

A bill for an act

relating to state government; establishing the health and human services budget; making changes to children and family services, Department of Health, health licensing boards, miscellaneous provisions, health licensing fees, health care, and continuing care; redesigning service delivery; making changes to chemical and mental health; modifying fee schedules; modifying program eligibility requirements; authorizing rulemaking; requiring reports; appropriating money for the Departments of Health and Human Services and other health-related boards and councils; making forecast adjustments; amending Minnesota Statutes 2010, sections 3.98, by adding a subdivision; 62D.08, subdivision 7; 62E.08, subdivision 1; 62E.14, by adding a subdivision; 62J.04, subdivisions 3, 9; 62J.17, subdivision 4a; 62J.495, by adding a subdivision; 62J.497, by adding a subdivision; 62J.692; 62Q.32; 62U.04, subdivisions 3, 9; 62U.06, subdivision 2; 119B.011, subdivision 13; 119B.035, subdivisions 1, 4; 119B.09, subdivision 10, by adding subdivisions; 119B.13, subdivisions 1, 1a, 7; 144.05, by adding a subdivision; 144.1499; 144.1501, subdivisions 1, 4; 144.98, subdivisions 2a, 7, by adding subdivisions; 144A.102; 144A.61, by adding a subdivision; 144E.123; 145.928, subdivision 2; 145.986, by adding subdivisions; 145A.17, subdivision 3; 148.07, subdivision 1; 148.10, subdivision 7; 148.108, by adding a subdivision; 148.191, subdivision 2; 148.212, subdivision 1; 148.231; 148B.17; 148B.33, subdivision 2; 148B.52; 148B.5301, subdivisions 1, 3, 4; 148B.54, subdivisions 2, 3; 148E.060, subdivisions 1, 2, 3, 5, by adding a subdivision; 148E.120; 150A.02; 150A.06, subdivisions 1c, 1d, 3, 4, 6; 150A.09, subdivision 3; 150A.091, subdivisions 2, 3, 4, 5, 8, by adding a subdivision; 150A.105, subdivision 7; 150A.106, subdivision 1; 150A.14; 151.07; 151.101; 151.102, by adding a subdivision; 151.12; 151.13, subdivision 1; 151.19; 151.25; 151.47, subdivision 1; 151.48; 152.12, subdivision 3; 157.15, by adding a subdivision; 157.20, by adding a subdivision; 214.09, by adding a subdivision; 214.103; 245A.03, subdivision 2; 245A.14, subdivision 4; 246B.10; 252.025, subdivision 7; 252.27, subdivision 2a; 252.291, subdivision 2; 253B.212; 254B.03, subdivisions 1, 4; 254B.04, subdivision 1, by adding a subdivision; 254B.06, subdivision 2; 256.01, subdivisions 14b, 24, 29, by adding subdivisions; 256.045, subdivision 4a; 256.969, subdivisions 2b, 3a, by adding a subdivision; 256B.04, subdivision 18; 256B.05, by adding a subdivision; 256B.055, subdivision 15; 256B.056, subdivision 3, by adding a subdivision; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8e, 13e, 13h, 17, 17a, 18, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.0657; 256B.0659, subdivisions 2, 11, 28; 256B.0751, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0753, by adding a subdivision; 256B.0754,

by adding a subdivision; 256B.0755, subdivision 4, by adding subdivisions; 256B.0756; 256B.0911, subdivisions 1a, 3a, 4a, 6; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 5, 10; 256B.0916, subdivision 6a; 256B.092, subdivisions 1a, 1b, 1e, 1g, 3, 8; 256B.0945, subdivision 4; 256B.14, by adding a subdivision; 256B.19, by adding a subdivision; 256B.37, subdivision 5; 256B.431, subdivision 2r, by adding a subdivision; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.441, by adding subdivisions; 256B.48, subdivision 1; 256B.49, subdivisions 12, 13, 14, 15, by adding a subdivision; 256B.5012, by adding subdivisions; 256B.69, subdivisions 3a, 4, 5a, 5c, 6, by adding subdivisions; 256B.692, subdivisions 2, 5, 7, by adding a subdivision; 256B.694; 256B.76, subdivision 4; 256D.05, subdivision 1; 256D.06, subdivisions 1, 1b; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.49, subdivision 3; 256G.02, subdivision 6; 256I.04, subdivision 2b; 256I.05, subdivision 1a; 256J.20, subdivision 3; 256J.38, subdivision 1; 256J.53, subdivision 2; 256L.01, subdivision 4a; 256L.02, subdivision 3; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivisions 2, 3a, 5, by adding a subdivision; 256L.07, subdivision 1; 256L.09, subdivision 4; 256L.11, subdivision 7; 256L.12, subdivision 9; 256L.15, subdivision 1a; 260C.157, subdivision 3; 260D.01; 297F.10, subdivision 1; 326B.175; 364.09; 393.07, subdivisions 10, 10a; 402A.10, subdivisions 4, 5; 402A.15; 402A.18; 402A.20; Laws 2008, chapter 363, article 18, section 3, subdivision 5; Laws 2009, chapter 79, article 8, sections 4, as amended; 51, as amended; article 13, section 3, subdivision 8, as amended; Laws 2010, chapter 349, sections 1; 2; Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6; article 25, section 3, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 62E; 62J; 62U; 119B; 137; 144; 145; 148; 151; 214; 256; 256B; 256D; 256L; 326B; 402A; repealing Minnesota Statutes 2010, sections 62J.07, subdivisions 1, 2, 3; 62J.17, subdivisions 1, 3, 5a, 6a, 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 144.1464; 145A.14, subdivisions 1, 2; 150A.22; 256.01, subdivision 2b; 256.979, subdivisions 5, 6, 7, 10; 256.9791; 256.9862, subdivision 2; 256B.055, subdivision 15; 256B.057, subdivision 2c; 256B.0756; 256I.05, subdivisions 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n; 256L.07, subdivision 7; 402A.30; 402A.45; Laws 2008, chapter 358, article 3, sections 8; 9; Laws 2009, chapter 79, article 3, section 18, as amended; article 5, sections 55, as amended; 56; 57; 60; 61; 62; 63; 64; 65; 66; 68; 69; 79; Laws 2010, First Special Session chapter 1, article 16, sections 6; 7; Minnesota Rules, parts 3400.0130, subpart 8; 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, 23; 4651.0110, subparts 2, 2a, 3, 4, 5; 4651.0120; 4651.0130; 4651.0140; 4651.0150; 6310.3100, subpart 2; 6310.3600; 6310.3700, subpart 1; 9500.1243, subpart 3.

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

ARTICLE 1

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2010, section 119B.011, subdivision 13, is amended to read:

Subd. 13. **Family.** "Family" means parents, stepparents, guardians and their spouses, or other eligible relative caregivers and their spouses, and their blood related dependent children and adoptive siblings under the age of 18 years living in the same home including children temporarily absent from the household in settings such as schools, foster care, and

residential treatment facilities or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60 days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents, stepparents, guardians, and their spouses or eligible relative caregivers and their spouses residing in the same household.

EFFECTIVE DATE. This section is effective April 16, 2012.

Sec. 2. Minnesota Statutes 2010, section 119B.035, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, except as provided in subdivision 4, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, and up to available appropriations, the commissioner shall provide assistance under the at-home infant child care program and for administrative costs associated with the program. The commissioner shall set aside two percent of the basic sliding fee child care appropriation under section 119B.03, for purposes of this section. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Sec. 3. Minnesota Statutes 2010, section 119B.035, subdivision 4, is amended to read:

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to ~~90~~ 64 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

(b) A participating family must report income and other family changes as specified in the county's plan under section 119B.08, subdivision 3.

(c) Persons who are admitted to the at-home infant child care program retain their position in any basic sliding fee program. Persons leaving the at-home infant child care program reenter the basic sliding fee program at the position they would have occupied.

(d) Assistance under this section does not establish an employer-employee relationship between any member of the assisted family and the county or state.

Sec. 4. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

Subd. 9a. **Child care centers; assistance.** (a) For the purposes of this subdivision, "qualifying child" means a child who satisfies both of the following:

(1) is not a child or dependent of an employee of the child care provider; and

(2) does not reside with an employee of the child care provider.

(b) Funds distributed under this chapter must not be paid for child care services that are provided for a child by a child care provider who employs either the parent of the child or a person who resides with the child, unless at all times at least 50 percent of the children for whom the child care provider is providing care are qualifying children under paragraph (a).

(c) If a child care provider satisfies the requirements for payment under paragraph (b), but the percentage of qualifying children under paragraph (a) for whom the provider is providing care falls below 50 percent, the provider shall have four weeks to raise the percentage of qualifying children for whom the provider is providing care to at least 50 percent before payments to the provider are discontinued for child care services provided for a child who is not a qualifying child.

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

Sec. 5. Minnesota Statutes 2010, section 119B.09, subdivision 10, is amended to read:

Subd. 10. **Payment of funds.** All federal, state, and local child care funds must be paid directly to the parent when a provider cares for children in the children's own home. In all other cases, all federal, state, and local child care funds must be paid directly to the child care provider, either licensed or legal nonlicensed, on behalf of the eligible family. Funds distributed under this chapter must not be used for child care services that are provided for a child by a child care provider who resides in the same household or occupies the same residence as the child.

EFFECTIVE DATE. This section is effective March 5, 2012.

Sec. 6. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

Subd. 13. **Child care in the child's home.** Child care assistance must only be authorized in the child's home if the child's parents have authorized activities outside of the home and if one or more of the following circumstances are met:

(1) the parents' qualifying activity occurs during times when out-of-home care is not available. If child care is needed during any period when out-of-home care is not available, in-home care can be approved for the entire time care is needed;

(2) the family lives in an area where out-of-home care is not available; or

(3) a child has a verified illness or disability that would place the child or other children in an out-of-home facility at risk or creates a hardship for the child and the family to take the child out of the home to a child care home or center.

EFFECTIVE DATE. This section is effective March 5, 2012.

Sec. 7. Minnesota Statutes 2010, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning July 1, 2006, the maximum rate paid for child care assistance in any county or multicounty region under the child care fund shall be the rate for like-care arrangements in the county effective January 1, 2006, increased by six percent.

(b) Rate changes shall be implemented for services provided in September 2006 unless a participant eligibility redetermination or a new provider agreement is completed between July 1, 2006, and August 31, 2006.

As necessary, appropriate notice of adverse action must be made according to Minnesota Rules, part 3400.0185, subparts 3 and 4.

New cases approved on or after July 1, 2006, shall have the maximum rates under paragraph (a), implemented immediately.

(c) Every year, the commissioner shall survey rates charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in counties. When the commissioner determines that, using the commissioner's established protocol, the number of providers responding to the survey is too small to determine the 75th percentile rate for like-care arrangements in a county or multicounty region, the commissioner may establish the 75th percentile maximum rate based on like-care arrangements in a county, region, or category that the commissioner deems to be similar.

(d) A rate which includes a special needs rate paid under subdivision 3 or under a school readiness service agreement paid under section 119B.231, may be in excess of the maximum rate allowed under this subdivision.

(e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care. The maximum payment to a provider for one day of care must not exceed the daily rate. The maximum payment to a provider for one week of care must not exceed the weekly rate.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

~~(f)~~ (g) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(g)~~ (h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

EFFECTIVE DATE. This section is effective September 3, 2012, except the amendments to paragraph (e) are effective April 16, 2012.

Sec. 8. Minnesota Statutes 2010, section 119B.13, subdivision 1a, is amended to read:

Subd. 1a. **Legal nonlicensed family child care provider rates.** (a) Legal nonlicensed family child care providers receiving reimbursement under this chapter must be paid on an hourly basis for care provided to families receiving assistance.

