 limits of funds appropriated for this purpose.

109.29 (b) The commissioner shall request proposals from nursing facilities every two years.
109.30 Proposals must be submitted in the form and according to the timelines established by
109.31 the commissioner. In selecting applicants to designate, the commissioner, in consultation
109.32 with the commissioner of health, and with input from stakeholders, shall develop criteria
109.33 designed to preserve access to nursing facility services in isolated areas, rebalance
109.34 long-term care, and improve quality.

110.1 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing
110.2 facilities designated as critical access nursing facilities:

110.3 (1) partial rebasing, with operating payment rates being the sum of 60 percent of the
110.4 operating payment rate determined in accordance with subdivision 54 and 40 percent of the
110.5 operating payment rate that would have been allowed had the facility not been designated;

110.6 (2) enhanced payments for leave days. Notwithstanding section 256B.431,
110.7 subdivision 2r, upon designation as a critical access nursing facility, the commissioner
110.8 shall limit payment for leave days to 60 percent of that nursing facility's total payment rate
110.9 for the involved resident, and shall allow this payment only when the occupancy of the
110.10 nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

110.11 (3) two designated critical access nursing facilities, with up to 100 beds in active
110.12 service, may jointly apply to the commissioner of health for a waiver of Minnesota
110.13 Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The
110.14 commissioner of health will consider each waiver request independently based on the
110.15 criteria under Minnesota Rules, part 4658.0040;

110.16 (4) the minimum threshold under section 256B.431, subdivisions 3f, paragraph (a),
110.17 and 17e, shall be 40 percent of the amount that would otherwise apply; and

110.18 (5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based
110.19 rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

110.20 (d) Designation of a critical access nursing facility shall be for a period of two
110.21 years, after which the benefits allowed under paragraph (c) shall be removed. Designated
110.22 facilities may apply for continued designation.

110.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

110.24 Sec. 33. Minnesota Statutes 2010, section 256B.48, is amended by adding a
110.25 subdivision to read:

110.26 **Subd. 6a. Referrals to Medicare providers required.** Notwithstanding subdivision
110.27 1, nursing facility providers that do not participate in or accept Medicare assignment
110.28 must refer and document the referral of dual eligible recipients for whom placement is
110.29 requested and for whom the resident would be qualified for a Medicare-covered stay to
110.30 Medicare providers. The commissioner shall audit nursing facilities that do not accept
110.31 Medicare and determine if dual eligible individuals with Medicare qualifying stays have
110.32 been admitted. If such a determination is made, the commissioner shall deny Medicaid
110.33 payment for the first 20 days of that resident's stay.

111.1 Sec. 34. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14,
111.2 is amended to read:

111.3 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
111.4 strengths, informal support systems, and need for services shall be completed within 20
111.5 working days of the recipient's request as provided in section 256B.0911. Reassessment of
111.6 each recipient's strengths, support systems, and need for services shall be conducted at
111.7 least every 12 months and at other times when there has been a significant change in the
111.8 recipient's functioning. With the permission of the recipient or the recipient's designated
111.9 legal representative, the recipient's current provider of services may submit a written
111.10 report outlining their recommendations regarding the recipient's care needs prepared by
111.11 a direct service employee with at least 20 hours of service to that client. The person
111.12 conducting the assessment or reassessment must notify the provider of the date by which
111.13 this information is to be submitted. This information shall be provided to the person
111.14 conducting the assessment and the person or the person's legal representative and must be
111.15 considered prior to the finalization of the assessment or reassessment.

111.16 (b) There must be a determination that the client requires a hospital level of care or a
111.17 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
111.18 (d), at initial and subsequent assessments to initiate and maintain participation in the
111.19 waiver program.

111.20 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
111.21 appropriate to determine nursing facility level of care for purposes of medical assistance
111.22 payment for nursing facility services, only face-to-face assessments conducted according
111.23 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
111.24 determination or a nursing facility level of care determination must be accepted for
111.25 purposes of initial and ongoing access to waiver services payment.

111.26 (d) Persons with developmental disabilities who apply for services under the nursing
111.27 facility level waiver programs shall be screened for the appropriate level of care according
111.28 to section 256B.092.

111.29 (e) Recipients who are found eligible for home and community-based services under
111.30 this section before their 65th birthday may remain eligible for these services after their
111.31 65th birthday if they continue to meet all other eligibility factors.

111.32 (f) The commissioner shall develop criteria to identify recipients whose level of
111.33 functioning is reasonably expected to improve and reassess these recipients to establish
111.34 a baseline assessment. Recipients who meet these criteria must have a comprehensive
111.35 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
111.36 reassessed every six months until there has been no significant change in the recipient's

112.1 functioning for at least 12 months. After there has been no significant change in the
112.2 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
112.3 informal support systems, and need for services shall be conducted at least every 12
112.4 months and at other times when there has been a significant change in the recipient's
112.5 functioning. Counties, case managers, and service providers are responsible for
112.6 conducting these reassessments and shall complete the reassessments out of existing funds.

112.7 Sec. 35. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15,
112.8 is amended to read:

112.9 Subd. 15. **Individualized service plan; comprehensive transitional service plan;**
112.10 **maintenance service plan.** (a) Each recipient of home and community-based waived
112.11 services shall be provided a copy of the written service plan which:

112.12 (1) is developed and signed by the recipient within ten working days of the
112.13 completion of the assessment;

112.14 (2) meets the assessed needs of the recipient;

112.15 (3) reasonably ensures the health and safety of the recipient;

112.16 (4) promotes independence;

112.17 (5) allows for services to be provided in the most integrated settings; and

112.18 (6) provides for an informed choice, as defined in section 256B.77, subdivision 2,
112.19 paragraph (p), of service and support providers.

112.20 (b) In developing the comprehensive transitional service plan, the individual
112.21 receiving services, the case manager, and the guardian, if applicable, will identify
112.22 the transitional service plan fundamental service outcome and anticipated timeline to
112.23 achieve this outcome. Within the first 20 days following a recipient's request for an
112.24 assessment or reassessment, the transitional service planning team must be identified. A
112.25 team leader must be identified who will be responsible for assigning responsibility and
112.26 communicating with team members to ensure implementation of the transition plan and
112.27 ongoing assessment and communication process. The team leader should be an individual,
112.28 such as the case manager or guardian, who has the opportunity to follow the recipient to
112.29 the next level of service.

112.30 Within ten days following an assessment, a comprehensive transitional service plan
112.31 must be developed incorporating elements of a comprehensive functional assessment and
112.32 including short-term measurable outcomes and timelines for achievement of and reporting
112.33 on these outcomes. Functional milestones must also be identified and reported according
112.34 to the timelines agreed upon by the transitional service planning team. In addition, the
112.35 comprehensive transitional service plan must identify additional supports that may assist

113.1 in the achievement of the fundamental service outcome such as the development of greater
113.2 natural community support, increased collaboration among agencies, and technological
113.3 supports.

113.4 The timelines for reporting on functional milestones will prompt a reassessment of
113.5 services provided, the units of services, rates, and appropriate service providers. It is
113.6 the responsibility of the transitional service planning team leader to review functional
113.7 milestone reporting to determine if the milestones are consistent with observable skills
113.8 and that milestone achievement prompts any needed changes to the comprehensive
113.9 transitional service plan.

113.10 For those whose fundamental transitional service outcome involves the need to
113.11 procure housing, a plan for the recipient to seek the resources necessary to secure the least
113.12 restrictive housing possible should be incorporated into the plan, including employment
113.13 and public supports such as housing access and shelter needy funding.

113.14 (c) Counties and other agencies responsible for funding community placement and
113.15 ongoing community supportive services are responsible for the implementation of the
113.16 comprehensive transitional service plans. Oversight responsibilities include both ensuring
113.17 effective transitional service delivery and efficient utilization of funding resources.

113.18 (d) Following one year of transitional services, the transitional services planning
113.19 team will make a determination as to whether or not the individual receiving services
113.20 requires the current level of continuous and consistent support in order to maintain the
113.21 recipient's current level of functioning. Recipients who are determined to have not had
113.22 a significant change in functioning for 12 months must move from a transitional to a
113.23 maintenance service plan. Recipients on a maintenance service plan must be reassessed
113.24 to determine if the recipient would benefit from a transitional service plan at least every
113.25 12 months and at other times when there has been a significant change in the recipient's
113.26 functioning. This assessment should consider any changes to technological or natural
113.27 community supports.

113.28 (e) When a county is evaluating denials, reductions, or terminations of home and
113.29 community-based services under section 256B.49 for an individual, the case manager
113.30 shall offer to meet with the individual or the individual's guardian in order to discuss the
113.31 prioritization of service needs within the individualized service plan, comprehensive
113.32 transitional service plan, or maintenance service plan. The reduction in the authorized
113.33 services for an individual due to changes in funding for waived services may not exceed
113.34 the amount needed to ensure medically necessary services to meet the individual's health,
113.35 safety, and welfare.

114.1 (f) At the time of reassessment, local agency case managers shall assess each
 114.2 recipient of community alternatives for disabled individuals or traumatic brain injury
 114.3 waived services currently residing in a licensed adult foster home that is not the primary
 114.4 residence of the license holder, or in which the license holder is not the primary caregiver,
 114.5 to determine if that recipient could appropriately be served in a community-living setting.
 114.6 If appropriate for the recipient, the case manager shall offer the recipient, through a
 114.7 person-centered planning process, the option to receive alternative housing and service
 114.8 options. In the event that the recipient chooses to transfer from the adult foster home,
 114.9 the vacated bed shall not be filled with another recipient of waiver services and group
 114.10 residential housing, ~~unless~~ and the licensed capacity shall be reduced accordingly, unless
 114.11 the savings required by the licensed bed closure reductions under Laws 2011, First Special
 114.12 Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where
 114.13 the physical location is not the primary residence of the license holder are met through
 114.14 voluntary changes described in section 245A.03, subdivision 7, paragraph (g), or as
 114.15 provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), and the
 114.16 ~~licensed capacity shall be reduced accordingly.~~ If the adult foster home becomes no longer
 114.17 viable due to these transfers, the county agency, with the assistance of the department,
 114.18 shall facilitate a consolidation of settings or closure. This reassessment process shall be
 114.19 completed by ~~June 30, 2012~~ July 1, 2013.