(b) The maximum rate paid to legal nonlicensed family child care providers must be ~~80~~ 64 percent of the county maximum hourly rate for licensed family child care providers. In counties where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by ~~0.80~~ 0.64. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

EFFECTIVE DATE. This section is effective April 16, 2012, except the amendment changing 80 to 64 and 0.80 to 0.64 is effective July 1, 2011.

Sec. 9. Minnesota Statutes 2010, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers ~~may~~ and license-exempt centers must not be reimbursed for more than ~~25~~ ten full-day absent days per child, excluding holidays, in a fiscal year, ~~or for more than ten consecutive full-day absent days, unless the child has a documented medical condition that causes more frequent absences. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the 25-day absent day limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.~~ Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time ~~will~~ must be reimbursed but the time ~~will~~ must not count toward the ~~ten consecutive or 25 cumulative absent day limits~~ limit. ~~Children in families where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, may be exempt from the absent day limits upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.~~ Child care providers ~~may~~ must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the ~~ten consecutive or 25 cumulative absent day limits~~ limit.

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

(d) ~~The provider and family must receive notification of the number of absent days used upon initial provider authorization for a family and when the family has used 15 cumulative absent days. Upon statewide implementation of the Minnesota Electronic Child Care System, the provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.~~

~~(e) A county may pay for more absent days than the statewide absent day policy established under this subdivision if current market practice in the county justifies payment for those additional days. County policies for payment of absent days in excess of the statewide absent day policy and justification for these county policies must be included in the county's child care fund plan under section 119B.08, subdivision 3.~~

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

Sec. 10. [119B.135] QUALITY RATING AND IMPROVEMENT SYSTEM IMPLEMENTATION.

Subdivision 1. Implementation of a quality rating and improvement system.

(a) The commissioner of human services shall phase in the implementation of a voluntary quality rating and improvement system for child care centers. The system must build on the quality rating and improvement system in use in fiscal year 2011. The program must be designed to ensure that Minnesota's children have access to high-quality services in child care centers so that children entering kindergarten are ready for kindergarten by 2020, as stated in section 124D.142.

(b) The quality rating and improvement system must:

(1) set research-based program standards and quality indicators designed to improve the educational outcomes of children so that they are ready for school;

(2) assess program quality using the program standards and indicators and issue quality ratings to participating child care centers;

(3) establish a database to collect, store, analyze, and report data for quality ratings and to track improvement supports and incentives to programs. The database must incorporate data from or be linked to related databases, such as those maintained by the child care resource and referral system;

(4) provide rating information to consumers to facilitate informed choices of child care centers;

(5) provide information to child care centers to enable them to measure the results of their quality improvement efforts; and

(6) provide supports to participating programs to help them improve their quality rating.

(c) A program that is accredited or has otherwise been evaluated may submit information to the commissioner of human services in the form and manner prescribed by the commissioner and may be rated on the basis of that information.

(d) A program that has previously been rated under this section or has been rated through the Parent Aware pilot program may continue with that rating for two years.

Subd. 2. **Phase-in of quality rating and improvement system.** The commissioner must continue the quality rating and improvement system in use in fiscal year 2011 in the original pilot areas and must expand the system to at least two new, rural geographic locations by June 30, 2012. The commissioner must use a competitive process to select the new pilot areas by targeting areas that meet one or more of the following criteria: existence of a local early care and education collaborative, existence of local matching funds, and demonstration of local support from community-based early learning and care programs. The commissioner must add one new pilot area per year and work toward statewide availability of ratings by 2015.

Sec. 11. **[256.987] ELECTRONIC BENEFIT TRANSFER CARD.**

Subdivision 1. **Electronic benefit transfer (EBT) card.** Beginning July 1, 2011, cash benefits for the general assistance and Minnesota supplemental aid programs under chapter 256D and programs under chapter 256J must be issued on a separate EBT card with the name of the head of household printed on the card. This card must be issued within 30 calendar days of an eligibility determination. During the initial 30 calendar days of eligibility, a recipient may have cash benefits issued on an EBT card without a name printed on the card. This card may be the same card on which food support benefits are issued and does not need to meet the requirements of this section.

Subd. 2. **EBT card use restricted to Minnesota vendors.** EBT cardholders receiving cash benefits under the general assistance and Minnesota supplemental aid programs under chapter 256D or programs under chapter 256J are prohibited from using their EBT cards at vendors located outside of Minnesota. This subdivision does not apply to food support benefits.

Sec. 12. Minnesota Statutes 2010, section 256D.05, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Each assistance unit with income and resources less than the standard of assistance established by the commissioner and with a member who is a resident of the state shall be eligible for and entitled to general assistance if the assistance unit is:

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than ~~30~~ 90 days and which prevents the person from obtaining or retaining employment;

~~(2) a person whose presence in the home on a substantially continuous basis is required because of the professionally certified illness, injury, incapacity, or the age of another member of the household;~~

~~(3)~~ (2) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative;

~~(4)~~ (3) a person who resides in a shelter facility described in subdivision 3;

~~(5)~~ (4) a person not described in clause (1) or ~~(3)~~ (2) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining employment;

~~(6) a person who has an application pending for, or is appealing termination of benefits from, the Social Security disability program or the program of supplemental security income for the aged, blind, and disabled, provided the person has a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;~~

~~(7) a person who is unable to obtain or retain employment because advanced age significantly affects the person's ability to seek or engage in substantial work;~~

~~(8)~~ (5) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the

date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

~~(9)~~ (6) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to ~~be learning disabled~~ have a condition that qualifies under Minnesota's special education rules as a specific learning disability, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan;

~~(10) a child under the age of 18 who is not living with a parent, stepparent, or legal custodian, and only if: the child is legally emancipated or living with an adult with the consent of an agency acting as a legal custodian; the child is at least 16 years of age and the general assistance grant is approved by the director of the county agency or a designated representative as a component of a social services case plan for the child; or the child is living with an adult with the consent of the child's legal custodian and the county agency. For purposes of this clause, "legally emancipated" means a person under the age of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv) is otherwise considered emancipated under Minnesota law, and for whom county social services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;~~

~~(11)~~ (7) a person who is eligible for displaced homemaker services, programs, or assistance under section 116L.96, but only if that person is enrolled as a full-time student;

~~(12) a person who lives more than four hours round-trip traveling time from any potential suitable employment;~~

~~(13)~~ (8) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day; or

~~(14) a person over age 18 whose primary language is not English and who is attending high school at least half time; or~~

~~(15)~~ (9) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; ~~if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a;~~ if the applicant is determined

to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.

(b) As a condition of eligibility under paragraph (a), clauses (1), ~~(3)~~ (2), ~~(5)~~ (4), ~~(8)~~ (5), and ~~(9)~~ (6), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision 5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) As a condition of eligibility under this section, the recipient must complete at least 20 hours per month of volunteer or paid work. The county of residence shall determine what may be included as volunteer work. Recipients must provide monthly proof of volunteer work on the forms established by the county. A person who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity must not be made ineligible for general assistance under this section.

~~(e)~~ (d) The burden of providing documentation for a county agency to use to verify eligibility for general assistance or for exemption from the food stamp employment and training program is upon the applicant or recipient. The county agency shall use documents already in its possession to verify eligibility, and shall help the applicant or recipient obtain other existing verification necessary to determine eligibility which the applicant or recipient does not have and is unable to obtain.

Sec. 13. Minnesota Statutes 2010, section 256D.06, subdivision 1, is amended to read:

Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be granted in an amount that when added to the nonexempt income actually available to the assistance unit, the total amount equals the applicable standard of assistance for general assistance. In determining eligibility for and the amount of assistance for an individual or married couple, the county agency shall disregard the first ~~\$50~~ \$150 of earned income per month.

Sec. 14. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

Subd. 1b. **Earned income savings account.** In addition to the ~~\$50~~ \$150 disregard required under subdivision 1, the county agency shall disregard an additional earned income up to a maximum of ~~\$150~~ \$500 per month for: (1) persons residing in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to

13.1 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons
13.2 living in supervised apartments with services funded under Minnesota Rules, parts
13.3 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan;
13.4 and (3) persons residing in group residential housing, as that term is defined in section
13.5 256I.03, subdivision 3, for whom the county agency has approved a discharge plan
13.6 which includes work. The additional amount disregarded must be placed in a separate
13.7 savings account by the eligible individual, to be used upon discharge from the residential
13.8 facility into the community. For individuals residing in a chemical dependency program
13.9 licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from
13.10 the savings account require the signature of the individual and for those individuals with
13.11 an authorized representative payee, the signature of the payee. A maximum of ~~\$1,000~~
13.12 \$2,000, including interest, of the money in the savings account must be excluded from
13.13 the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in
13.14 that account in excess of ~~\$1,000~~ \$2,000 must be applied to the resident's cost of care. If
13.15 excluded money is removed from the savings account by the eligible individual at any
13.16 time before the individual is discharged from the facility into the community, the money is
13.17 income to the individual in the month of receipt and a resource in subsequent months. If
13.18 an eligible individual moves from a community facility to an inpatient hospital setting,
13.19 the separate savings account is an excluded asset for up to 18 months. During that time,
13.20 amounts that accumulate in excess of the ~~\$1,000~~ \$2,000 savings limit must be applied to
13.21 the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the
13.22 18-month period, the entire account must be applied to the patient's cost of care.

13.23 Sec. 15. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health

residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

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

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. In a multifamily building of more than four ~~or more~~ units, the maximum number of apartments at one address that may be used by recipients of this program shall be 50 percent of the units in a building. This paragraph expires on June 30, ~~2012~~ 2014.

Sec. 16. **[256D.461] EMERGENCY AID.**

Applicants for or recipients of Supplemental Security Income or Minnesota supplemental aid who have emergent need may apply for emergency general assistance under section 256D.06, subdivision 2.

Sec. 17. Minnesota Statutes 2010, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Group residential housing agreements.** (a) Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number

of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections. Group residential housing agreements may be terminated with or without cause by either the county or the provider with two calendar months prior notice.

(b) Beginning July 1, 2011, counties must not enter into agreements with providers of group residential housing that do not include a residency requirement of at least 20 hours per week of volunteer or paid work. A person who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity must not be made ineligible for group residential housing under this section.

Sec. 18. Minnesota Statutes 2010, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and can demonstrate a chemical dependency success rate of at least 30 percent for participants six months after completing the program, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. The county agency is limited to negotiating a payment not to exceed \$100 for residences that provide other services necessary to provide room and board if the residence does not allow alcohol on the property, provides minimal services, and is unable to demonstrate a chemical dependency success rate of at least 30 percent for participants six months after completing the program. Unless otherwise provided in law, in no case may the supplementary service rate exceed \$426.37. The registration and licensure requirement does not apply to

establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

Sec. 19. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

(1) a licensed vehicle up to a loan value of less than or equal to ~~\$15,000~~ \$10,000. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the loan value of all additional vehicles and exclude the combined loan value of less than or equal to \$7,500. The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a disabled member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

To establish the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed

in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2010, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the ~~plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35~~ participant must be working in unsubsidized employment at least 20 hours per week.

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

(1) the employment goal can only be met with the additional education or training;

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

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

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

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

(c) The hourly unsubsidized employment requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

Sec. 21. Minnesota Statutes 2010, section 260C.157, subdivision 3, is amended to read:

20.1 Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services
20.2 agency shall establish a juvenile treatment screening team to conduct screenings and
20.3 prepare case plans under ~~this subdivision~~ section 245.487, subdivision 3, and chapters
20.4 260C and 260D. Screenings shall be conducted within 15 days of a request for a screening.
20.5 The team, which may be the team constituted under section 245.4885 or 256B.092 or
20.6 Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile
20.7 justice professionals, and persons with expertise in the treatment of juveniles who are
20.8 emotionally disabled, chemically dependent, or have a developmental disability. ~~The team~~
20.9 ~~shall involve parents or guardians in the screening process as appropriate, and the child's~~
20.10 parent, guardian, or permanent legal custodian under section 260C.201, subdivision 11.
20.11 The team may be the same team as defined in section 260B.157, subdivision 3.

20.12 (b) The social services agency shall determine whether a child brought to its
20.13 attention for the purposes described in this section is an Indian child, as defined in section
20.14 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as
20.15 defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child,
20.16 the team provided in paragraph (a) shall include a designated representative of the Indian
20.17 child's tribe, unless the child's tribal authority declines to appoint a representative. The
20.18 Indian child's tribe may delegate its authority to represent the child to any other federally
20.19 recognized Indian tribe, as defined in section 260.755, subdivision 12.

20.20 (c) If the court, prior to, or as part of, a final disposition, proposes to place a child:

20.21 (1) for the primary purpose of treatment for an emotional disturbance, a
20.22 developmental disability, or chemical dependency in a residential treatment facility out
20.23 of state or in one which is within the state and licensed by the commissioner of human
20.24 services under chapter 245A; or

20.25 (2) in any out-of-home setting potentially exceeding 30 days in duration, including a
20.26 postdispositional placement in a facility licensed by the commissioner of corrections or
20.27 human services, the court shall ascertain whether the child is an Indian child and shall
20.28 notify the county welfare agency and, if the child is an Indian child, shall notify the Indian
20.29 child's tribe. The county's juvenile treatment screening team must either: (i) screen and
20.30 evaluate the child and file its recommendations with the court within 14 days of receipt
20.31 of the notice; or (ii) elect not to screen a given case and notify the court of that decision
20.32 within three working days.

20.33 (d) ~~If the screening team has elected to screen and evaluate the child,~~ The child
20.34 may not be placed for the primary purpose of treatment for an emotional disturbance, a
20.35 developmental disability, or chemical dependency, in a residential treatment facility out of

21.1 state nor in a residential treatment facility within the state that is licensed under chapter
21.2 245A, unless one of the following conditions applies:

21.3 (1) a treatment professional certifies that an emergency requires the placement
21.4 of the child in a facility within the state;

21.5 (2) the screening team has evaluated the child and recommended that a residential
21.6 placement is necessary to meet the child's treatment needs and the safety needs of the
21.7 community, that it is a cost-effective means of meeting the treatment needs, and that it
21.8 will be of therapeutic value to the child; or

21.9 (3) the court, having reviewed a screening team recommendation against placement,
21.10 determines to the contrary that a residential placement is necessary. The court shall state
21.11 the reasons for its determination in writing, on the record, and shall respond specifically
21.12 to the findings and recommendation of the screening team in explaining why the
21.13 recommendation was rejected. The attorney representing the child and the prosecuting
21.14 attorney shall be afforded an opportunity to be heard on the matter.

21.15 (e) When the county's juvenile treatment screening team has elected to screen and
21.16 evaluate a child determined to be an Indian child, the team shall provide notice to the
21.17 tribe or tribes that accept jurisdiction for the Indian child or that recognize the child as a
21.18 member of the tribe or as a person eligible for membership in the tribe, and permit the
21.19 tribe's representative to participate in the screening team.

21.20 (f) When the Indian child's tribe or tribal health care services provider or Indian
21.21 Health Services provider proposes to place a child for the primary purpose of treatment
21.22 for an emotional disturbance, a developmental disability, or co-occurring emotional
21.23 disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by
21.24 the child's tribe shall submit necessary documentation to the county juvenile treatment
21.25 screening team, which must invite the Indian child's tribe to designate a representative to
21.26 the screening team.

21.27 Sec. 22. Minnesota Statutes 2010, section 260D.01, is amended to read:

21.28 **260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.**

21.29 (a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care
21.30 for treatment" provisions of the Juvenile Court Act.

21.31 (b) The juvenile court has original and exclusive jurisdiction over a child in
21.32 voluntary foster care for treatment upon the filing of a report or petition required under
21.33 this chapter. All obligations of the agency to a child and family in foster care contained in
21.34 chapter 260C not inconsistent with this chapter are also obligations of the agency with
21.35 regard to a child in foster care for treatment under this chapter.

22.1 (c) This chapter shall be construed consistently with the mission of the children's
22.2 mental health service system as set out in section 245.487, subdivision 3, and the duties
22.3 of an agency under section 256B.092, 260C.157, and Minnesota Rules, parts 9525.0004
22.4 to 9525.0016, to meet the needs of a child with a developmental disability or related
22.5 condition. This chapter:

22.6 (1) establishes voluntary foster care through a voluntary foster care agreement as the
22.7 means for an agency and a parent to provide needed treatment when the child must be in
22.8 foster care to receive necessary treatment for an emotional disturbance or developmental
22.9 disability or related condition;

22.10 (2) establishes court review requirements for a child in voluntary foster care for
22.11 treatment due to emotional disturbance or developmental disability or a related condition;

22.12 (3) establishes the ongoing responsibility of the parent as legal custodian to visit the
22.13 child, to plan together with the agency for the child's treatment needs, to be available and
22.14 accessible to the agency to make treatment decisions, and to obtain necessary medical,
22.15 dental, and other care for the child; and

22.16 (4) applies to voluntary foster care when the child's parent and the agency agree that
22.17 the child's treatment needs require foster care either:

22.18 (i) due to a level of care determination by the agency's screening team informed by
22.19 the diagnostic and functional assessment under section 245.4885; or

22.20 (ii) due to a determination regarding the level of services needed by the responsible
22.21 social services' screening team under section 256B.092, and Minnesota Rules, parts
22.22 9525.0004 to 9525.0016.

22.23 (d) This chapter does not apply when there is a current determination under section
22.24 626.556 that the child requires child protective services or when the child is in foster care
22.25 for any reason other than treatment for the child's emotional disturbance or developmental
22.26 disability or related condition. When there is a determination under section 626.556 that
22.27 the child requires child protective services based on an assessment that there are safety
22.28 and risk issues for the child that have not been mitigated through the parent's engagement
22.29 in services or otherwise, or when the child is in foster care for any reason other than
22.30 the child's emotional disturbance or developmental disability or related condition, the
22.31 provisions of chapter 260C apply.

22.32 (e) The paramount consideration in all proceedings concerning a child in voluntary
22.33 foster care for treatment is the safety, health, and the best interests of the child. The
22.34 purpose of this chapter is:

22.35 (1) to ensure a child with a disability is provided the services necessary to treat or
22.36 ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires it and the child cannot be maintained in the home of the parent; and

(3) to ensure the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, where necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs; and

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply. This chapter shall be construed consistently with the requirements of the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et al., and the provisions of the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 23. Minnesota Statutes 2010, section 393.07, subdivision 10a, is amended to read:

Subd. 10a. **Expedited issuance of food stamps.** The commissioner of human services shall continually monitor the expedited issuance of food stamp benefits to ensure that each county complies with federal regulations and that households eligible for expedited issuance of food stamps are identified, processed, and certified within the time frames prescribed in federal regulations.

County food stamp offices shall screen and issue food stamps to applicants on the day of application. Applicants who meet the federal criteria for expedited issuance and have an immediate need for food assistance shall receive within two working days either:

(1) a manual Authorization to Participate (ATP) card; or

(2) the ~~immediate~~ issuance of food stamp coupons.

The local food stamp agency shall conspicuously post in each food stamp office a notice of the availability of and the procedure for applying for expedited issuance and verbally advise each applicant of the availability of the expedited process.

Sec. 24. **GRANT PROGRAM TO PROMOTE HEALTHY COMMUNITY INITIATIVES.**

(a) The commissioner of human services must contract with the Search Institute to help local communities develop, expand, and maintain the tools, training, and resources needed to foster positive community development and effectively engage people in their community. The Search Institute must: (1) provide training in community mobilization, youth development, and assets getting to outcomes; (2) provide ongoing technical assistance to communities receiving grants under this section; (3) use best practices to promote community development; (4) share best program practices with other interested communities; (5) create electronic and other opportunities for communities to share experiences in and resources for promoting healthy community development; and (6) provide an annual report of the strong communities project.

(b) Specifically, the Search Institute must use a competitive grant process to select four interested communities throughout Minnesota to undertake strong community mobilization initiatives to support communities wishing to catalyze multiple sectors to create or strengthen a community collaboration to address issues of poverty in their communities. The Search Institute must provide the selected communities with the tools, training, and resources they need for successfully implementing initiatives focused on strengthening the community. The Search Institute also must use a competitive grant process to provide four strong community innovation grants to encourage current community initiatives to bring new innovation approaches to their work to reduce poverty. Finally, the Search Institute must work to strengthen networking and information sharing activities among all healthy community initiatives throughout Minnesota, including sharing best program practices and providing personal and electronic opportunities for peer learning and ongoing program support.

(c) In order to receive a grant under paragraph (b), a community must show involvement of at least three sectors of their community and the active leadership of both

youth and adults. Sectors may include, but are not limited to, local government, schools, community action agencies, faith communities, businesses, higher education institutions, and the medical community. In addition, communities must agree to: (1) attend training on community mobilization processes and strength-based approaches; (2) apply the assets getting to outcomes process in their initiative; (3) meet at least two times during the grant period to share successes and challenges with other grantees; (4) participate on an electronic listserv to share information throughout the period on their work; and (5) all communication requirements and reporting processes.

(d) The commissioner of human services must evaluate the effectiveness of this program and must recommend to the committees of the legislature with jurisdiction over health and human services reform and finance by February 15, 2013, whether or not to make the program available statewide. The Search Institute annually must report to the commissioner of human services on the services it provided and the grant money it expended under this section.

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

Sec. 25. **CIRCLES OF SUPPORT GRANTS.**

The commissioner of human services must provide grants to community action agencies to help local communities develop, expand, and maintain the tools, training, and resources needed to foster social assets to assist people out of poverty through circles of support. The circles of support model must provide a framework for a community to build relationships across class and race lines so that people can work together to advocate for change in their communities and move individuals toward self-sufficiency.

Specifically, circles of support initiatives must focus on increasing social capital, income, educational attainment, and individual accountability, while reducing debt, service dependency, and addressing systemic disparities that hold poverty in place. The effort must support the development of local guiding coalitions as the link between the community and circles of support for resource development and funding leverage.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 26. **PILOT PROJECT FOR HOMELESS ADULTS TO BE IN-HOME CARETAKERS OF FORECLOSED HOMES.**

(a) Stepping Stone Emergency Housing may form a partnership with local banks who own foreclosed homes to:

(1) utilize foreclosed homes for graduates of Stepping Stone Emergency Housing to become in-home caretakers of those homes;

(2) provide the security needed by the homes' banking owners and others to help stabilize neighborhoods through carefully maintained homes that will prevent vandalism, squatters, and drug houses;

(3) provide transitional housing to up to four homeless clients per home after they graduate from emergency housing allowing the clients time to find permanent housing in a tight affordable housing market; and

(4) provide management of the project to ensure proper oversight for the homes' owners and support of the caretakers.

(b) This section expires June 30, 2013.

Sec. 27. HOMELESS SHELTERS; SCHOOL DISTRICTS.

School districts may coordinate with local units of government and homeless services providers to use empty school buildings as homeless shelters.

Sec. 28. REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES, GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.