114.20 Sec. 36. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 23,
 114.21 is amended to read:

114.22 Subd. 23. **Community-living settings.** "Community-living settings" means a
 114.23 single-family home or apartment where the service recipient or their family owns or rents,
 114.24 ~~as demonstrated by a lease agreement,~~ and maintains control over the individual unit as
 114.25 demonstrated by the lease agreement, or has a plan for transition of a lease from a service
 114.26 provider to the individual. Within two years of signing the initial lease, the service provider
 114.27 shall transfer the lease to the individual. In the event the landlord denies the transfer, the
 114.28 commissioner may approve an exception within sufficient time to ensure the continued
 114.29 occupancy by the individual. Community-living settings are subject to the following:

- 114.30 (1) individuals are not required to receive services;
- 114.31 (2) individuals are not required to have a disability or specific diagnosis to live
 114.32 in the community-living setting;
- 114.33 (3) individuals may hire service providers of their choice;
- 114.34 (4) individuals may choose whether to share their household and with whom;
- 114.35 (5) the home or apartment must include living, sleeping, bathing, and cooking areas;

- 115.1 (6) individuals must have lockable access and egress;
- 115.2 (7) individuals must be free to receive visitors and leave the settings at times and for
- 115.3 durations of their own choosing;
- 115.4 (8) leases must not reserve the right to assign units or change unit assignments; and
- 115.5 (9) access to the greater community must be easily facilitated based on the
- 115.6 individual's needs and preferences.

115.7 Sec. 37. **[256B.492] HOME AND COMMUNITY-BASED SETTINGS FOR**

115.8 **PEOPLE WITH DISABILITIES.**

115.9 (a) Individuals receiving services under a home and community-based waiver under

115.10 Minnesota Statutes, section 256B.092 or 256B.49, may receive services in the following

115.11 settings:

115.12 (1) an individual's own home or family home;

115.13 (2) a licensed adult foster care setting of up to five people; and

115.14 (3) community living settings as defined in Minnesota Statutes, section 256B.49,

115.15 subdivision 23, where individuals with disabilities may reside in all of the units in a

115.16 building of four or fewer units, and no more than the greater of four or 25 percent of the

115.17 units in a multifamily building of more than four units.

115.18 (b) The settings in paragraph (a) must not:

115.19 (1) be located in a building that is a publicly or privately operated facility that

115.20 provides institutional treatment or custodial care;

115.21 (2) be located in a building on the grounds of or adjacent to a public or private

115.22 institution;

115.23 (3) be a housing complex designed expressly around an individual's diagnosis or

115.24 disability;

115.25 (4) be segregated based on a disability, either physically or because of setting

115.26 characteristics, from the larger community; and

115.27 (5) have the qualities of an institution which include, but are not limited to:

115.28 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions

115.29 agreed to and documented in the person's individual service plan shall not result in a

115.30 residence having the qualities of an institution as long as the restrictions for the person are

115.31 not imposed upon others in the same residence and are the least restrictive alternative,

115.32 imposed for the shortest possible time to meet the person's needs.

115.33 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which

115.34 individuals receive services under a home and community-based waiver as of the effective

115.35 date of this section and the setting does not meet the criteria of this section.

116.1 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
116.2 part of a Hennepin County demonstration project is qualified for the exception allowed
116.3 under paragraph (c).

116.4 (e) The commissioner shall submit an amendment to the waiver plan no later than
116.5 December 31, 2012.

116.6 Sec. 38. **[256B.493] ADULT FOSTER CARE PLANNED CLOSURE.**

116.7 Subdivision 1. Commissioner's duties; report. The commissioner of human
116.8 services shall solicit proposals for the conversion of services provided for persons with
116.9 disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, to
116.10 other types of community settings in conjunction with the closure of identified licensed
116.11 adult foster care settings.

116.12 Subd. 2. Planned closure process needs determination. The commissioner shall
116.13 announce and implement a program for planned closure of adult foster care homes.
116.14 Planned closure shall be the preferred method for achieving necessary budgetary savings
116.15 required by the licensed bed closure budget reduction in section 245A.03, subdivision 7,
116.16 paragraph (e). If additional closures are required to achieve the necessary savings, the
116.17 commissioner shall use the process and priorities in section 245A.03, subdivision 7,
116.18 paragraph (e).

116.19 Subd. 3. Application process. (a) The commissioner shall establish a process for
116.20 the application, review, and approval of proposals from license holders for the closure of
116.21 adult foster care settings.

116.22 (b) When an application for a planned closure rate adjustment is submitted, the
116.23 license holder shall provide written notification within five working days to the lead
116.24 agencies responsible for authorizing the licensed services for the residents of the affected
116.25 adult foster care settings. This notification shall be deemed confidential until the license
116.26 holder has received approval of the application by the commissioner.

116.27 Subd. 4. Review and approval process. (a) To be considered for approval, an
116.28 application must include:

116.29 (1) a description of the proposed closure plan, which must identify the home or
116.30 homes, and occupied beds for which a planned closure rate adjustment is requested;

116.31 (2) the proposed timetable for any proposed closure, including the proposed dates
116.32 for notification to residents and the affected lead agencies, commencement of closure,
116.33 and completion of closure;

116.34 (3) the proposed relocation plan jointly developed by the counties of financial
116.35 responsibility, the residents and their legal representatives, if any, who wish to continue to

117.1 receive services from the provider, and the providers for current residents of any adult
117.2 foster care home designated for closure; and

117.3 (4) documentation in a format approved by the commissioner that all the adult foster
117.4 care homes receiving a planned closure rate adjustment under the plan have accepted joint
117.5 and several liability for recovery of overpayments under section 256B.0641, subdivision
117.6 2, for the facilities designated for closure under this plan.

117.7 (b) In reviewing and approving closure proposals, the commissioner shall give first
117.8 priority to proposals that:

117.9 (1) target counties and geographic areas which have:

117.10 (i) need for other types of services;

117.11 (ii) need for specialized services;

117.12 (iii) higher than average per capita use of foster care settings where the license
117.13 holder does not reside; or

117.14 (iv) residents not living in the geographic area of their choice;

117.15 (2) demonstrate savings of medical assistance expenditures; and

117.16 (3) demonstrate that alternative services are based on the recipient's choice of
117.17 provider and are consistent with federal law, state law, and federally approved waiver
117.18 plans.

117.19 The commissioner shall also consider any information provided by service
117.20 recipients, their legal representatives, family members, or the lead agency on the impact of
117.21 the planned closure on the recipients and the services they need.

117.22 (c) The commissioner shall select proposals that best meet the criteria established in
117.23 this subdivision for planned closure of adult foster care settings. The commissioner shall
117.24 notify license holders of the selections approved by the commissioner.

117.25 (d) For each proposal approved by the commissioner, a contract must be established
117.26 between the commissioner, the counties of financial responsibility, and the participating
117.27 license holder.

117.28 Subd. 5. **Notification of approved proposal.** (a) Once the license holder receives
117.29 notification from the commissioner that the proposal has been approved, the license holder
117.30 shall provide written notification within five working days to:

117.31 (1) the lead agencies responsible for authorizing the licensed services for the
117.32 residents of the affected adult foster care settings; and

117.33 (2) current and prospective residents, any legal representatives, and family members
117.34 involved.

117.35 (b) This notification must occur at least 45 days prior to the implementation of
117.36 the closure proposal.

118.1 Subd. 6. **Adjustment to rates.** (a) For purposes of this section, the commissioner
118.2 shall establish enhanced medical assistance payment rates under sections 256B.092 and
118.3 256B.49, to facilitate an orderly transition for persons with disabilities from adult foster
118.4 care to other community-based settings.

118.5 (b) The enhanced payment rate shall be effective the day after the first resident has
118.6 moved until the day the last resident has moved, not to exceed six months.

118.7 Sec. 39. Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13,
118.8 is amended to read:

118.9 Subd. 13. **ICF/DD rate decrease effective July 1, ~~2012~~ 2013.** Notwithstanding
118.10 subdivision 12, and if the commissioner has not received federal approval before July 1,
118.11 2013, of the Long-Term Care Realignment Waiver application submitted under Laws
118.12 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to
118.13 implement portions of the waiver request, for each facility reimbursed under this section
118.14 for services provided from July 1, 2013, through December 31, 2013, the commissioner
118.15 shall decrease operating payments ~~equal~~ up to 1.67 percent of the operating payment rates
118.16 in effect on June 30, ~~2012~~ 2013. The commissioner shall prorate the reduction in the
118.17 event that only portions of the waiver request are approved and after application of the
118.18 continuing care provider payment delay provision in article 6, section 2, subdivision 4,
118.19 paragraph (f). For each facility, the commissioner shall apply the rate reduction based on
118.20 occupied beds, using the percentage specified in this subdivision multiplied by the total
118.21 payment rate, including the variable rate but excluding the property-related payment rate,
118.22 in effect on the preceding date. The total rate reduction shall include the adjustment
118.23 provided in section 256B.501, subdivision 12.

118.24 Sec. 40. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

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

118.29 (a) The county agency shall pay a monthly allowance for medically prescribed
118.30 diets if the cost of those additional dietary needs cannot be met through some other
118.31 maintenance benefit. The need for special diets or dietary items must be prescribed by
118.32 a licensed physician. Costs for special diets shall be determined as percentages of the
118.33 allotment for a one-person household under the thrifty food plan as defined by the United

119.1 States Department of Agriculture. The types of diets and the percentages of the thrifty
119.2 food plan that are covered are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

119.24 (d) The county agency shall continue to pay a monthly allowance of \$68 for
119.25 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
119.26 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
119.27 until the person has not received Minnesota supplemental aid for one full calendar month
119.28 or until the person's living arrangement changes and the person no longer meets the criteria
119.29 for the restaurant meal allowance, whichever occurs first.

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

119.35 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
119.36 maximum allotment authorized by the federal Food Stamp Program for a single individual

120.1 which is in effect on the first day of July of each year will be added to the standards of
120.2 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
120.3 as shelter needy and are: (i) relocating from an institution, or an adult mental health
120.4 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
120.5 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
120.6 community-based waiver recipients living in their own home or rented or leased apartment
120.7 which is not owned, operated, or controlled by a provider of service not related by blood
120.8 or marriage, unless allowed under paragraph (g).

120.9 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
120.10 shelter needy benefit under this paragraph is considered a household of one. An eligible
120.11 individual who receives this benefit prior to age 65 may continue to receive the benefit
120.12 after the age of 65.