Liquor stores, tobacco stores, gambling establishments, and tattoo parlors must negotiate with their third-party processors to block EBT card cash transactions at their places of business and withdrawals of cash at automatic teller machines located in their places of business.

Sec. 29. MINNESOTA EBT BUSINESS TASK FORCE.

Subdivision 1. **Members.** The Minnesota EBT Business Task Force includes seven members, appointed as follows:

(1) two members of the Minnesota house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members of the Minnesota senate, one appointed by the senate majority leader and one appointed by the senate minority leader;

(3) the commissioner of human services, or designee;

(4) an appointee of the Minnesota Grocers Association; and

(5) a credit card processor, appointed by the commissioner of human services.

Subd. 2. **Duties.** The Minnesota EBT Business Task Force shall create a workable strategy to eliminate the purchase of tobacco and alcoholic beverages by recipients of the general assistance program and Minnesota supplemental aid program under Minnesota

27.1 Statutes, chapter 256D, and programs under Minnesota Statutes, chapter 256J, using EBT
27.2 cards. The task force will consider cost to the state, feasibility of execution at retail, and
27.3 ease of use and privacy for EBT cardholders.

27.4 Subd. 3. **Report.** The task force will report back to the legislative committees with
27.5 jurisdiction over health and human services policy and finance by April 1, 2012, with
27.6 recommendations related to the task force duties under subdivision 2.

27.7 Subd. 4. **Expiration.** The task force expires on June 30, 2012.

27.8 Sec. 30. **REPEALER.**

27.9 (a) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10;
27.10 256.9791; 256.9862, subdivision 2; and 256I.05, subdivisions 1d, 1e, 1f, 1g, 1h, 1i, 1j,
27.11 1k, 1l, 1m, and 1n, are repealed.

27.12 (b) Minnesota Rules, part 3400.0130, subpart 8, is repealed effective September
27.13 3, 2012.

27.14 **ARTICLE 2**

27.15 **DEPARTMENT OF HEALTH**

27.16 Section 1. Minnesota Statutes 2010, section 62D.08, subdivision 7, is amended to read:

27.17 Subd. 7. **Consistent administrative expenses and investment income reporting.**

27.18 (a) Every health maintenance organization must directly allocate administrative expenses
27.19 to specific lines of business or products when such information is available. The definition
27.20 of administrative expenses must be consistent with that of the National Association of
27.21 Insurance Commissioners (NAIC) as provided in the most current NAIC blank. Remaining
27.22 expenses that cannot be directly allocated must be allocated based on other methods, as
27.23 recommended by the Advisory Group on Administrative Expenses. Health maintenance
27.24 organizations must submit this information, including administrative expenses for dental
27.25 services, using the reporting template provided by the commissioner of health.

27.26 (b) Every health maintenance organization must allocate investment income based
27.27 on cumulative net income over time by business line or product and must submit this
27.28 information, including investment income for dental services, using the reporting template
27.29 provided by the commissioner of health.

27.30 Sec. 2. Minnesota Statutes 2010, section 62J.04, subdivision 3, is amended to read:

27.31 Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to ~~62J.41~~ and 62J.40 to monitor statewide achievement of the cost containment goals;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 3. Minnesota Statutes 2010, section 62J.17, subdivision 4a, is amended to read:

Subd. 4a. **Expenditure reporting.** Each hospital, outpatient surgical center, ~~and diagnostic imaging center, and physician clinic~~ shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(a) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

(b) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(c) the cost of purchased or leased medical equipment, by type of equipment;

(d) expenditures by type for specialty care and new specialized services;

(e) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(f) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. ~~For physician clinics, this information shall be included in reports to the commissioner that are required under section 62J.41.~~ For all other health care providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 4. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 7. **Exemption.** Any clinical practice with a total annual net revenue of less than \$500,000, and that has not received a state or federal grant for implementation of electronic health records, is exempt from the requirements of subdivision 1. This subdivision expires December 31, 2020.

Sec. 5. Minnesota Statutes 2010, section 62J.497, is amended by adding a subdivision to read:

Subd. 6. **Additional standards for electronic prescribing.** By January 1, 2012, the commissioner of health, in consultation with the Minnesota e-Health Advisory

Committee, must develop a method for incorporation of the following transactions into the requirements and standards for electronic prescribing provided in subdivisions 2 and 3:

(1) submission of requests for a formulary exception based on information required on the form developed according to subdivision 4; and

(2) submission of prior authorization requests based on information required on the form developed according to subdivision 5.

Sec. 6. Minnesota Statutes 2010, section 62J.692, is amended to read:

62J.692 MEDICAL EDUCATION.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health in consultation with the Medical Education and Research Advisory Committee.

(b) "Commissioner" means the commissioner of health.

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(e) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(f) "Trainee" means a student or resident involved in a clinical medical education program.

(g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where

the training is funded, in part, by patient care revenues. ~~Training that occurs in nursing facility settings is not eligible for funding under this section.~~

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, advanced dental therapists, chiropractors, or physician assistants is eligible for funds under subdivision 4 or 11, as appropriate, if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of ~~competition with nonteaching patient care entities~~ training activities; and

(3) emphasizes primary care ~~or specialties that are in undersupply in Minnesota in rural areas or for racial, ethnic, or cultural populations in the state experiencing health disparities.~~

~~A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.~~

(b) A clinical medical education program for advanced practice nursing, registered nurses, or licensed practical nurses is eligible for funds under subdivision 4 or 11, as appropriate, if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number or National Provider Identification number (NPI) of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the ~~equitable~~ appropriate distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 4. **Distribution of funds.** (a) Following the distribution described under paragraph (b), the commissioner shall annually distribute the available medical education funds to all qualifying applicants based on ~~a distribution formula that reflects a summation of two factors:~~

~~(1) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and~~

~~(2) a supplemental public program volume factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.~~

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee

in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students. Training sites whose training-site level grant is less than \$1,000, based on the formula described in this paragraph, are ineligible for funds available under this subdivision.

(b) ~~\$5,350,000~~ \$4,900,000 of the available medical education funds in fiscal year 2012 and \$3,044,000 beginning in fiscal year 2013 shall be distributed to fund training designed to address health disparities as follows:

(1) ~~\$1,475,000~~ \$500,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 to the University of Minnesota Medical Center-Fairview, the White Earth Band of Ojibwe Indians according to section 145.9271;

(2) ~~\$2,075,000~~ \$600,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 to the University of Minnesota School of Dentistry, University of Minnesota according to section 137.395; and

(3) \$500,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 shall be distributed to the community health centers development grants program according to section 145.987;

(4) \$500,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 shall be distributed to the community mental health centers grant program according to section 145.9272;

(5) \$1,000,000 in fiscal year 2012 and \$444,000 beginning in fiscal year 2013 shall be distributed to the health careers opportunities grant program according to section 144.1499; and

~~(3)~~ (6) \$1,800,000 to the Academic Health Center. \$150,000 of the funds distributed to the Academic Health Center under this paragraph shall be used for a program to assist internationally trained physicians who are legal residents and who commit to serving underserved Minnesota communities in a health professional shortage area to successfully compete for family medicine residency programs at the University of Minnesota.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph

(a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(f) A maximum of \$150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

(1) the total number of eligible trainee FTEs in each clinical medical education program;

(2) the name of each funded program and, for each program, the dollar amount distributed to each training site;

(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;

(4) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

(5) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) By February 15 of each year, the commissioner, with advice from the advisory committee, shall provide an annual summary report to the legislature on the implementation of this section.

Subd. 6. Other available funds. The commissioner is authorized to distribute, in accordance with subdivision 4, funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the commissioner of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the fund.

Subd. 7. Transfers from the commissioner of human services. Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), \$21,714,000 shall be distributed as follows:

(1) \$2,157,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

(2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education;

(3) \$17,400,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for purposes of medical education;

(4) ~~\$1,121,640~~ \$1,021,640 shall be distributed by the commissioner to clinical medical education dental innovation grants in accordance with subdivision 7a; ~~and~~

(5) \$100,000 shall be distributed to the health careers opportunities grant program according to section 144.1499; and

(6) the remainder of the amount transferred according to section 256B.69, subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a), or subdivision 11, as appropriate.

Subd. 7a. Clinical medical education innovations grants. (a) The commissioner shall award grants to teaching institutions and clinical training sites ~~for projects that provide training to~~ increase dental access for underserved populations ~~and promote innovative clinical training of dental professionals and for racial, ethnic, or cultural populations in the state experiencing health disparities.~~ In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;
(2) ~~the long-term viability of the project to improve access beyond the period of initial funding;~~
(3) evidence of collaboration between the applicant and local communities; and
(4) ~~the efficiency in the use of the funding; and~~
(5) (3) the priority level of the project in relation to ~~state clinical education, access,~~
and health disparity workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek to maximize federal financial participation in payments for medical education and research costs.

The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a), or 11, as appropriate.

Subd. 9. **Review of eligible providers.** The commissioner and the Medical Education and Research Costs Advisory Committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. ~~The results of any such reviews must be reported to the Legislative Commission on Health Care Access.~~

Subd. 11. **Distribution of funds.** (a) Upon receiving federal approval, the commissioner shall annually distribute the available medical education funds to all qualifying applicants based on the following distribution formula, which supersedes the formula described in subdivision 4, paragraphs (a) and (b):

(1) funds received pursuant to section 297F.10 shall be distributed to eligible clinical training sites using a public program volume factor, which is determined by the total volume of public program revenue received by each eligible training site as a percentage of all public program revenue received by all eligible training sites in the fund pool. Only clinical training that occurs in a hospital that reports financial, utilization, and services data to the commissioner of health, pursuant to sections 144.564 and 144.695 to 144.703 and Minnesota Rules, chapter 4650, is eligible for funding under this clause; and

(2) funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), shall be distributed to eligible training sites based on the total number of eligible trainee FTEs and the total statewide average costs per FTE, by type of trainee, in

each clinical medical education program. The number of eligible trainee FTEs for funds distributed under this clause is determined using the following steps:

(i) each FTE trainee from an advanced practice nursing, physician assistant, family medicine, internal medicine, general pediatrics, or psychiatry program is weighted at 1.25. Each FTE trainee from any other eligible training program is weighted at 1.0;

(ii) each FTE trainee at a clinical training site located in an isolated rural area according to the four category classification of the Rural Urban Commuting Area (RUCA) system developed for the United States Health Resources and Services Administration shall be weighted at the weight in item (i) multiplied by 1.5; each FTE trainee at a clinical training site located in a small rural area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.25; each FTE trainee at a clinical training site located in a large rural area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.1; and each FTE trainee at a clinical training site located in an urban area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.0;

(iii) each FTE trainee at a clinical training site that is a hospital eligible for funding under clause (1) shall be weighted at the weight in item (ii) multiplied by 0.85; and each FTE trainee at a clinical training site that is an ambulatory, nursing home, or other eligible nonhospital setting shall be weighted at the weight in item (ii) multiplied by 1.15; and

(iv) grants to hospitals under this item are limited to a percentage share of the total pool of funds available under this item that is no more than 1.5 times the percentage of the hospital's total revenue that comes from public programs. Grants to hospitals in excess of this amount will be redistributed to other sites eligible for funding under this item. Each eligible clinical training site's grant under this item will be calculated by multiplying the training site's adjusted FTE count upon completion of items (i) to (iv) by the statewide average cost per trainee for each provider type to determine an adjusted clinical training cost for each site. The grant to each eligible clinical training site under this item shall equal that site's share of total adjusted clinical training costs for all eligible training sites receiving funding under this item. Any clinical training site with fewer than 0.1 FTE eligible trainees from all programs upon completion of items (i) to (iv) and any clinical training site that would receive less than a cumulative \$1,000 under clauses (1) and (2) will be eliminated from the distribution.