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

120.20 (g) Notwithstanding this subdivision, to access housing and services as provided
120.21 in paragraph (f), the recipient may choose housing that may be owned, operated, or
120.22 controlled by the recipient's service provider. In a multifamily building ~~of four or more~~
120.23 ~~units, the maximum number of apartments that may be used by recipients of this program~~
120.24 ~~shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012. of~~
120.25 more than four units, the maximum number of units that may be used by recipients of this
120.26 program shall be the greater of four units or 25 percent of the units in the building. In
120.27 multifamily buildings of four or fewer units, all of the units may be used by recipients
120.28 of this program. When housing is controlled by the service provider, the individual may
120.29 choose their own service provider as provided in section 256B.49, subdivision 23, clause
120.30 (3). When the housing is controlled by the service provider, the service provider shall
120.31 implement a plan with the recipient to transition the lease to the recipient's name. Within
120.32 two years of signing the initial lease, the service provider shall transfer the lease entered
120.33 into under this subdivision to the recipient. In the event the landlord denies this transfer,
120.34 the commissioner may approve an exception within sufficient time to ensure the continued
120.35 occupancy by the recipient. This paragraph expires June 30, 2016.

121.1 Sec. 41. Laws 2011, First Special Session chapter 9, article 7, section 52, is amended to
121.2 read:

121.3 **Sec. 52. IMPLEMENT NURSING HOME LEVEL OF CARE CRITERIA.**

121.4 The commissioner shall seek any necessary federal approval in order to implement
121.5 the changes to the level of care criteria in Minnesota Statutes, section 144.0724,
121.6 subdivision 11, on or after July 1, 2012, for adults and children.

121.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

121.8 Sec. 42. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to
121.9 read:

121.10 **Sec. 54. CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

121.11 (a) Notwithstanding any other rate reduction in this article, if the commissioner of
121.12 human services has not received federal approval before July 1, 2013, of the long-term
121.13 care realignment waiver application submitted under Laws 2011, First Special Session
121.14 chapter 9, article 7, section 52, or only receives approval to implement portions of the
121.15 waiver request, the commissioner ~~of human services~~ shall decrease grants, allocations,
121.16 reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent
121.17 effective July 1, ~~2012~~ 2013, for services rendered ~~on or after those dates~~ from July 1,
121.18 2013, through December 31, 2013. The commissioner shall prorate the reduction in the
121.19 event that only portions of the waiver request are approved and after application of the
121.20 continuing care provider payment delay provision in article 6, section 2, subdivision 4,
121.21 paragraph (f). County or tribal contracts for services specified in this section must be
121.22 amended to pass through these rate reductions within 60 days of the effective date of the
121.23 decrease, and must be retroactive from the effective date of the rate decrease.

121.24 (b) The rate changes described in this section must be provided to:

121.25 (1) home and community-based waived services for persons with developmental
121.26 disabilities or related conditions, including consumer-directed community supports, under
121.27 Minnesota Statutes, section 256B.501;

121.28 (2) home and community-based waived services for the elderly, including
121.29 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

121.30 (3) waived services under community alternatives for disabled individuals,
121.31 including consumer-directed community supports, under Minnesota Statutes, section
121.32 256B.49;

121.33 (4) community alternative care waived services, including consumer-directed
121.34 community supports, under Minnesota Statutes, section 256B.49;

- 122.1 (5) traumatic brain injury waived services, including consumer-directed
- 122.2 community supports, under Minnesota Statutes, section 256B.49;
- 122.3 (6) nursing services and home health services under Minnesota Statutes, section
- 122.4 256B.0625, subdivision 6a;
- 122.5 (7) personal care services and qualified professional supervision of personal care
- 122.6 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;
- 122.7 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
- 122.8 subdivision 7;
- 122.9 (9) day training and habilitation services for adults with developmental disabilities
- 122.10 or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the
- 122.11 additional cost of rate adjustments on day training and habilitation services, provided as a
- 122.12 social service under Minnesota Statutes, section 256M.60; and
- 122.13 (10) alternative care services under Minnesota Statutes, section 256B.0913.

122.14 (c) A managed care plan receiving state payments for the services in this section
 122.15 must include these decreases in their payments to providers. To implement the rate
 122.16 reductions in this section, capitation rates paid by the commissioner to managed care
 122.17 organizations under Minnesota Statutes, section 256B.69, shall reflect up to a 2.34 ~~up to a 2.34~~ 1.67
 122.18 percent reduction for the specified services for the period of ~~January 1, 2013, through~~
 122.19 ~~June 30, 2013, and a 1.67 percent reduction for those services on and after July 1~~ July 1,
 122.20 2013, through December 31, 2013.

122.21 The above payment rate reduction, allocation rates, and rate limits shall expire for
 122.22 services rendered on December 31, 2013.

122.23 Sec. 43. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 122.24 3, is amended to read:

122.25 **Subd. 3. Forecasted Programs**

122.26 The amounts that may be spent from this
 122.27 appropriation for each purpose are as follows:

122.28 **(a) MFIP/DWP Grants**

122.29 Appropriations by Fund

122.30	General	84,680,000	91,978,000
122.31	Federal TANF	84,425,000	75,417,000

122.32 **(b) MFIP Child Care Assistance Grants** 55,456,000 30,923,000

122.33 **(c) General Assistance Grants** 49,192,000 46,938,000

123.1 **General Assistance Standard.** The
 123.2 commissioner shall set the monthly standard
 123.3 of assistance for general assistance units
 123.4 consisting of an adult recipient who is
 123.5 childless and unmarried or living apart
 123.6 from parents or a legal guardian at \$203.
 123.7 The commissioner may reduce this amount
 123.8 according to Laws 1997, chapter 85, article
 123.9 3, section 54.

123.10 **Emergency General Assistance.** The
 123.11 amount appropriated for emergency general
 123.12 assistance funds is limited to no more
 123.13 than \$6,689,812 in fiscal year 2012 and
 123.14 \$6,729,812 in fiscal year 2013. Funds
 123.15 to counties shall be allocated by the
 123.16 commissioner using the allocation method
 123.17 specified in Minnesota Statutes, section
 123.18 256D.06.

123.19	(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
123.20	(e) Group Residential Housing Grants	121,080,000	129,238,000
123.21	(f) MinnesotaCare Grants	295,046,000	317,272,000

123.22 This appropriation is from the health care
 123.23 access fund.

123.24	(g) Medical Assistance Grants	4,501,582,000	4,437,282,000
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123.25 **Managed Care Incentive Payments.** The
 123.26 commissioner shall not make managed care
 123.27 incentive payments for expanding preventive
 123.28 services during fiscal years beginning July 1,
 123.29 2011, and July 1, 2012.

123.30 **Reduction of Rates for Congregate**
 123.31 **Living for Individuals with Lower Needs.**
 123.32 Beginning October 1, 2011, lead agencies
 123.33 must reduce rates in effect on January 1,
 123.34 2011, by ten percent for individuals with

124.1 lower needs living in foster care settings
124.2 where the license holder does not share the
124.3 residence with recipients on the CADI and
124.4 DD waivers and customized living settings
124.5 for CADI. Lead agencies shall consult
124.6 with providers to review individual service
124.7 plans and identify changes or modifications
124.8 to reduce the utilization of services while
124.9 maintaining the health and safety of the
124.10 individual receiving services. Lead agencies
124.11 must adjust contracts within 60 days of the
124.12 effective date. If federal waiver approval
124.13 is obtained under the long-term care
124.14 realignment waiver application submitted
124.15 on February 13, 2012, and federal financial
124.16 participation is authorized for the alternative
124.17 care program, the commissioner shall adjust
124.18 this payment rate reduction from ten to five
124.19 percent for services rendered on or after
124.20 July 1, 2012, or the first day of the month
124.21 following federal approval, whichever is
124.22 later.

124.23 **Reduction of Lead Agency Waiver**
124.24 **Allocations to Implement Rate Reductions**
124.25 **for Congregate Living for Individuals**
124.26 **with Lower Needs.** Beginning October 1,
124.27 2011, the commissioner shall reduce lead
124.28 agency waiver allocations to implement the
124.29 reduction of rates for individuals with lower
124.30 needs living in foster care settings where the
124.31 license holder does not share the residence
124.32 with recipients on the CADI and DD waivers
124.33 and customized living settings for CADI.
124.34 **Reduce customized living and 24-hour**
124.35 **customized living component rates.**
124.36 Effective July 1, 2011, the commissioner

125.1 shall reduce elderly waiver customized living
125.2 and 24-hour customized living component
125.3 service spending by five percent through
125.4 reductions in component rates and service
125.5 rate limits. The commissioner shall adjust
125.6 the elderly waiver capitation payment
125.7 rates for managed care organizations paid
125.8 under Minnesota Statutes, section 256B.69,
125.9 subdivisions 6a and 23, to reflect reductions
125.10 in component spending for customized living
125.11 services and 24-hour customized living
125.12 services under Minnesota Statutes, section
125.13 256B.0915, subdivisions 3e and 3h, for the
125.14 contract period beginning January 1, 2012.
125.15 To implement the reduction specified in
125.16 this provision, capitation rates paid by the
125.17 commissioner to managed care organizations
125.18 under Minnesota Statutes, section 256B.69,
125.19 shall reflect a ten percent reduction for the
125.20 specified services for the period January 1,
125.21 2012, to June 30, 2012, and a five percent
125.22 reduction for those services on or after July
125.23 1, 2012.

125.24 **Limit Growth in the Developmental**
125.25 **Disability Waiver.** The commissioner
125.26 shall limit growth in the developmental
125.27 disability waiver to six diversion allocations
125.28 per month beginning July 1, 2011, through
125.29 June 30, 2013, and 15 diversion allocations
125.30 per month beginning July 1, 2013, through
125.31 June 30, 2015. Waiver allocations shall
125.32 be targeted to individuals who meet the
125.33 priorities for accessing waiver services
125.34 identified in Minnesota Statutes, 256B.092,
125.35 subdivision 12. The limits do not include
125.36 conversions from intermediate care facilities

126.1 for persons with developmental disabilities.

126.2 Notwithstanding any contrary provisions in
126.3 this article, this paragraph expires June 30,
126.4 2015.

126.5 **Limit Growth in the Community**

126.6 **Alternatives for Disabled Individuals**

126.7 **Waiver.** The commissioner shall limit
126.8 growth in the community alternatives for
126.9 disabled individuals waiver to 60 allocations
126.10 per month beginning July 1, 2011, through
126.11 June 30, 2013, and 85 allocations per
126.12 month beginning July 1, 2013, through
126.13 June 30, 2015. Waiver allocations must
126.14 be targeted to individuals who meet the
126.15 priorities for accessing waiver services
126.16 identified in Minnesota Statutes, section
126.17 256B.49, subdivision 11a. The limits include
126.18 conversions and diversions, unless the
126.19 commissioner has approved a plan to convert
126.20 funding due to the closure or downsizing
126.21 of a residential facility or nursing facility
126.22 to serve directly affected individuals on
126.23 the community alternatives for disabled
126.24 individuals waiver. Notwithstanding any
126.25 contrary provisions in this article, this
126.26 paragraph expires June 30, 2015.

126.27 **Personal Care Assistance Relative**

126.28 **Care.** The commissioner shall adjust the
126.29 capitation payment rates for managed care
126.30 organizations paid under Minnesota Statutes,
126.31 section 256B.69, to reflect the rate reductions
126.32 for personal care assistance provided by
126.33 a relative pursuant to Minnesota Statutes,
126.34 section 256B.0659, subdivision 11. This rate
126.35 reduction is effective July 1, 2013.

127.1	(h) Alternative Care Grants	46,421,000	46,035,000
127.2	Alternative Care Transfer. Any money		
127.3	allocated to the alternative care program that		
127.4	is not spent for the purposes indicated does		
127.5	not cancel but shall be transferred to the		
127.6	medical assistance account.		
127.7	(i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000

127.8 Sec. 44. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 127.9 4, is amended to read:

127.10 Subd. 4. **Grant Programs**

127.11 The amounts that may be spent from this
 127.12 appropriation for each purpose are as follows:

127.13 **(a) Support Services Grants**

127.14	Appropriations by Fund		
127.15	General	8,715,000	8,715,000
127.16	Federal TANF	100,525,000	94,611,000

127.17 **MFIP Consolidated Fund Grants.** The
 127.18 TANF fund base is reduced by \$10,000,000
 127.19 each year beginning in fiscal year 2012.

127.20 **Subsidized Employment Funding Through**

127.21 **ARRA.** The commissioner is authorized to
 127.22 apply for TANF emergency fund grants for
 127.23 subsidized employment activities. Growth
 127.24 in expenditures for subsidized employment
 127.25 within the supported work program and the
 127.26 MFIP consolidated fund over the amount
 127.27 expended in the calendar year quarters in
 127.28 the TANF emergency fund base year shall
 127.29 be used to leverage the TANF emergency
 127.30 fund grants for subsidized employment and
 127.31 to fund supported work. The commissioner
 127.32 shall develop procedures to maximize
 127.33 reimbursement of these expenditures over the

128.1 TANF emergency fund base year quarters,
 128.2 and may contract directly with employers
 128.3 and providers to maximize these TANF
 128.4 emergency fund grants.

128.5	(b) Basic Sliding Fee Child Care Assistance		
128.6	Grants	37,144,000	38,678,000

128.7 **Base Adjustment.** The general fund base is
 128.8 decreased by \$990,000 in fiscal year 2014
 128.9 and \$979,000 in fiscal year 2015.

128.10 **Child Care and Development Fund**

128.11 **Unexpended Balance.** In addition to
 128.12 the amount provided in this section, the
 128.13 commissioner shall expend \$5,000,000
 128.14 in fiscal year 2012 from the federal child
 128.15 care and development fund unexpended
 128.16 balance for basic sliding fee child care under
 128.17 Minnesota Statutes, section 119B.03. The
 128.18 commissioner shall ensure that all child
 128.19 care and development funds are expended
 128.20 according to the federal child care and
 128.21 development fund regulations.

128.22	(c) Child Care Development Grants	774,000	774,000
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128.23 **Base Adjustment.** The general fund base is
 128.24 increased by \$713,000 in fiscal years 2014
 128.25 and 2015.

128.26	(d) Child Support Enforcement Grants	50,000	50,000
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128.27 **Federal Child Support Demonstration**

128.28 **Grants.** Federal administrative
 128.29 reimbursement resulting from the federal
 128.30 child support grant expenditures authorized
 128.31 under section 1115a of the Social Security
 128.32 Act is appropriated to the commissioner for
 128.33 this activity.

128.34 **(e) Children's Services Grants**

129.1	Appropriations by Fund		
129.2	General	47,949,000	48,507,000
129.3	Federal TANF	140,000	140,000

129.4 **Adoption Assistance and Relative Custody**

129.5 **Assistance Transfer.** The commissioner
 129.6 may transfer unencumbered appropriation
 129.7 balances for adoption assistance and relative
 129.8 custody assistance between fiscal years and
 129.9 between programs.

129.10 **Privatized Adoption Grants.** Federal
 129.11 reimbursement for privatized adoption grant
 129.12 and foster care recruitment grant expenditures
 129.13 is appropriated to the commissioner for
 129.14 adoption grants and foster care and adoption
 129.15 administrative purposes.

129.16 **Adoption Assistance Incentive Grants.**

129.17 Federal funds available during fiscal year
 129.18 2012 and fiscal year 2013 for adoption
 129.19 incentive grants are appropriated to the
 129.20 commissioner for these purposes.

129.21 **(f) Children and Community Services Grants** 53,301,000 53,301,000

129.22 **(g) Children and Economic Support Grants**

129.23	Appropriations by Fund		
129.24	General	16,103,000	16,180,000
129.25	Federal TANF	700,000	0

129.26 **Long-Term Homeless Services.** \$700,000

129.27 is appropriated from the federal TANF
 129.28 fund for the biennium beginning July
 129.29 1, 2011, to the commissioner of human
 129.30 services for long-term homeless services
 129.31 for low-income homeless families under
 129.32 Minnesota Statutes, section 256K.26. This
 129.33 is a onetime appropriation and is not added
 129.34 to the base.

130.1 **Base Adjustment.** The general fund base is
 130.2 increased by \$42,000 in fiscal year 2014 and
 130.3 \$43,000 in fiscal year 2015.

130.4 **Minnesota Food Assistance Program.**
 130.5 \$333,000 in fiscal year 2012 and \$408,000 in
 130.6 fiscal year 2013 are to increase the general
 130.7 fund base for the Minnesota food assistance
 130.8 program. Unexpended funds for fiscal year
 130.9 2012 do not cancel but are available to the
 130.10 commissioner for this purpose in fiscal year
 130.11 2013.

130.12 **(h) Health Care Grants**

130.13	Appropriations by Fund		
130.14	General	26,000	66,000
130.15	Health Care Access	190,000	190,000

130.16 **Base Adjustment.** The general fund base is
 130.17 increased by \$24,000 in each of fiscal years
 130.18 2014 and 2015.

130.19 **(i) Aging and Adult Services Grants** 12,154,000 11,456,000

130.20 **Aging Grants Reduction.** Effective July
 130.21 1, 2011, funding for grants made under
 130.22 Minnesota Statutes, sections 256.9754 and
 130.23 256B.0917, subdivision 13, is reduced by
 130.24 \$3,600,000 for each year of the biennium.
 130.25 These reductions are onetime and do
 130.26 not affect base funding for the 2014-2015
 130.27 biennium. Grants made during the 2012-2013
 130.28 biennium under Minnesota Statutes, section
 130.29 256B.9754, must not be used for new
 130.30 construction or building renovation.

130.31 **Essential Community Support Grant**
 130.32 **Delay.** Upon federal approval to implement
 130.33 the nursing facility level of care on July
 130.34 1, 2013, essential community supports
 130.35 grants under Minnesota Statutes, section

131.1 256B.0917, subdivision 14, are reduced by
 131.2 \$6,410,000 in fiscal year 2013. Base level
 131.3 funding is increased by \$5,541,000 in fiscal
 131.4 year 2014 and \$6,410,000 in fiscal year 2015.

131.5 **Base Level Adjustment.** The general fund
 131.6 base is increased by \$10,035,000 in fiscal
 131.7 year 2014 and increased by \$10,901,000 in
 131.8 fiscal year 2015.

131.9 (j) Deaf and Hard-of-Hearing Grants	1,936,000	1,767,000
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131.10 (k) Disabilities Grants	15,945,000	18,284,000
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131.11 **Grants for Housing Access Services.** In
 131.12 fiscal year 2012, the commissioner shall
 131.13 make available a total of \$161,000 in housing
 131.14 access services grants to individuals who
 131.15 relocate from an adult foster care home to
 131.16 a community living setting for assistance
 131.17 with completion of rental applications or
 131.18 lease agreements; assistance with publicly
 131.19 financed housing options; development of
 131.20 household budgets; and assistance with
 131.21 funding affordable furnishings and related
 131.22 household matters.

131.23 **HIV Grants.** The general fund appropriation
 131.24 for the HIV drug and insurance grant
 131.25 program shall be reduced by \$2,425,000 in
 131.26 fiscal year 2012 and increased by \$2,425,000
 131.27 in fiscal year 2014. These adjustments are
 131.28 onetime and shall not be applied to the base.
 131.29 Notwithstanding any contrary provision, this
 131.30 provision expires June 30, 2014.

131.31 **Region 10.** Of this appropriation, \$100,000
 131.32 each year is for a grant provided under
 131.33 Minnesota Statutes, section 256B.097.

132.1 **Base Level Adjustment.** The general fund
132.2 base is increased by \$2,944,000 in fiscal year
132.3 2014 and \$653,000 in fiscal year 2015.

132.4 **Local Planning Grants for Creating**
132.5 **Alternatives to Congregate Living for**
132.6 **Individuals with Lower Needs.** (1) The
132.7 commissioner shall make available a total
132.8 of \$250,000 per year in local planning
132.9 grants, beginning July 1, 2011, to assist
132.10 lead agencies and provider organizations in
132.11 developing alternatives to congregate living
132.12 within the available level of resources for the
132.13 home and community-based services waivers
132.14 for persons with disabilities.

132.15 (2) Notwithstanding clause (1), for fiscal
132.16 years 2012 and 2013 only, the appropriation
132.17 of \$250,000 for fiscal year 2012 carries
132.18 forward to fiscal year 2013, effective the day
132.19 following final enactment.

132.20 Of the appropriations available for fiscal
132.21 year 2013, \$100,000 is for administrative
132.22 functions related to the planning process
132.23 required under Minnesota Statutes, sections
132.24 144A.351 and 245A.03, subdivision 7,
132.25 paragraphs (e) and (g), and \$400,000 is for
132.26 grants required to accomplish that planning
132.27 process.

132.28 (3) Base funding for the grants under clause
132.29 (1) is not affected by the appropriations
132.30 under clause (2).

132.31 **Disability Linkage Line.** Of this
132.32 appropriation, \$125,000 in fiscal year 2012
132.33 and \$300,000 in fiscal year 2013 are for
132.34 assistance to people with disabilities who are
132.35 considering enrolling in managed care.