(b) Public program revenue for the distribution formula includes revenue for the relevant MERC reporting period from medical assistance, prepaid medical assistance, general assistance medical care, MinnesotaCare, and prepaid general assistance medical care, as reported to the Department of Health pursuant to sections 144.562, 144.564,

and 144.695 to 144.703 and Minnesota Rules, chapter 4650, by December 31 of the year in which the MERC application is submitted. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), clause (2), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

Sec. 7. **[62U.15] ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.**

Subdivision 1. Data from providers. (a) By July 1, 2012, the commissioner shall review currently available quality measures and make recommendations for future measurement aimed at improving assessment and care related to Alzheimer's disease and other dementia diagnoses, including improved rates and results of cognitive screening, rates of Alzheimer's and other dementia diagnoses, and prescribed care and treatment plans.

(b) The commissioner may contract with a private entity to complete the requirements in this subdivision. If the commissioner contracts with a private entity already under contract through section 62U.02, then the commissioner may use a sole source contract and is exempt from competitive procurement processes.

Subd. 2. Learning collaborative. By July 1, 2012, the commissioner shall develop a health care home learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients under section 256B.0751, subdivision 5, for providers, clinics, care coordinators, clinic administrators, patient partners and families, and community resources including public health.

Subd. 3. Comparison data. The commissioner, with the commissioner of human services, the Minnesota Board on Aging, and other appropriate state offices, shall jointly review existing and forthcoming literature in order to estimate differences in the outcomes and costs of current practices for caring for those with Alzheimer's disease and other dementias, compared to the outcomes and costs resulting from:

(1) earlier identification of Alzheimer's and other dementias;

(2) improved support of family caregivers; and
(3) improved collaboration between medical care management and community-based supports.

Subd. 4. **Reporting.** By January 15, 2013, the commissioner must report to the legislature on progress toward establishment and collection of quality measures required under this section.

Sec. 8. **[137.395] EDUCATION AND TRAINING FOR HEALTH DISPARITY POPULATIONS.**

Subdivision 1. **Condition.** If the Board of Regents accepts the amount transferred under section 62J.692, subdivision 4, paragraph (b), clause (2), then it must be used for the purposes provided in this section.

Subd. 2. **Purpose.** The Board of Regents, through the Academic Health Center, is required to implement a scholarship program in order to increase the number of graduates of the Academic Health Center programs who are from racial, ethnic, or cultural populations in the state that experience health disparities.

Subd. 3. **Scholarships.** The Board of Regents is required to provide full scholarships to Academic Health Center programs for students who are from racial, ethnic, or cultural populations that experience health disparities. One-third of the scholarship funding available under this program must go to students at the University of Minnesota, Medical School, Duluth.

Sec. 9. Minnesota Statutes 2010, section 144.05, is amended by adding a subdivision to read:

Subd. 6. **Elimination of certain provider reporting requirements; sunset of new requirements.** (a) Notwithstanding any other law, rule, or provision to the contrary, effective July 1, 2012, the commissioner shall cease collecting from health care providers and purchasers all reports and data related to health care costs, quality, utilization, access, patient encounters, and disease surveillance and public health, and related to provider licensure, monitoring, finances, and regulation, unless the reports or data are necessary for federal compliance. For purposes of this subdivision, the term "health care providers and purchasers" has the meaning provided in section 62J.03, subdivision 8, except that it also includes nursing homes, health plan companies as defined in section 62Q.01, subdivision 4, and managed care and county-based purchasing plans delivering services under sections 256B.69 and 256B.692.

(b) The commissioner shall present to the 2012 legislature draft legislation to repeal, effective July 1, 2012, the provider reporting requirements identified under paragraph (a) that are not necessary for federal compliance.

(c) The commissioner may establish new provider reporting requirements to take effect on or after July 1, 2012. These new reporting requirements must sunset five years from their effective date, unless they are renewed by the commissioner. All new provider reporting requirements and requests for their renewal shall not take effect unless they are enacted in state law.

Sec. 10. Minnesota Statutes 2010, section 144.1499, is amended to read:

144.1499 PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS HEALTH CAREERS OPPORTUNITIES GRANT PROGRAM.

Subdivision. 1. Program. The commissioner of health, in consultation with an organization representing health care employers, long-term care employers, and educational institutions, may make grants to qualifying consortia as defined in section 116L.11, subdivision 4, for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. To qualify for a grant under this section, a consortium shall: health care employers, educational institutions, and related organizations for eligible activities intended to increase the number of people from racial, ethnic, or cultural populations that experience health disparities who are entering health careers in Minnesota.

(1) develop a health and long-term care careers curriculum that provides career exploration and training in national skill standards for health care and long-term care and that is consistent with Minnesota graduation standards and other related requirements;

(2) offer programs for high school students that provide training in health and long-term care careers with credits that articulate into postsecondary programs; and

(3) provide technical support to the participating health care and long-term care employer to enable the use of the employer's facilities and programs for kindergarten to grade 12 health and long-term care careers education.

Subd. 2. Eligible activities. Eligible activities must focus on students from racial, ethnic, or cultural populations experiencing health disparities. Eligible activities include the following:

(1) health careers exploration activities for students from racial, ethnic, or cultural populations experiencing health disparities;

(2) elementary, secondary, and postsecondary education activities to improve the academic readiness to enter health professions education programs for students from racial, ethnic, or cultural populations experiencing health disparities;

(3) health careers mentoring for students from racial, ethnic, or cultural populations experiencing health disparities, including support for faculty involved in mentoring these students enrolled in or interested in entering health professions education programs;

(4) secondary and postsecondary summer health care internships that provide students from racial, ethnic, or cultural populations experiencing health disparities with formal exposure to a health care profession in an employment setting;

(5) health careers preparation, guidance, and support for students from racial, ethnic, or cultural populations experiencing health disparities who are interested in entering health professions education programs;

(6) health careers preparation, guidance, and support for students from racial, ethnic, or cultural populations experiencing health disparities who are enrolled in health professions education programs and other activities to improve retention of these students in health professions education programs; or

(7) other activities the commissioner has reason to believe will prepare, attract, and educate for health careers students from racial, ethnic, or cultural populations experiencing health disparities.

Subd. 3. **Applications.** Applicants seeking a grant must apply to the commissioner. Applications must include the following:

(1) a description of the need, challenges, or barriers that the proposed project will address;

(2) a detailed description of the project and how it proposes to address the challenges or barriers;

(3) a budget detailing all sources of funds for the project and how project funds will be used;

(4) baseline data showing the current percentage of program applicants and current students who are from racial, ethnic, or cultural populations experiencing health disparities;

(5) a description of achievable objectives that demonstrate how the project will contribute to increasing the number of students from racial, ethnic, or cultural populations experiencing health disparities who are entering health professions in Minnesota;

(6) a timeline for completion of the project;

(7) roles and capabilities of responsible individuals and organizations, including partner organizations;

(8) a plan to evaluate project outcomes; and

(9) other information the commissioner believes necessary to evaluate the application.

Subd. 4. Consideration of applications. The commissioner must review each application to determine whether or not the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner must evaluate each application based on the following:

(1) the extent to which the applicant has demonstrated that its project is likely to contribute to increasing the number of American Indians and underrepresented populations of color entering health professions in Minnesota;

(2) the application's clarity and thoroughness in describing the challenges and barriers it is addressing;

(3) the extent to which the applicant appears likely to coordinate project efforts with other organizations;

(4) the reasonableness of the project budget; and

(5) the organizational capacity of the applicant and its partners.

The commissioner may also take into account other relevant factors. During application review the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

Subd. 5. Program oversight. The commissioner shall determine the amount of a grant to be given to an eligible applicant based on the relative strength of each eligible application and the funds available to the commissioner. The commissioner may collect from grantees any information necessary to evaluate the program.

Sec. 11. Minnesota Statutes 2010, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Dentist" means an individual who is licensed to practice dentistry.

(c) "Designated rural area" means:

~~(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or~~

~~(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).~~
an area defined as a small rural area or isolated rural area according to the four category

classifications of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration.

(d) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(e) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(f) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(g) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(h) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(i) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(j) "Pharmacist" means an individual with a valid license issued under chapter 151.

(k) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(l) "Physician assistant" means a person licensed under chapter 147A.

(m) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(n) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 12. Minnesota Statutes 2010, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for

physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants from racial, ethnic, or cultural populations experiencing health disparities who are closest to completing their training and who agree to serve in settings in Minnesota that provide health care services to at least 50 percent American Indian or other populations of color, such as a federally recognized Native American reservation. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 13. **[144.1503] HEALTH PROFESSIONS OPPORTUNITIES**
SCHOLARSHIP PROGRAM.

Subdivision 1. Definitions. For purposes of this section, the following definitions apply:

(a) "Certified clinical nurse specialist" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a clinical nurse specialist.

(b) "Certified nurse midwife" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a nurse midwife.

(c) "Certified nurse practitioner" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a nurse practitioner.

(d) "Chiropractor" means an individual licensed and regulated under sections 148.02 to 148.108.

(e) "Dental therapist" means an individual licensed in the state and includes advanced dental therapists certified under section 150A.106.

(f) "Dentist" means an individual licensed in Minnesota as a dentist under chapter 150A.

(g) "Eligible scholarship placement site" means a nonprofit, private, or public entity located in Minnesota that provides at least 50 percent of its health care services to American Indian or other populations of color, such as federally recognized American Indian reservations.

(h) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the contractual requirements, including death, total and permanent disability, or temporary disability lasting more than two years.

(i) "Participant" means an individual receiving a scholarship under this program.

(j) "Physician assistant" means a person licensed in Minnesota under chapter 147A.

(k) "Primary care physician" means an individual licensed in Minnesota as a physician and board-certified in family practice, internal medicine, obstetrics and gynecology, pediatrics, geriatrics, emergency medicine, hospital medicine, or psychiatry.

(l) "Registered nurse" means an individual licensed by the Minnesota Board of Nursing to practice professional nursing.

Subd. 2. Establishment and purpose. The commissioner shall establish a health professions opportunities scholarship program. The purpose of the program is to increase the number of students from racial, ethnic, or cultural populations experiencing health disparities who enter health professions.

Subd. 3. Eligible students. To be eligible to apply to the commissioner for the scholarship program, an applicant must be:

(1) accepted for full-time study in a program of study that will result in licensure as a primary care physician, certified nurse practitioner, certified nurse midwife, certified clinical nurse specialist, chiropractor, physician assistant, registered nurse, dentist, or dental therapist;

46.1 (2) a Minnesota resident; and
46.2 (3) an individual from a racial, ethnic, or cultural population experiencing health
46.3 disparities in the state.

46.4 Subd. 4. **Scholarship.** The commissioner may award a scholarship for the cost of
46.5 full tuition, fees, and living expenses up to \$40,000 per year to eligible students. The
46.6 commissioner will subtract the amount of other scholarship, grant, and gift awards to the
46.7 participant from the award made by this program. Scholarship awards will be limited to
46.8 the number of years for full-time enrollment in the applicant's program of study but will
46.9 not include any years completed prior to applying. The commissioner shall determine the
46.10 number of new scholarship awards made per fiscal year based on availability of state
46.11 funding. Scholarship awards will be paid by the commissioner directly to the participant's
46.12 educational institution after full-time enrollment is verified. Appropriations made to the
46.13 scholarship program do not cancel and are available until expended.