133.1 **(l) Adult Mental Health Grants**

133.2 Appropriations by Fund

133.3	General	70,570,000	70,570,000
133.4	Health Care Access	750,000	750,000
133.5	Lottery Prize	1,508,000	1,508,000

133.6 **Funding Usage.** Up to 75 percent of a fiscal
 133.7 year's appropriation for adult mental health
 133.8 grants may be used to fund allocations in that
 133.9 portion of the fiscal year ending December
 133.10 31.

133.11 **Base Adjustment.** The general fund base is
 133.12 increased by \$200,000 in fiscal years 2014
 133.13 and 2015.

133.14	(m) Children's Mental Health Grants	16,457,000	16,457,000
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133.15 **Funding Usage.** Up to 75 percent of a fiscal
 133.16 year's appropriation for children's mental
 133.17 health grants may be used to fund allocations
 133.18 in that portion of the fiscal year ending
 133.19 December 31.

133.20 **Base Adjustment.** The general fund base is
 133.21 increased by \$225,000 in fiscal years 2014
 133.22 and 2015.

133.23	(n) Chemical Dependency Nonentitlement		
133.24	Grants	1,336,000	1,336,000

133.25 Sec. 45. **INDEPENDENT LIVING SERVICES BILLING.**

133.26 The commissioner shall allow for daily rate and 15-minute increment billing for
 133.27 independent living services under the brain injury (BI) and CADI waivers. If necessary to
 133.28 comply with this requirement, the commissioner shall submit a waiver amendment to the
 133.29 state plan no later than December 31, 2012.

133.30 Sec. 46. **HOME AND COMMUNITY-BASED SERVICES WAIVERS**
 133.31 **AMENDMENT FOR EXCEPTION.**

133.32 By September 1, 2012, the commissioner of human services shall submit
 133.33 amendments to the home and community-based waiver plans consistent with the definition

134.1 of home and community-based settings under Minnesota Statutes, section 256B.492,
134.2 including a request to allow an exception for those settings that serve persons with
134.3 disabilities under a home and community-based service waiver in more than 25 percent
134.4 of the units in a building as of January 1, 2012, but otherwise meet the definition under
134.5 Minnesota Statutes, section 256B.492.

134.6 Sec. 47. **COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION**
134.7 **TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
134.8 **METHODOLOGY.**

134.9 By July 1, 2012, the commissioner shall request an amendment to the home and
134.10 community-based services waivers authorized under Minnesota Statutes, sections
134.11 256B.092 and 256B.49, to establish an exception to the consumer-directed community
134.12 supports budget methodology to provide up to 20 percent more funds for those
134.13 participants who have their 21st birthday and graduate from high school during 2013 and
134.14 are authorized for more services under consumer-directed community supports prior to
134.15 graduation than what they are eligible to receive under the current consumer-directed
134.16 community supports budget methodology. The exception is limited to those who can
134.17 demonstrate that they will have to leave consumer-directed community supports and use
134.18 other waiver services because their need for day or employment supports cannot be met
134.19 within the consumer-directed community supports budget limits. The commissioner
134.20 shall consult with the stakeholder group authorized under Minnesota Statutes, section
134.21 256B.0657, subdivision 11, to implement this provision. The exception process shall be
134.22 effective upon federal approval for persons eligible during 2013 and 2014.

134.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

134.24 Sec. 48. **DIRECTION TO OMBUDSMAN FOR LONG-TERM CARE.**

134.25 The ombudsman for long-term care shall:

134.26 (1) research the existence of differential treatment based on source of payment in
134.27 assisted living settings;

134.28 (2) convene stakeholders to provide technical assistance and expertise in studying
134.29 and addressing these issues, including but not limited to consumers, health care and
134.30 housing providers, advocates representing seniors and younger persons with disabilities or
134.31 mental health challenges, county representatives, and representatives of the Departments
134.32 of Health and Human Services; and

134.33 (3) submit a report of findings to the legislature no later than January 31, 2013,
134.34 with recommendations for the development of policies and procedures to prevent and

135.1 remedy instances of discrimination based on participation in or potential eligibility for
135.2 medical assistance.

135.3 **Sec. 49. LICENSING PERSONAL CARE ATTENDANT SERVICES.**

135.4 The commissioner of human services shall study the feasibility of licensing personal
135.5 care attendant services and issue a report to the legislature no later than January 15, 2013,
135.6 that includes recommendations and proposed legislation for licensure and oversight of
135.7 these services.

135.8 **Sec. 50. AUTISM HOUSING WITH SUPPORTS STUDY.**

135.9 The commissioner of human services, in consultation with the commissioners of
135.10 education, health, and employment and economic development, shall complete a study
135.11 to determine one or more models of housing with supports that involve coordination or
135.12 integration across the human services, educational, and vocational systems for children
135.13 with a diagnosis of autistic disorder as defined by diagnostic code 299.0 in the Diagnostic
135.14 and Statistical Manual of Mental Disorders (DSM-IV). This study must include research
135.15 on recent efforts undertaken or under consideration in other states to address the housing
135.16 and long-term support needs of children with severe autism, including a campus model.
135.17 The study shall result in an implementation plan that responds to the housing and service
135.18 needs of persons with autism. The study is due to the chairs and ranking minority
135.19 members of the legislative committees with jurisdiction over health and human services
135.20 by January 15, 2013.

135.21 **Sec. 51. REPEALER.**

135.22 (a) Minnesota Statutes 2010, sections 144A.073, subdivision 9; and 256B.48,
135.23 subdivision 6, are repealed.

135.24 (b) Minnesota Rules, part 4640.0800, subpart 4, is repealed.

135.25 **ARTICLE 5**

135.26 **MISCELLANEOUS**

135.27 Section 1. Minnesota Statutes 2010, section 62A.047, is amended to read:

135.28 **62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND**
135.29 **PRENATAL CARE SERVICES.**

135.30 A policy of individual or group health and accident insurance regulated under this
135.31 chapter, or individual or group subscriber contract regulated under chapter 62C, health

136.1 maintenance contract regulated under chapter 62D, or health benefit certificate regulated
136.2 under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota
136.3 resident, must provide coverage for child health supervision services and prenatal care
136.4 services. The policy, contract, or certificate must specifically exempt reasonable and
136.5 customary charges for child health supervision services and prenatal care services from a
136.6 deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing
136.7 in this section prohibits a health carrier that has a network of providers from imposing
136.8 a deductible, co-payment, or other coinsurance or dollar limitation requirement for
136.9 child health supervision services and prenatal care services that are delivered by an
136.10 out-of-network provider. This section does not prohibit the use of policy waiting periods
136.11 or preexisting condition limitations for these services. Minimum benefits may be limited
136.12 to one visit payable to one provider for all of the services provided at each visit cited in
136.13 this section subject to the schedule set forth in this section. ~~Nothing in this section applies~~
136.14 ~~to a commercial health insurance policy issued as a companion to a health maintenance~~
136.15 ~~organization contract, a policy designed primarily to provide coverage payable on a per~~
136.16 ~~diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only~~
136.17 ~~accident coverage.~~ Nothing in this section applies to a policy designed primarily to provide
136.18 coverage payable on a per diem, fixed indemnity, or non-expense-incurred basis, or a
136.19 policy that provides only accident coverage.

136.20 "Child health supervision services" means pediatric preventive services, appropriate
136.21 immunizations, developmental assessments, and laboratory services appropriate to the age
136.22 of a child from birth to age six, and appropriate immunizations from ages six to 18, as
136.23 defined by Standards of Child Health Care issued by the American Academy of Pediatrics.
136.24 Reimbursement must be made for at least five child health supervision visits from birth
136.25 to 12 months, three child health supervision visits from 12 months to 24 months, once a
136.26 year from 24 months to 72 months.

136.27 "Prenatal care services" means the comprehensive package of medical and
136.28 psychosocial support provided throughout the pregnancy, including risk assessment,
136.29 serial surveillance, prenatal education, and use of specialized skills and technology,
136.30 when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the
136.31 American College of Obstetricians and Gynecologists.

136.32 **EFFECTIVE DATE.** The amendments to this section are effective for policies
136.33 issued on or after August 1, 2012, and expire June 30, 2013.

136.34 Sec. 2. Minnesota Statutes 2010, section 245.697, subdivision 1, is amended to read:

- 137.1 Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created.
- 137.2 The council must have ~~30~~ members appointed by the governor in accordance with federal
- 137.3 requirements. In making the appointments, the governor shall consider appropriate
- 137.4 representation of communities of color. The council must be composed of:
- 137.5 (1) the assistant commissioner of mental health for the department of human services;
- 137.6 (2) a representative of the Department of Human Services responsible for the
- 137.7 medical assistance program;
- 137.8 (3) one member of each of the ~~four core mental health professional disciplines~~
- 137.9 ~~(psychiatry, psychology, social work, nursing);~~ following professions:
- 137.10 (i) psychiatry;
- 137.11 (ii) psychology;
- 137.12 (iii) social work;
- 137.13 (iv) nursing;
- 137.14 (v) marriage and family therapy; and
- 137.15 (vi) professional clinical counseling;
- 137.16 (4) one representative from each of the following advocacy groups: Mental Health
- 137.17 Association of Minnesota, NAMI-MN, Mental Health Consumer/Survivor Network of
- 137.18 Minnesota, and Minnesota Disability Law Center;
- 137.19 (5) providers of mental health services;
- 137.20 (6) consumers of mental health services;
- 137.21 (7) family members of persons with mental illnesses;
- 137.22 (8) legislators;
- 137.23 (9) social service agency directors;
- 137.24 (10) county commissioners; and
- 137.25 (11) other members reflecting a broad range of community interests, including
- 137.26 family physicians, or members as the United States Secretary of Health and Human
- 137.27 Services may prescribe by regulation or as may be selected by the governor.
- 137.28 (b) The council shall select a chair. Terms, compensation, and removal of members
- 137.29 and filling of vacancies are governed by section 15.059. Notwithstanding provisions
- 137.30 of section 15.059, the council and its subcommittee on children's mental health do not
- 137.31 expire. The commissioner of human services shall provide staff support and supplies
- 137.32 to the council.

137.33 Sec. 3. Minnesota Statutes 2010, section 254A.19, is amended by adding a subdivision

137.34 to read:

138.1 Subd. 4. **Civil commitments.** A Rule 25 assessment, under Minnesota Rules,
138.2 part 9530.6615, does not need to be completed for an individual being committed as a
138.3 chemically dependent person, as defined in section 253B.02, and for the duration of a civil
138.4 commitment under section 253B.065, 253B.09, or 253B.095 in order for a county to
138.5 access consolidated chemical dependency treatment funds under section 254B.04. The
138.6 county must determine if the individual meets the financial eligibility requirements for the
138.7 consolidated chemical dependency treatment funds under section 254B.04. Nothing in
138.8 this subdivision prohibits placement in a treatment facility or treatment program governed
138.9 under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.

138.10 Sec. 4. Minnesota Statutes 2010, section 256B.0943, subdivision 9, is amended to read:

138.11 **Subd. 9. Service delivery criteria.** (a) In delivering services under this section, a
138.12 certified provider entity must ensure that:

138.13 (1) each individual provider's caseload size permits the provider to deliver services
138.14 to both clients with severe, complex needs and clients with less intensive needs. The
138.15 provider's caseload size should reasonably enable the provider to play an active role in
138.16 service planning, monitoring, and delivering services to meet the client's and client's
138.17 family's needs, as specified in each client's individual treatment plan;

138.18 (2) site-based programs, including day treatment and preschool programs, provide
138.19 staffing and facilities to ensure the client's health, safety, and protection of rights, and that
138.20 the programs are able to implement each client's individual treatment plan;

138.21 (3) a day treatment program is provided to a group of clients by a multidisciplinary
138.22 team under the clinical supervision of a mental health professional. The day treatment
138.23 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
138.24 Commission on Accreditation of Health Organizations and licensed under sections 144.50
138.25 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity
138.26 that is ~~under contract with the county board~~ certified under subdivision 4 to operate a
138.27 program that meets the requirements of section ~~245.4712, subdivision 2,~~ or 245.4884,
138.28 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment
138.29 program must stabilize the client's mental health status while developing and improving
138.30 the client's independent living and socialization skills. The goal of the day treatment
138.31 program must be to reduce or relieve the effects of mental illness and provide training to
138.32 enable the client to live in the community. The program must be available at least one day
138.33 a week for a two-hour time block. The two-hour time block must include at least one hour
138.34 of individual or group psychotherapy. The remainder of the structured treatment program
138.35 may include individual or group psychotherapy, and individual or group skills training, if

139.1 included in the client's individual treatment plan. Day treatment programs are not part of
139.2 inpatient or residential treatment services. A day treatment program may provide fewer
139.3 than the minimally required hours for a particular child during a billing period in which
139.4 the child is transitioning into, or out of, the program; and

139.5 (4) a therapeutic preschool program is a structured treatment program offered
139.6 to a child who is at least 33 months old, but who has not yet reached the first day of
139.7 kindergarten, by a preschool multidisciplinary team in a day program licensed under
139.8 Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available two
139.9 hours per day, five days per week, and 12 months of each calendar year. The structured
139.10 treatment program may include individual or group psychotherapy and individual or
139.11 group skills training, if included in the client's individual treatment plan. A therapeutic
139.12 preschool program may provide fewer than the minimally required hours for a particular
139.13 child during a billing period in which the child is transitioning into, or out of, the program.

139.14 (b) A provider entity must deliver the service components of children's therapeutic
139.15 services and supports in compliance with the following requirements:

139.16 (1) individual, family, and group psychotherapy must be delivered as specified in
139.17 Minnesota Rules, part 9505.0323;

139.18 (2) individual, family, or group skills training must be provided by a mental health
139.19 professional or a mental health practitioner who has a consulting relationship with a
139.20 mental health professional who accepts full professional responsibility for the training;

139.21 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
139.22 through arrangements for direct intervention and support services to the child and the
139.23 child's family. Crisis assistance must utilize resources designed to address abrupt or
139.24 substantial changes in the functioning of the child or the child's family as evidenced by
139.25 a sudden change in behavior with negative consequences for well being, a loss of usual
139.26 coping mechanisms, or the presentation of danger to self or others;

139.27 (4) mental health behavioral aide services must be medically necessary treatment
139.28 services, identified in the child's individual treatment plan and individual behavior plan,
139.29 which are performed minimally by a paraprofessional qualified according to subdivision
139.30 7, paragraph (b), clause (3), and which are designed to improve the functioning of the
139.31 child in the progressive use of developmentally appropriate psychosocial skills. Activities
139.32 involve working directly with the child, child-peer groupings, or child-family groupings
139.33 to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph
139.34 (p), as previously taught by a mental health professional or mental health practitioner
139.35 including:

- 140.1 (i) providing cues or prompts in skill-building peer-to-peer or parent-child
 140.2 interactions so that the child progressively recognizes and responds to the cues
 140.3 independently;
- 140.4 (ii) performing as a practice partner or role-play partner;
- 140.5 (iii) reinforcing the child's accomplishments;
- 140.6 (iv) generalizing skill-building activities in the child's multiple natural settings;
- 140.7 (v) assigning further practice activities; and
- 140.8 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
 140.9 behavior that puts the child or other person at risk of injury.

140.10 A mental health behavioral aide must document the delivery of services in written
 140.11 progress notes. The mental health behavioral aide must implement treatment strategies
 140.12 in the individual treatment plan and the individual behavior plan. The mental health
 140.13 behavioral aide must document the delivery of services in written progress notes. Progress
 140.14 notes must reflect implementation of the treatment strategies, as performed by the mental
 140.15 health behavioral aide and the child's responses to the treatment strategies; and

140.16 (5) direction of a mental health behavioral aide must include the following:

- 140.17 (i) a clinical supervision plan approved by the responsible mental health professional;
- 140.18 (ii) ongoing on-site observation by a mental health professional or mental health
 140.19 practitioner for at least a total of one hour during every 40 hours of service provided
 140.20 to a child; and
- 140.21 (iii) immediate accessibility of the mental health professional or mental health
 140.22 practitioner to the mental health behavioral aide during service provision.

140.23 Sec. 5. Minnesota Statutes 2010, section 518A.40, subdivision 4, is amended to read:

140.24 Subd. 4. **Change in child care.** (a) When a court order provides for child care
 140.25 expenses, and child care support is not assigned under section 256.741, the public
 140.26 authority, if the public authority provides child support enforcement services, ~~must~~ may
 140.27 suspend collecting the amount allocated for child care expenses when:

140.28 ~~(1)~~ either party informs the public authority that no child care costs are being
 140.29 incurred; and;

140.30 ~~(2)~~ (1) the public authority verifies the accuracy of the information with the obligee;
 140.31 or

140.32 (2) the obligee fails to respond within 30 days of the date of a written request
 140.33 from the public authority for information regarding child care costs. A written or oral
 140.34 response from the obligee that child care costs are being incurred is sufficient for the
 140.35 public authority to continue collecting child care expenses.

141.1 The suspension is effective as of the first day of the month following the date that the
 141.2 public authority ~~received the verification~~ either verified the information with the obligee
 141.3 or the obligee failed to respond. The public authority will resume collecting child care
 141.4 expenses when either party provides information that child care costs ~~have resumed~~ are
 141.5 incurred, or when a child care support assignment takes effect under section 256.741,
 141.6 subdivision 4. The resumption is effective as of the first day of the month after the date
 141.7 that the public authority received the information.

141.8 (b) If the parties provide conflicting information to the public authority regarding
 141.9 whether child care expenses are being incurred, ~~or if the public authority is unable to~~
 141.10 ~~verify with the obligee that no child care costs are being incurred~~, the public authority will
 141.11 continue or resume collecting child care expenses. Either party, by motion to the court,
 141.12 may challenge the suspension, continuation, or resumption of the collection of child care
 141.13 expenses under this subdivision. If the public authority suspends collection activities
 141.14 for the amount allocated for child care expenses, all other provisions of the court order
 141.15 remain in effect.

141.16 (c) In cases where there is a substantial increase or decrease in child care expenses,
 141.17 the parties may modify the order under section 518A.39.

141.18 Sec. 6. Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8,
 141.19 is amended to read:

141.20 Subd. 8. **Board of Nursing Home**
 141.21 **Administrators** 2,153,000 2,145,000

141.22 **Rulemaking.** Of this appropriation, \$44,000
 141.23 in fiscal year 2012 is for rulemaking. This is
 141.24 a onetime appropriation.

141.25 **Electronic Licensing System Adaptors.**
 141.26 Of this appropriation, \$761,000 in fiscal
 141.27 year 2013 from the state government special
 141.28 revenue fund is to the administrative services
 141.29 unit to cover the costs to connect to the
 141.30 e-licensing system. Minnesota Statutes,
 141.31 section 16E.22. Base level funding for this
 141.32 activity in fiscal year 2014 shall be \$100,000.
 141.33 Base level funding for this activity in fiscal
 141.34 year 2015 shall be \$50,000.

142.1 **Development and Implementation of a**
142.2 **Disciplinary, Regulatory, Licensing and**
142.3 **Information Management System.** Of this
142.4 appropriation, \$800,000 in fiscal year 2012
142.5 and \$300,000 in fiscal year 2013 are for the
142.6 development of a shared system. Base level
142.7 funding for this activity in fiscal year 2014
142.8 shall be \$50,000.

142.9 **Administrative Services Unit - Operating**
142.10 **Costs.** Of this appropriation, \$526,000
142.11 in fiscal year 2012 and \$526,000 in
142.12 fiscal year 2013 are for operating costs
142.13 of the administrative services unit. The
142.14 administrative services unit may receive
142.15 and expend reimbursements for services
142.16 performed by other agencies.

142.17 **Administrative Services Unit - Retirement**
142.18 **Costs.** Of this appropriation in fiscal year
142.19 2012, \$225,000 is for onetime retirement
142.20 costs in the health-related boards. This
142.21 funding may be transferred to the health
142.22 boards incurring those costs for their
142.23 payment. These funds are available either
142.24 year of the biennium.

142.25 **Administrative Services Unit - Volunteer**
142.26 **Health Care Provider Program.** Of this
142.27 appropriation, \$150,000 in fiscal year 2012
142.28 and \$150,000 in fiscal year 2013 are to pay
142.29 for medical professional liability coverage
142.30 required under Minnesota Statutes, section
142.31 214.40.