46.14 Subd. 5. **Obligated service.** A participant shall agree in contract to fulfill a
46.15 three-year service obligation at an eligible scholar placement site upon completion of
46.16 training, including residency, and obtaining Minnesota licensure. Participants must
46.17 provide at least 32 hours of direct patient care per week for at least 45 weeks per year.
46.18 Obligated service must start by March 31 of the year following completion of required
46.19 training.

46.20 Subd. 6. **Affidavit of service required.** Before starting a service obligation and
46.21 annually thereafter, participants shall submit to the commissioner an affidavit of practice
46.22 signed by a representative of their eligible scholar placement site verifying employment
46.23 status and the number of weekly hours of direct patient care provided by the participant.
46.24 Participants must also provide written notice to the commissioner within 30 days of:

- 46.25 (1) a change in name or address;
46.26 (2) a decision not to fulfill a service obligation; or
46.27 (3) cessation of obligated practice.

46.28 Subd. 7. **Penalty for nonfulfillment.** If a participant does not complete the
46.29 educational program, successfully obtain licensure, or fulfill the required minimum
46.30 commitment of service according to subdivision 6, the commissioner of health shall collect
46.31 from the participant the total amount awarded to the participant under the scholarship
46.32 program plus interest at a rate established according to section 270C.40. Funds collected
46.33 for nonfulfillment shall be credited to the health professions opportunities scholarship
46.34 program. The commissioner shall allow waivers of all or part of the money owed the
46.35 commissioner as a result of a nonfulfillment penalty due to emergency circumstances.

Sec. 14. [144.586] PATIENT SAFETY SURVEY.

Hospitals licensed under section 144.55 must submit necessary information to the Leapfrog Group patient safety survey on an annual basis in order to publicly report patient safety information and track the progress of each hospital to improve quality, safety, and efficiency of care delivery.

Sec. 15. Minnesota Statutes 2010, section 144.98, subdivision 2a, is amended to read:

Subd. 2a. **Standards.** Notwithstanding the exemptions in subdivisions 8 and 9, the commissioner shall accredit laboratories according to the most current environmental laboratory accreditation standards under subdivision 1 and as accepted by the accreditation bodies recognized by the National Environmental Laboratory Accreditation Program (NELAP) of the NELAC Institute.

Sec. 16. Minnesota Statutes 2010, section 144.98, subdivision 7, is amended to read:

Subd. 7. **Initial accreditation and annual accreditation renewal.** (a) The commissioner shall issue or renew accreditation after receipt of the completed application and documentation required in this section, provided the laboratory maintains compliance with the standards specified in subdivision 2a, notwithstanding any exemptions under subdivisions 8 and 9, and attests to the compliance on the application form.

(b) The commissioner shall prorate the fees in subdivision 3 for laboratories applying for accreditation after December 31. The fees are prorated on a quarterly basis beginning with the quarter in which the commissioner receives the completed application from the laboratory.

(c) Applications for renewal of accreditation must be received by November 1 and no earlier than October 1 of each year. The commissioner shall send annual renewal notices to laboratories 90 days before expiration. Failure to receive a renewal notice does not exempt laboratories from meeting the annual November 1 renewal date.

(d) The commissioner shall issue all accreditations for the calendar year for which the application is made, and the accreditation shall expire on December 31 of that year.

(e) The accreditation of any laboratory that fails to submit a renewal application and fees to the commissioner expires automatically on December 31 without notice or further proceeding. Any person who operates a laboratory as accredited after expiration of accreditation or without having submitted an application and paid the fees is in violation of the provisions of this section and is subject to enforcement action under sections 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired accreditation may reapply under subdivision 6.

Sec. 17. Minnesota Statutes 2010, section 144.98, is amended by adding a subdivision to read:

Subd. 8. Exemption from national standards for quality control and personnel requirements. Effective January 1, 2012, a laboratory that analyzes samples for compliance with a permit issued under section 115.03, subdivision 5, may request exemption from the personnel requirements and specific quality control provisions for microbiology and chemistry stated in the national standards as incorporated by reference in subdivision 2a. The commissioner shall grant the exemption if the laboratory:

(1) complies with the methodology and quality control requirements, where available, in the most recent, approved edition of the Standard Methods for the Examination of Water and Wastewater as published by the Water Environment Federation; and

(2) supplies the name of the person meeting the requirements in section 115.73, or the personnel requirements in the national standard pursuant to subdivision 2a.

A laboratory applying for this exemption shall not apply for simultaneous accreditation under the national standard.

Sec. 18. Minnesota Statutes 2010, section 144.98, is amended by adding a subdivision to read:

Subd. 9. Exemption from national standards for proficiency testing frequency.

(a) Effective January 1, 2012, a laboratory applying for or requesting accreditation under the exemption in subdivision 8 must obtain an acceptable proficiency test result for each of the laboratory's accredited or requested fields of testing. The laboratory must analyze proficiency samples selected from one of two annual proficiency testing studies scheduled by the commissioner.

(b) If a laboratory fails to successfully complete the first scheduled proficiency study, the laboratory shall:

(1) obtain and analyze a supplemental test sample within 15 days of receiving the test report for the initial failed attempt; and

(2) participate in the second annual study as scheduled by the commissioner.

(c) If a laboratory does not submit results or fails two consecutive proficiency samples, the commissioner will revoke the laboratory's accreditation for the affected fields of testing.

(d) The commissioner may require a laboratory to analyze additional proficiency testing samples beyond what is required in this subdivision if information available to

the commissioner indicates that the laboratory's analysis for the field of testing does not meet the requirements for accreditation.

(e) The commissioner may collect from laboratories accredited under the exemption in subdivision 8 any additional costs required to administer this subdivision and subdivision 8.

Sec. 19. Minnesota Statutes 2010, section 144A.102, is amended to read:

**144A.102 WAIVER FROM FEDERAL RULES AND REGULATIONS;
PENALTIES.**

(a) By January 2000, the commissioner of health shall work with providers to examine state and federal rules and regulations governing the provision of care in licensed nursing facilities and apply for federal waivers and identify necessary changes in state law to:

(1) allow the use of civil money penalties imposed upon nursing facilities to abate any deficiencies identified in a nursing facility's plan of correction; and

(2) stop the accrual of any fine imposed by the Health Department when a follow-up inspection survey is not conducted by the department within the regulatory deadline.

(b) By January 2012, the commissioner of health shall work with providers to examine state and federal rules and regulations governing the provision of care in licensed nursing facilities and apply for federal waivers and identify necessary changes in state law to:

(1) eliminate the requirement for written plans of correction from nursing homes for federal deficiencies issued at a scope and severity that is not widespread or in immediate jeopardy; and

(2) issue the federal survey form electronically to nursing homes.

The commissioner shall issue a report to the legislative chairs of the committees with jurisdiction over health and human services by January 31, 2012, on the status of implementation of this paragraph.

Sec. 20. Minnesota Statutes 2010, section 144A.61, is amended by adding a subdivision to read:

Subd. 9. **Electronic transmission.** The commissioner of health must accept electronic transmission of applications and supporting documentation for interstate endorsement for the nursing assistant registry.

Sec. 21. Minnesota Statutes 2010, section 144E.123, is amended to read:

144E.123 PREHOSPITAL CARE DATA.

Subdivision 1. **Collection and maintenance.** Until July 1, 2014, a licensee shall
may collect and provide prehospital care data to the board in a manner prescribed by the
board. At a minimum, the data must include items identified by the board that are part of
the National Uniform Emergency Medical Services Data Set. A licensee shall maintain
prehospital care data for every response.

Subd. 2. **Copy to receiving hospital.** If a patient is transported to a hospital, a copy
of the ambulance report delineating prehospital medical care given shall be provided
to the receiving hospital.

Subd. 3. **Review.** Prehospital care data may be reviewed by the board or its
designees. The data shall be classified as private data on individuals under chapter 13, the
Minnesota Government Data Practices Act.

~~Subd. 4. **Penalty.** Failure to report all information required by the board under this
section shall constitute grounds for license revocation.~~

Subd. 5. **Working group.** By October 1, 2011, the board must convene a working
group composed of six members, three of which must be appointed by the board and three
of which must be appointed by the Minnesota Ambulance Association, to redesign the
board's policies related to collection of data from licenses. The issues to be considered
include, but are not limited to, the following: user-friendly reporting requirements; data
sets; improved accuracy of reported information; appropriate use of information gathered
through the reporting system; and methods for minimizing the financial impact of data
reporting on licenses, particularly for rural volunteer services. The working group must
report its findings and recommendations to the board no later than January 1, 2014.

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

Sec. 22. **[145.9271] WHITE EARTH BAND URBAN CLINIC.**

Subdivision 1. **Condition.** If the White Earth Band of Ojibwe Indians accepts the
amount transferred under section 62J.692, subdivision 4, paragraph (b), clause (1), then it
must use the funds for purposes of this section.

Subd. 2. **Establish urban clinic.** The White Earth Band of Ojibwe Indians shall
establish and operate one or more health care clinics in the Minneapolis area or greater
Minnesota to serve members of the White Earth Tribe and may use funds received under
section 62J.692, subdivision 4, paragraph (b), clause (1), for application to qualify as a
federally qualified health center.

51.1 Subd. 3. **Grant agreements.** Before receiving the funds to be transferred under
51.2 section 62J.692, subdivision 4, paragraph (b), clause (1), the White Earth Band of Ojibwe
51.3 Indians is requested to submit to the commissioner of health a work plan and budget that
51.4 describes its annual plan for the funds. The commissioner will incorporate the work
51.5 plan and budget into a grant agreement between the commissioner and the White Earth
51.6 Band of Ojibwe Indians. Before each successive disbursement, the White Earth Band of
51.7 Ojibwe Indians is requested to submit a narrative progress report and an expenditure
51.8 report to the commissioner.

51.9 Sec. 23. **[145.9272] COMMUNITY MENTAL HEALTH CENTER GRANTS.**

51.10 Subdivision 1. **Definitions.** For purposes of this section, "community mental
51.11 health center" means an entity that is eligible for payment under section 256B.0625,
51.12 subdivision 5.

51.13 Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute, from
51.14 money appropriated for this purpose, grants to community mental health centers operating
51.15 in the state on July 1 of the year 2011 and each subsequent year for community mental
51.16 health center services to low-income consumers and patients with mental illness. The
51.17 amount of each grant shall be in proportion to each community mental health center's
51.18 revenues received from state health care programs in the most recent calendar year for
51.19 which data is available.

51.20 Sec. 24. Minnesota Statutes 2010, section 145.928, subdivision 2, is amended to read:

51.21 Subd. 2. **State-community partnerships; plan.** The commissioner, in partnership
51.22 with culturally based community organizations; the Indian Affairs Council under section
51.23 3.922; the Council on Affairs of Chicano/Latino People under section 3.9223; the Council
51.24 on Black Minnesotans under section 3.9225; the Council on Asian-Pacific Minnesotans
51.25 under section 3.9226; the Alliance for Racial and Cultural Health Equity; community
51.26 health boards as defined in section 145A.02; and tribal governments, shall develop and
51.27 implement a comprehensive, coordinated plan to reduce health disparities in the health
51.28 disparity priority areas identified in subdivision 1.

51.29 Sec. 25. **[145.929] PROFESSIONALS FROM POPULATIONS WITH HEALTH**
51.30 **DISPARITIES.**

51.31 The commissioner of health shall survey the diversity of the work force for
51.32 health-related professions and compare proportions in the allied health professions
51.33 among populations experiencing health disparities, including cultural, racial, ethnic,

52.1 and geographic factors, compared to the population of the state. Based on this survey,
52.2 the commissioner shall determine on an annual basis the ratio of training and residency
52.3 positions needed versus those available based on funding capacity.