142.32 **Administrative Services Unit - Contested**
142.33 **Cases and Other Legal Proceedings.** Of
142.34 this appropriation, \$200,000 in fiscal year
142.35 2012 and \$200,000 in fiscal year 2013 are

143.1 for costs of contested case hearings and other
143.2 unanticipated costs of legal proceedings
143.3 involving health-related boards funded
143.4 under this section. Upon certification of a
143.5 health-related board to the administrative
143.6 services unit that the costs will be incurred
143.7 and that there is insufficient money available
143.8 to pay for the costs out of money currently
143.9 available to that board, the administrative
143.10 services unit is authorized to transfer money
143.11 from this appropriation to the board for
143.12 payment of those costs with the approval
143.13 of the commissioner of management and
143.14 budget. This appropriation does not cancel.
143.15 Any unencumbered and unspent balances
143.16 remain available for these expenditures in
143.17 subsequent fiscal years.

143.18 **Base Adjustment.** The State Government
143.19 Special Revenue Fund base is decreased by
143.20 \$911,000 in fiscal year 2014 and ~~\$1,011,000~~
143.21 \$961,000 in fiscal year 2015.

143.22 Sec. 7. **FOSTER CARE FOR INDIVIDUALS WITH AUTISM.**

143.23 The commissioner of human services shall identify and coordinate with one or more
143.24 counties that agree to issue a foster care license and authorize funding for people with
143.25 autism who are currently receiving home and community-based services under Minnesota
143.26 Statutes, section 256B.092 or 256B.49. Children eligible under this section must be in an
143.27 out-of-home placement approved by the lead agency that has legal responsibility for the
143.28 placement. Nothing in this section must be construed as restricting an individual's choice
143.29 of provider. The commissioner will assist the interested county or counties with obtaining
143.30 necessary capacity within the moratorium under Minnesota Statutes, section 245A.03,
143.31 subdivision 7. The commissioner shall coordinate with the interested counties and issue a
143.32 request for information to identify providers who have the training and skills to meet the
143.33 needs of the individuals identified in this section.

145.1				
145.2				
145.3				
145.4				
				<u>APPROPRIATIONS</u>
				<u>Available for the Year</u>
				<u>Ending June 30</u>
				<u>2012</u> <u>2013</u>
145.5	Sec. 2. <u>COMMISSIONER OF HUMAN</u>			
145.6	<u>SERVICES</u>			
145.7	<u>Subdivision 1. Total Appropriation</u>		<u>\$ 1,352,000</u>	<u>\$ 19,849,000</u>
145.8	<u>Appropriations by Fund</u>			
145.9		<u>2012</u>	<u>2013</u>	
145.10	<u>General</u>	<u>803,000</u>	<u>9,680,000</u>	
145.11	<u>Health Care Access</u>	<u>-0-</u>	<u>3,000</u>	
145.12	<u>Federal TANF</u>	<u>-0-</u>	<u>7,453,000</u>	
145.13	<u>Special Revenue</u>	<u>549,000</u>	<u>2,713,000</u>	
145.14	<u>Subd. 2. Central Office Operations</u>			
145.15	<u>(a) Operations</u>		<u>118,000</u>	<u>356,000</u>
145.16	<u>Base Level Adjustment.</u> The general fund			
145.17	<u>base is increased by \$91,000 in fiscal year</u>			
145.18	<u>2014 and \$44,000 in fiscal year 2015.</u>			
145.19	<u>(b) Health Care</u>		<u>24,000</u>	<u>346,000</u>
145.20	<u>This is a onetime appropriation.</u>			
145.21	<u>Managed Care Audit Activities.</u> In fiscal			
145.22	<u>year 2014, and in each even-numbered year</u>			
145.23	<u>thereafter, the commissioner shall transfer</u>			
145.24	<u>from the health care access fund \$1,740,000</u>			
145.25	<u>to the legislative auditor for managed care</u>			
145.26	<u>audit services under Minnesota Statutes,</u>			
145.27	<u>section 256B.69, subdivision 9d. This is</u>			
145.28	<u>a biennial appropriation. The health care</u>			
145.29	<u>access fund base is increased by \$1,842,000</u>			
145.30	<u>in fiscal year 2014. Notwithstanding any</u>			
145.31	<u>contrary provision in this article, this</u>			
145.32	<u>paragraph does not expire.</u>			
145.33	<u>(c) Continuing Care</u>		<u>19,000</u>	<u>375,000</u>

146.1 **Base Level Adjustment.** The general fund
 146.2 base is decreased by \$159,000 in fiscal years
 146.3 2014 and 2015.

146.4 **Subd. 3. Chemical and Mental Health** 19,000 68,000

146.5 **Base Level Adjustment.** The general fund
 146.6 base is decreased by \$68,000 in fiscal years
 146.7 2014 and 2015.

146.8 **Subd. 4. Forecasted Programs**

146.9 **(a) MFIP/DWP Grants**

146.10 Appropriations by Fund

	<u>2012</u>	<u>2013</u>
146.11 <u>General</u>	<u>-0-</u>	<u>(7,009,000)</u>
146.12 <u>Federal TANF</u>	<u>-0-</u>	<u>7,000,000</u>

146.14 **(b) General Assistance Grants** -0- (8,000)

146.15 **(c) Minnesota Supplemental Aid Grants** -0- 152,000

146.16 **(d) MinnesotaCare Grants** -0- 3,000

146.17 This appropriation is from the health care
 146.18 access fund.

146.19 **(e) Group Residential Housing Grants** -0- (202,000)

146.20 **(f) Medical Assistance Grants** 623,000 14,303,000

146.21 **PCA Relative Care Payment Recovery.**
 146.22 Notwithstanding any law to the contrary, and
 146.23 if, at the conclusion of the HealthStar Home
 146.24 Health, Inc et al v. Commissioner of Human
 146.25 Services litigation, the PCA relative rate
 146.26 reduction under Minnesota Statutes, section
 146.27 256B.0659, subdivision 11, paragraph (c),
 146.28 is upheld, the commissioner is prohibited
 146.29 from recovering the difference between the
 146.30 100 percent rate paid to providers and the
 146.31 80 percent rate, during the period of the
 146.32 temporary injunction issued on October 26,
 146.33 2011. This section does not prohibit the

147.1 commissioner from recovering any other
147.2 overpayments from providers.

147.3 **Long-Term Care Realignment Waiver**

147.4 **Conformity.** Notwithstanding Minnesota
147.5 Statutes, section 256B.0916, subdivision 14,
147.6 and upon federal approval of the long-term
147.7 care realignment waiver application,
147.8 essential community support grants must be
147.9 made available in a manner that is consistent
147.10 with the state's long-term care realignment
147.11 waiver application submitted on February
147.12 13, 2012. The commissioner is authorized
147.13 to use increased federal matching funds
147.14 resulting from approval of the long-term care
147.15 realignment waiver as necessary to meet
147.16 the fiscal year 2013 demand for essential
147.17 community support grants administered in a
147.18 manner that is consistent with the terms and
147.19 conditions of the long-term care realignment
147.20 waiver, and that amount of federal funds is
147.21 appropriated to the commissioner for this
147.22 purpose.

147.23 **Continuing Care Provider Payment**

147.24 **Delay.** The commissioner of human services
147.25 shall delay the last payment or payments
147.26 in fiscal year 2013 to providers listed in
147.27 Minnesota Statutes 2011 Supplement,
147.28 section 256B.5012, subdivision 13, and
147.29 Laws 2011, First Special Session chapter
147.30 9, article 7, section 54, paragraph (b),
147.31 by up to \$20,688,000. In calculating the
147.32 actual payment amounts to be delayed, the
147.33 commissioner must reduce the \$20,688,000
147.34 amount by any cash basis state share
147.35 savings to be realized in fiscal year 2013
147.36 from implementing the long-term care

148.1 realignment waiver before July 1, 2013.
 148.2 The commissioner shall make the delayed
 148.3 payments in July 2013. Notwithstanding
 148.4 any contrary provision in this article, this
 148.5 provision expires on August 1, 2013.

148.6 **Critical Access Nursing Facilities**

148.7 **Designation.** \$500,000 is appropriated in
 148.8 fiscal year 2013 for critical access nursing
 148.9 facilities under Minnesota Statutes, section
 148.10 256B.441, subdivision 63. This is a onetime
 148.11 appropriation and is available until expended.

148.12 **Subd. 5. Grant Programs**

148.13	<u>(a) Children and Economic Support Grants</u>	-0-	<u>450,000</u>
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148.14 **Long-Term Homeless Supportive Services.**
 148.15 \$200,000 in fiscal year 2013 from the TANF
 148.16 fund is for long-term homeless supportive
 148.17 services for low-income families under
 148.18 Minnesota Statutes, section 256K.26. This is
 148.19 a onetime appropriation.

148.20 **Family Assets for Independence Program.**
 148.21 \$250,000 in fiscal year 2013 from the
 148.22 TANF fund is for grants for the family
 148.23 assets for independence program under
 148.24 Minnesota Statutes, section 256E.35. This
 148.25 appropriation must be used to serve families
 148.26 with income below 200 percent of the federal
 148.27 poverty guidelines and minor children in the
 148.28 household. This is a onetime appropriation
 148.29 and is available until June 30, 2014.

148.30 **TANF Transfer to Federal Child Care**
 148.31 **and Development Fund.** (1) In addition
 148.32 to the amount provided in this section, the
 148.33 commissioner shall transfer TANF funds to
 148.34 basic sliding fee child care assistance under
 148.35 Minnesota Statutes, section 119B.03:

149.1 (i) fiscal year 2013, \$1,000; and
 149.2 (ii) fiscal year 2014 and ongoing, \$6,000.
 149.3 (2) The commissioner shall authorize the
 149.4 transfer of sufficient TANF funds to the
 149.5 federal child care and development fund to
 149.6 meet this appropriation and shall ensure that
 149.7 all transferred funds are expended according
 149.8 to federal child care and development fund
 149.9 regulations.

149.10 **(b) Aging and Adult Services Grants** -0- 999,000

149.11 In fiscal year 2013, upon federal approval
 149.12 to implement the nursing facility level
 149.13 of care under Minnesota Statutes, section
 149.14 144.0724, subdivision 11, \$999,000 is for
 149.15 essential community supports grants. This is
 149.16 a onetime appropriation.

149.17 **(c) Disabilities Grants** -0- 300,000

149.18 **Intractable Epilepsy.** This appropriation
 149.19 includes \$65,000 for living skills training
 149.20 programs for persons with intractable
 149.21 epilepsy who need assistance in the transition
 149.22 to independent living under Laws 1988,
 149.23 chapter 689, article 2, section 251. This
 149.24 appropriation is ongoing.