52.4 Sec. 26. Minnesota Statutes 2010, section 145.986, is amended by adding a subdivision
52.5 to read:

52.6 Subd. 7. **Consultation and engagement of consumers and communities with**
52.7 **poorer health and outcomes.** Communities who receive statewide health improvement
52.8 grants must demonstrate to the commissioner that the applicant or grantee consulted
52.9 with and engaged local consumers, community organizations, and leaders representing
52.10 the subgroups of the community that experience the greatest health disparities in the
52.11 development of the local plan and that the plan incorporates components and activities
52.12 that reflect the needs and preferences of these communities. The plan must also include
52.13 a process for ongoing consultation and engagement of these consumers, community
52.14 organizations, and leaders in the implementation of the plan and activities funded by
52.15 state grants.

52.16 Sec. 27. Minnesota Statutes 2010, section 145.986, is amended by adding a subdivision
52.17 to read:

52.18 Subd. 8. **Coordination with payment reform demonstration projects.** A
52.19 community who received a health improvement plan grant under this section and
52.20 a payment reform demonstration project authorized under section 256B.0755 shall
52.21 coordinate activities to improve the health of the communities and patients served by both
52.22 the health improvement plan and the demonstration project provider.

52.23 Sec. 28. **[145.987] COMMUNITY HEALTH CENTERS DEVELOPMENT**
52.24 **GRANTS FOR UNDERSERVED COMMUNITIES.**

52.25 (a) The commissioner of health shall award grants from money appropriated for this
52.26 purpose to expand community health centers, as defined in section 145.9269, subdivision
52.27 1, in the state through the establishment of new community health centers or sites in
52.28 areas defined as small rural areas or isolated rural areas according to the four category
52.29 classification of the Rural Urban Commuting Area system developed for the United States
52.30 Health Resources and Services Administration or serving underserved patient populations
52.31 who experience the greatest disparities in health outcomes.

52.32 (b) Grant funds may be used to pay for:

(1) costs for an organization to develop and submit a proposal to the federal government for the designation of a new community health center or site;

(2) costs of engaging underserved communities, health care providers, local government agencies, or businesses in a process of developing a plan for a new center or site to serve people in that community; and

(3) costs of planning, designing, remodeling, constructing, or purchasing equipment for a new center or site.

Funds may not be used for operating costs.

(d) A proposal must demonstrate that racial and ethnic communities to be served by the community health center were consulted with and participated in the development of the proposal.

(e) The commissioner shall award grants on a competitive basis based on the following criteria:

(1) the unmet need in the underserved community;

(2) the degree of disparities in health outcomes in the underserved community; and

(3) the extent to which people from the underserved community participated in the development of the proposal.

Sec. 29. Minnesota Statutes 2010, section 145A.17, subdivision 3, is amended to read:

Subd. 3. Requirements for programs; process. (a) Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home

visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:

(1) use a community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(8) maximize resources and minimize duplication by coordinating or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies;

(9) utilize appropriate racial and ethnic approaches to providing home visiting services; and

(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

(c) When available, programs that receive funds under this section must offer or provide the family with a referral to center-based or group meetings that meet at least once per month for those families identified with additional needs. The meetings must focus on further enhancing the information, activities, and skill-building addressed during home visitation; offering opportunities for parents to meet with and support each other;

55.1 and offering infants and toddlers a safe, nurturing, and stimulating environment for
55.2 socialization and supervised play with qualified teachers.

55.3 (d) Funds available under this section shall not be used for medical services. The
55.4 commissioner shall establish an administrative cost limit for recipients of funds. The
55.5 outcome measures established under subdivision 6 must be specified to recipients of
55.6 funds at the time the funds are distributed.

55.7 (e) Data collected on individuals served by the home visiting programs must remain
55.8 confidential and must not be disclosed by providers of home visiting services without a
55.9 specific informed written consent that identifies disclosures to be made. Upon request,
55.10 agencies providing home visiting services must provide recipients with information on
55.11 disclosures, including the names of entities and individuals receiving the information and
55.12 the general purpose of the disclosure. Prospective and current recipients of home visiting
55.13 services must be told and informed in writing that written consent for disclosure of data is
55.14 not required for access to home visiting services.

55.15 (f) Upon initial contact with a family, programs that receive funding under this
55.16 section must request permission from the family to share with other family service
55.17 providers information about services the family is receiving and unmet needs of the family
55.18 in order to select a lead agency for the family and coordinate available resources. For
55.19 purposes of this paragraph, the term "family service providers" includes local public
55.20 health, social services, school districts, Head Start programs, health care providers, and
55.21 other public agencies.

55.22 Sec. 30. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision
55.23 to read:

55.24 Subd. 21. **Limited food establishment.** "Limited food establishment" means a food
55.25 establishment that is low risk, as defined by section 157.20, subdivision 2a, paragraph
55.26 (c), and where the operation consists primarily of combining dry mixes and water or ice
55.27 for immediate service to the consumer. Limited food establishments are exempt from the
55.28 NSF International food service equipment standards and the room finish requirements of
55.29 Minnesota Rules, chapter 4626.

55.30 Sec. 31. Minnesota Statutes 2010, section 157.20, is amended by adding a subdivision
55.31 to read:

55.32 Subd. 5. **Waivers during inspection.** Notwithstanding any provision of this chapter
55.33 or Minnesota Rules, chapter 4626, any plumbing or other facility requirement may be
55.34 waived by the inspector if the inspector deems a waiver appropriate and reasonable and

56.1 determines that no significant adverse effect on public health, safety, or the environment
56.2 would result from such waiver.

56.3 Sec. 32. Minnesota Statutes 2010, section 297F.10, subdivision 1, is amended to read:

56.4 Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette
56.5 taxes, as well as related penalties, interest, license fees, and miscellaneous sources of
56.6 revenue shall be deposited by the commissioner in the state treasury and credited as
56.7 follows:

56.8 (1) \$22,220,000 for fiscal year 2006 and \$22,250,000 for fiscal year 2007 and each
56.9 year thereafter must be credited to the Academic Health Center special revenue fund
56.10 hereby created and is annually appropriated to the Board of Regents at the University of
56.11 Minnesota for Academic Health Center funding at the University of Minnesota; and

56.12 (2) \$8,553,000 for fiscal year 2006 ~~and~~, \$8,550,000 for fiscal year 2007 ~~and~~,
56.13 \$8,337,000 for fiscal year 2012, and \$6,781,000 each year thereafter must be credited to
56.14 the medical education and research costs account hereby created in the special revenue
56.15 fund and is annually appropriated to the commissioner of health for distribution under
56.16 section 62J.692, subdivision 4 or 11, as appropriate; and

56.17 (3) the balance of the revenues derived from taxes, penalties, and interest (under
56.18 this chapter) and from license fees and miscellaneous sources of revenue shall be credited
56.19 to the general fund.

56.20 Sec. 33. **TRANSFER OF HEALTH QUALITY DATA COLLECTION.**

56.21 Subdivision 1. **Transfer.** The duties and activities of the commissioner of
56.22 health conducted pursuant to Minnesota Statutes, chapter 62U, are transferred to the
56.23 commissioner of human services.

56.24 Subd. 2. **Effect of transfer.** Minnesota Statutes, section 15.039 applies to the
56.25 transfer required in subdivision 1.

56.26 Subd. 3. **Effective date.** The transfer required in subdivision 1 is effective July 1,
56.27 2011.

56.28 Subd. 4. **Suspended data collection.** Data collection under Minnesota Statutes,
56.29 section 62U.04, subdivision 4, is suspended, effective July 1, 2011.

56.30 Subd. 5. **Commissioner of human services.** (a) During the 2012 legislative session,
56.31 the commissioner of human services, in consultation with the revisor of statutes, shall
56.32 submit to the legislature a bill making all statutory changes required by the reorganization
56.33 required under subdivision 1.

(b) By July 1, 2013, the commissioner must make recommendations to the legislature for collection of encounter data for state health care programs, including SEGIP, through a mechanism that allows a third-party contractor to capture data as it is transmitted through existing claims processing mechanisms.

Sec. 34. **PATIENT AND COMMUNITY ENGAGEMENT IN PAYMENT REFORM AND HEALTH CARE PROGRAM REFORMS.**

Subdivision 1. **Implementation of data system improvements.** The commissioners of health and human services shall implement the recommendations regarding data on health disparities that were contained in the report prepared under Laws 2010, First Special Session chapter 1, article 19, section 23, in consultation with an advisory work group representing racial and ethnic groups and representatives of government and private sector health care organizations. Among other activities, the commissioners shall:

(1) continue engagement with diverse communities on collection of and access to racial and ethnic data from state agencies, health care providers, and health plans;

(2) develop a plan to make data more accessible to communities;

(3) develop consistent data elements across programs when feasible; and

(4) develop consistent policies on data sampling.

Subd. 2. **Patient and community engagement.** The commissioner of health, in cooperation with the commissioners of human services and commerce, shall consult with an advisory committee representing racial and ethnic groups regarding the implementation of subdivision 1 and major agency activities related to state and federal health care reform, payment reform demonstration projects, state health care program reforms, improvements in quality and patient satisfaction measures, and major changes in state public health priorities and strategies. At the request of the advisory committee established under Laws 2010, First Special Session chapter 1, article 19, section 23, the commissioner shall designate a private sector organization of multiple racial and ethnic groups to serve as the advisory committee under this subdivision.

Sec. 35. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

(a) The commissioner of health, in consultation with the commissioner of human services, shall evaluate and recommend options for reorganizing health and human services regulatory responsibilities in both agencies to provide better efficiency and operational cost savings while maintaining the protection of the health, safety, and welfare of the public. Regulatory responsibilities that are to be evaluated are those found in

Minnesota Statutes, chapters 62D, 62N, 62R, 62T, 144A, 144D, 144G, 146A, 146B, 149A, 153A, 245A, 245B, and 245C, and sections 62Q.19, 144.058, 144.0722, 144.50, 144.651, 148.511, 148.6401, 148.995, 256B.692, 626.556, and 626.557.

(b) The evaluation and recommendations shall be submitted in a report to the legislative committees with jurisdiction over health and human services no later than February 15, 2012, and shall include, at a minimum, the following:

(1) whether the regulatory responsibilities of each agency should be combined into a separate agency;

(2) whether the regulatory responsibilities of each agency should be merged into an existing agency;

(3) what cost savings would result by merging the activities regardless of where they are located;

(4) what additional costs would result if the activities were merged;

(5) whether there are additional regulatory responsibilities in both agencies that should be considered in any reorganization; and

(6) for each option recommended, projected cost and a timetable and identification of the necessary steps and requirements for a successful transition period.

Sec. 36. TRANSFER OF THE HEALTH ECONOMICS PROGRAM.

Subdivision 1. **Transfer.** The duties and activities of the health economics program at the Minnesota Department of Health conducted pursuant to Minnesota Statutes, chapter 62J, are transferred to the commissioner of commerce.

Subd. 2. **Effect of transfer.** Minnesota Statutes, section 15.039, applies to the transfer required in subdivision 1.

Subd. 3. **Commissioner of commerce.** During the 2012 legislative session, the commissioner of commerce, in consultation with the revisor of statutes, shall submit to the legislature a bill making all statutory changes required by the reorganization required under subdivision 1.

Subd. 4. **Effective date.** The transfer required in subdivision 1 is effective July 1, 2011.

Sec. 37. STUDY OF FOR-PROFIT HEALTH MAINTENANCE ORGANIZATIONS.