149.25 **Self-advocacy Network for Persons with**
 149.26 **Disabilities.**

149.27 (1) \$50,000 is appropriated in fiscal year
 149.28 2013 to establish and maintain a statewide
 149.29 self-advocacy network for persons with
 149.30 intellectual and developmental disabilities.
 149.31 This is a onetime appropriation and is
 149.32 available until expended.

149.33 (2) The self-advocacy network must focus on
 149.34 ensuring that persons with disabilities are:

150.1 (i) informed of and educated about their legal
 150.2 rights in the areas of education, employment,
 150.3 housing, transportation, and voting; and
 150.4 (ii) educated and trained to self-advocate for
 150.5 their rights under law.
 150.6 (3) Self-advocacy network activities under
 150.7 this section include but are not limited to:
 150.8 (i) education and training, including
 150.9 preemployment and workplace skills;
 150.10 (ii) establishment and maintenance of a
 150.11 communication and information exchange
 150.12 system for self-advocacy groups; and
 150.13 (iii) financial and technical assistance to
 150.14 self-advocacy groups.

150.15 **Base Level Adjustment.** The general fund
 150.16 base is increased by \$23,000 in fiscal year
 150.17 2014 and decreased by \$235,000 in fiscal
 150.18 year 2015.

150.19 <u>Subd. 6. State-Operated Services</u>	<u>549,000</u>	<u>2,713,000</u>
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150.20 **Minnesota Specialty Health Services -**
 150.21 **Willmar.** \$549,000 in fiscal year 2012
 150.22 and \$2,713,000 in fiscal year 2013 from
 150.23 the account established under Minnesota
 150.24 Statutes, section 246.18, subdivision 8, is
 150.25 for continued operation of the Minnesota
 150.26 Specialty Health Services - Willmar. These
 150.27 appropriations are onetime from the special
 150.28 revenue fund. Closure of the facility shall
 150.29 not occur prior to June 30, 2013.

150.30 <u>Subd. 7. Technical Activities</u>	<u>-0-</u>	<u>3,000</u>
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150.31 This appropriation is from the TANF fund.

151.1 **Base Level Adjustment.** The TANF fund
 151.2 base is increased by \$13,000 in fiscal years
 151.3 2014 and 2015.

151.4 Sec. 3. **COMMISSIONER OF HEALTH**

151.5 **Subdivision 1. Total Appropriation** \$ -0- \$ 501,000

151.6 Appropriations by Fund

	<u>2012</u>	<u>2013</u>
151.7 <u>General</u>	<u>-0-</u>	<u>364,000</u>
151.8 <u>Health Care Access</u>	<u>-0-</u>	<u>137,000</u>

151.10 **Subd. 2. Community and Family Health**

151.11 **Promotions** -0- 200,000

151.12 **Autism Study.** \$200,000 is for the
 151.13 commissioner of health, in partnership with
 151.14 the University of Minnesota, to conduct a
 151.15 qualitative study focused on cultural and
 151.16 resource-based aspects of autism spectrum
 151.17 disorders (ASD) that are unique to the
 151.18 Somali community. By February 15,
 151.19 2014, the commissioner shall report the
 151.20 findings of this study to the legislature. The
 151.21 report must include recommendations as to
 151.22 establishment of a population-based public
 151.23 health surveillance system for ASD. This is a
 151.24 onetime appropriation and is available until
 151.25 June 30, 2014.

151.26 **Subd. 3. Policy Quality and Compliance**

151.27 Appropriations by Fund

	<u>2012</u>	<u>2013</u>
151.28 <u>General</u>	<u>-0-</u>	<u>164,000</u>
151.29 <u>Health Care Access</u>	<u>-0-</u>	<u>137,000</u>

151.31 **Web Site Changes.** \$36,000 is for
 151.32 Web site changes required as part of the
 151.33 evaluation of health and human services
 151.34 regulatory responsibilities. This is a onetime
 151.35 appropriation and must be shared with the

152.1 Department of Human Services through an
 152.2 interagency agreement.

152.3 **Management and Budget.** \$100,000 is for
 152.4 transfer to the commissioner of management
 152.5 and budget for the evaluation of health and
 152.6 human services regulatory responsibilities.

152.7 This is a onetime appropriation.

152.8 **Nursing Facility Moratorium Exceptions.**

152.9 In fiscal year 2013, \$8,000 is for
 152.10 administrative costs related to review
 152.11 of moratorium exception projects under
 152.12 Minnesota Statutes, section 144A.073,
 152.13 subdivision 13. This is a onetime

152.14 appropriation.

152.15 **Health Record Access Study.** \$20,000
 152.16 in fiscal year 2013 is for the health record
 152.17 access study. This is a onetime appropriation.

152.18 **Radiation Therapy Facilities Study.** In
 152.19 fiscal year 2013, \$137,000 from the health
 152.20 care access fund is for a study of radiation
 152.21 therapy facilities capacity. This is a onetime
 152.22 appropriation.

152.23 **Sec. 4. BOARD OF NURSING HOME**
 152.24 **ADMINISTRATORS**

\$

-0- **\$**

10,000

152.25 **Administrative Services Unit.** This
 152.26 appropriation is to provide a grant to the
 152.27 Minnesota Ambulance Association to
 152.28 coordinate and prepare an assessment of
 152.29 the extent and costs of uncompensated care
 152.30 as a direct result of emergency responses
 152.31 on interstate highways in Minnesota.
 152.32 The study will collect appropriate
 152.33 information from medical response units
 152.34 and ambulance services regulated under
 152.35 Minnesota Statutes, chapter 144E, and to

153.1 the extent possible, firefighting agencies.
153.2 In preparing the assessment, the Minnesota
153.3 Ambulance Association shall consult with
153.4 its membership, the Minnesota Fire Chiefs
153.5 Association, the Office of the State Fire
153.6 Marshal, and the Emergency Medical
153.7 Services Regulatory Board. The findings
153.8 of the assessment will be reported to the
153.9 chairs and ranking minority members of the
153.10 legislative committees with jurisdiction over
153.11 health and public safety by January 1, 2013.

153.12 Sec. 5. **MANAGED CARE ORGANIZATION EXCESS PROFITS.**

153.13 Excess profits of managed care organizations paid to the commissioner of human
153.14 services in fiscal year 2013 shall be deposited in the funds from which the payments
153.15 originated. These amounts are estimated to be \$27,740,000 for the general fund and
153.16 \$7,300,000 for the health care access fund.

153.17 Sec. 6. **EXPIRATION OF UNCODIFIED LANGUAGE.**

153.18 All uncodified language contained in this article expires on June 30, 2013, unless a
153.19 different expiration date is explicit.

153.20 Sec. 7. **EFFECTIVE DATE.**

153.21 The provisions in this article are effective July 1, 2012, unless a different effective
153.22 date is explicit.

APPENDIX
Article locations in H2294-4

ARTICLE 1	HEALTH CARE	Page.Ln 2.4
ARTICLE 2	DEPARTMENT OF HEALTH	Page.Ln 29.13
ARTICLE 3	CHILDREN AND FAMILY SERVICES	Page.Ln 42.29
ARTICLE 4	CONTINUING CARE	Page.Ln 68.1
ARTICLE 5	MISCELLANEOUS	Page.Ln 135.25
ARTICLE 6	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 144.22

62M.09 STAFF AND PROGRAM QUALIFICATIONS; ANNUAL REPORT.

Subd. 9. **Annual report.** A utilization review organization shall file an annual report with the annual financial statement it submits to the commissioner of commerce that includes:

- (1) per 1,000 utilization reviews, the number and rate of determinations not to certify based on medical necessity for each procedure or service; and
- (2) the number and rate of denials overturned on appeal.

A utilization review organization that is not a licensed health carrier must submit the annual report required by this subdivision on April 1 of each year.

62Q.64 DISCLOSURE OF EXECUTIVE COMPENSATION.

(a) Each health plan company doing business in this state whose annual Minnesota premiums exceed \$10,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association shall annually file with either the commissioner of commerce or the commissioner of health, as appropriate:

- (1) a copy of the health plan company's form 990 filed with the federal Internal Revenue Service; or
- (2) if the health plan company did not file a form 990 with the federal Internal Revenue Service, a list of the amount and recipients of the health plan company's five highest salaries, including all types of compensation, in excess of \$50,000.

(b) A filing under this section is public data under section 13.03.

144A.073 EXCEPTIONS TO MORATORIUM; REVIEW.

Subd. 9. **Budget request.** The commissioner of human services, in consultation with the commissioner of management and budget, shall include in each biennial budget request a line item for the nursing home moratorium exception process. If the commissioner of human services does not request funding for this item, the commissioner of human services must justify the decision in the budget pages.

256B.48 CONDITIONS FOR PARTICIPATION.

Subd. 6. **Medicare certification.** (a) For purposes of this subdivision, "nursing facility" means a nursing facility that is certified as a skilled nursing facility or, after September 30, 1990, a nursing facility licensed under chapter 144A that is certified as a nursing facility.

(b) All nursing facilities shall participate in Medicare Part A and Part B unless, after submitting an application, Medicare certification is denied by the federal Centers for Medicare and Medicaid Services. Medicare review shall be conducted at the time of the annual medical assistance review. Charges for Medicare-covered services provided to residents who are simultaneously eligible for medical assistance and Medicare must be billed to Medicare Part A or Part B before billing medical assistance. Medical assistance may be billed only for charges not reimbursed by Medicare.

(c) After September 30, 1990, a nursing facility satisfies the requirements of paragraph (b) if at least 50 percent of the facility's beds certified as nursing facility beds under the medical assistance program are Medicare certified.

(d) At the request of a facility, the commissioner of human services may reduce the 50 percent Medicare participation requirement in paragraph (c) to no less than 20 percent if the commissioner of health determines that, due to the facility's physical plant configuration, the facility cannot satisfy Medicare distinct part requirements at the 50 percent certification level. To receive a reduction in the participation requirement, a facility must demonstrate that the reduction will not adversely affect access of Medicare-eligible residents to Medicare-certified beds.

(e) The commissioner may grant exceptions to the requirements of paragraph (b) for nursing facilities that are designated as institutions for mental disease.

(f) The commissioner shall inform recipients of their rights under this subdivision and section 144.651, subdivision 29.

APPENDIX
Repealed Minnesota Rule: H2294-4

4640.0800 THE MEDICAL STAFF.

Subp. 4. **Orders for treatment.** No medication or treatment shall be given to a patient except on the written order of a member of the medical staff. Emergency orders given by telephone shall be reduced to writing immediately upon receipt and shall be signed by the staff member within 24 hours after the order is given.

4685.2000 [Repealed, L 2012 c 247 art 1 s 32]