The commissioner of health shall contract with an entity with expertise in health economics and health care delivery and quality to study the efficiency, costs, service quality, and enrollee satisfaction of for-profit health maintenance organizations, relative to

59.1 not-for-profit health maintenance organizations operating in Minnesota and other states.
59.2 The study findings must address whether the state of Minnesota could: (1) reduce medical
59.3 assistance and MinnesotaCare costs and costs of providing coverage to state employees;
59.4 and (2) maintain or improve the quality of care provided to state health care program
59.5 enrollees and state employees if for-profit health maintenance organizations were allowed
59.6 to operate in the state. The commissioner shall require the entity under contract to report
59.7 study findings to the commissioner and the legislature by January 15, 2012.

59.8 Sec. 38. **MINNESOTA TASK FORCE ON PREMATUREITY.**

59.9 Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is
59.10 established to evaluate and make recommendations on methods for reducing prematurity
59.11 and improving premature infant health care in the state.

59.12 Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at
59.13 least the following members, who serve at the pleasure of their appointing authority:

59.14 (1) 15 representatives of the Minnesota Prematurity Coalition including, but not
59.15 limited to, health care providers who treat pregnant women or neonates, organizations
59.16 focused on preterm births, early childhood education and development professionals, and
59.17 families affected by prematurity;

59.18 (2) one representative appointed by the commissioner of human services;

59.19 (3) two representatives appointed by the commissioner of health;

59.20 (4) one representative appointed by the commissioner of education;

59.21 (5) two members of the house of representatives, one appointed by the speaker of
59.22 the house and one appointed by the minority leader; and

59.23 (6) two members of the senate, appointed according to the rules of the senate.

59.24 (b) Members of the task force serve without compensation or payment of expenses.

59.25 (c) The commissioner of health must convene the first meeting of the Minnesota
59.26 Task Force on Prematurity by July 31, 2011. The task force must continue to meet at
59.27 least quarterly. Staffing and technical assistance shall be provided by the Minnesota
59.28 Perinatal Coalition.

59.29 Subd. 3. **Duties.** The task force must report the current state of prematurity in
59.30 Minnesota and develop recommendations on strategies for reducing prematurity and
59.31 improving premature infant health care in the state by considering the following:

59.32 (1) standards of care for premature infants born less than 37 weeks gestational age,
59.33 including recommendations to improve hospital discharge and follow-up care procedures;

59.34 (2) coordination of information among appropriate professional and advocacy
59.35 organizations on measures to improve health care for infants born prematurely;

(3) identification and centralization of available resources to improve access and awareness for caregivers of premature infants;

(4) development and dissemination of evidence-based practices through networking and educational opportunities;

(5) a review of relevant evidence-based research regarding the causes and effects of premature births in Minnesota;

(6) a review of relevant evidence-based research regarding premature infant health care, including methods for improving quality of and access to care for premature infants; and

(7) identification of gaps in public reporting measures and possible effects of these measures on prematurity rates.

Subd. 4. **Report; expiration.** (a) By November 30, 2011, the task force must submit a report on the current state of prematurity in Minnesota to the chairs of the legislative policy committees on health and human services.

(b) By January 15, 2013, the task force must report its final recommendations, including any draft legislation necessary for implementation, to the chairs of the legislative policy committees on health and human services.

(c) This task force expires on January 31, 2013, or upon submission of the final report required in paragraph (b), whichever is earlier.

Sec. 39. NURSING HOME REGULATORY EFFICIENCY.

The commissioner of health shall work with stakeholders to review, develop, implement, and recommend legislative changes in the nursing home licensure process that address efficiency, eliminate duplication, and ensure positive resident clinical outcomes. The commissioner shall ensure that the changes are cost-neutral.

Sec. 40. REPEALER.

(a) Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; 144.1464; and 150A.22, are repealed.

(b) Minnesota Statutes 2010, section 145A.14, subdivisions 1 and 2, are repealed effective January 1, 2012.

(c) Minnesota Rules, parts 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, and 23; 4651.0110, subparts 2, 2a, 3, 4, and 5; 4651.0120; 4651.0130; 4651.0140; and 4651.0150, are repealed effective July 1, 2011.

ARTICLE 3

HEALTH BOARDS

Section 1. Minnesota Statutes 2010, section 148.10, subdivision 7, is amended to read:

Subd. 7. **Conviction of a felony-level criminal sexual conduct offense.** (a) Except as provided in paragraph ~~(e)~~ (f), the board shall not grant or renew a license to practice chiropractic to any person who has been convicted on or after August 1, 2010, of any of the provisions of sections 609.342, subdivision 1, 609.343, subdivision 1, 609.344, subdivision 1, paragraphs (c) to (o), or 609.345, subdivision 1, paragraphs (b) to (o).

(b) The board shall not grant or renew a license to practice chiropractic to any person who has been convicted in any other state or country on or after August 1, 2011, of an offense where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a).

~~(b)~~ (c) A license to practice chiropractic is automatically revoked if the licensee is convicted of an offense listed in paragraph (a) ~~of this section.~~

~~(e)~~ (d) A license to practice chiropractic that has been denied or revoked under this subdivision is not subject to chapter 364.

~~(d)~~ (e) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

~~(e)~~ (f) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) of this subdivision may become licensed provided that the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for licensing or credentialing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant was released from any incarceration or supervisory jurisdiction related to the offense.

The board shall not consider an application under this paragraph if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

Sec. 2. Minnesota Statutes 2010, section 148.231, is amended to read:

148.231 REGISTRATION; FAILURE TO REGISTER; REREGISTRATION; VERIFICATION.

Subdivision 1. **Registration.** Every person licensed to practice professional or practical nursing must maintain with the board a current registration for practice as a registered nurse or licensed practical nurse which must be renewed at regular intervals established by the board by rule. No ~~certificate of~~ registration shall be issued by the board to a nurse until the nurse has submitted satisfactory evidence of compliance with the procedures and minimum requirements established by the board.

The fee for periodic registration for practice as a nurse shall be determined by the board by rule law. ~~A penalty fee shall be added for any application received after the required date as specified by the board by rule.~~ Upon receipt of the application and the required fees, the board shall verify the application and the evidence of completion of continuing education requirements in effect, and thereupon issue to the nurse ~~a certificate of~~ registration for the next renewal period.

Subd. 4. **Failure to register.** Any person licensed under the provisions of sections 148.171 to 148.285 who fails to register within the required period shall not be entitled to practice nursing in this state as a registered nurse or licensed practical nurse.

Subd. 5. **Reregistration.** A person whose registration has lapsed desiring to resume practice shall make application for reregistration, submit satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the ~~registration~~ reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, ~~the~~ registration ~~certificate~~ shall be issued to the person who shall immediately be placed on the practicing list as a registered nurse or licensed practical nurse.

Subd. 6. **Verification.** A person licensed under the provisions of sections 148.171 to 148.285 who requests the board to verify a Minnesota license to another state, territory, or country or to an agency, facility, school, or institution shall pay a fee ~~to the board~~ for each verification.

Sec. 3. Minnesota Statutes 2010, section 148B.5301, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional clinical counselor (LPCC), an applicant must provide satisfactory evidence to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in items (i) to (x), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field

experience in counseling that is not fewer than 700 hours. The degree must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include coursework in each of the following subject areas:

- (i) helping relationship, including counseling theory and practice;
- (ii) human growth and development;
- (iii) lifestyle and career development;
- (iv) group dynamics, processes, counseling, and consulting;
- (v) assessment and appraisal;
- (vi) social and cultural foundations, including multicultural issues;
- (vii) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
- (viii) family counseling and therapy;
- (ix) research and evaluation; and
- (x) professional counseling orientation and ethics;

(4) has demonstrated competence in professional counseling by passing the National Clinical Mental Health Counseling Examination (NCMHCE), administered by the National Board for Certified Counselors, Inc. (NBCC) and ethical, oral, and situational examinations as prescribed by the board. ~~In lieu of the NCMHCE, applicants who have taken and passed the National Counselor Examination (NCE) administered by the NBCC, or another board-approved examination, need only take and pass the Examination of Clinical Counseling Practice (ECCP) administered by the NBCC;~~

(5) has earned graduate-level semester credits or quarter-credit equivalents in the following clinical content areas as follows:

- (i) six credits in diagnostic assessment for child or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
- (ii) three credits in clinical treatment planning, with measurable goals;
- (iii) six credits in clinical intervention methods informed by research evidence and community standards of practice;
- (iv) three credits in evaluation methodologies regarding the effectiveness of interventions;
- (v) three credits in professional ethics applied to clinical practice; and
- (vi) three credits in cultural diversity; and

(6) has demonstrated successful completion of 4,000 hours of supervised, post-master's degree professional practice in the delivery of clinical services in the diagnosis and treatment of child and adult mental illnesses and disorders, conducted according to subdivision 2.

(b) If coursework in paragraph (a) was not completed as part of the degree program required by paragraph (a), clause (3), the coursework must be taken and passed for credit, and must be earned from a counseling program or institution that meets the requirements of paragraph (a), clause (3).

Sec. 4. Minnesota Statutes 2010, section 148B.5301, subdivision 3, is amended to read:

Subd. 3. Conversion from licensed professional counselor to licensed professional clinical counselor. (a) Until August 1, ~~2011~~ 2013, an individual currently licensed in the state of Minnesota as a licensed professional counselor may convert to a LPCC by providing evidence satisfactory to the board that the applicant has met the following requirements:

- (1) is at least 18 years of age;
- (2) is of good moral character;
- (3) has a license that is active and in good standing;
- (4) has no complaints pending, uncompleted disciplinary orders, or corrective action agreements;
- (5) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board, and whose degree was from a counseling program recognized by CACREP or from an institution of higher education that is accredited by a regional accrediting organization recognized by CHEA;

(6) has earned 24 graduate-level semester credits or quarter-credit equivalents in clinical coursework which includes content in the following clinical areas:

- (i) diagnostic assessment for child and adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
- (ii) clinical treatment planning, with measurable goals;
- (iii) clinical intervention methods informed by research evidence and community standards of practice;
- (iv) evaluation methodologies regarding the effectiveness of interventions;
- (v) professional ethics applied to clinical practice; and
- (vi) cultural diversity;

(7) has demonstrated, to the satisfaction of the board, successful completion of 4,000 hours of supervised, post-master's degree professional practice in the delivery of

65.1 clinical services in the diagnosis and treatment of child and adult mental illnesses and
65.2 disorders; and

65.3 (8) has paid the LPCC application and licensure fees required in section 148B.53,
65.4 subdivision 3.

65.5 (b) If the coursework in paragraph (a) was not completed as part of the degree
65.6 program required by paragraph (a), clause (5), the coursework must be taken and passed
65.7 for credit, and must be earned from a counseling program or institution that meets the
65.8 requirements in paragraph (a), clause (5).

65.9 (c) This subdivision expires August 1, ~~2011~~ 2013.

65.10 Sec. 5. Minnesota Statutes 2010, section 148B.5301, subdivision 4, is amended to read:

65.11 Subd. 4. **Conversion to licensed professional clinical counselor after August 1,**
65.12 **~~2011~~ 2013.** An individual licensed in the state of Minnesota as a licensed professional
65.13 counselor may convert to a LPCC by providing evidence satisfactory to the board that the
65.14 applicant has met the requirements of subdivisions 1 and 2, subject to the following:

65.15 (1) the individual's license must be active and in good standing;

65.16 (2) the individual must not have any complaints pending, uncompleted disciplinary
65.17 orders, or corrective action agreements; and

65.18 (3) the individual has paid the LPCC application and licensure fees required in
65.19 section 148B.53, subdivision 3.

65.20 Sec. 6. Minnesota Statutes 2010, section 148B.54, subdivision 2, is amended to read:

65.21 Subd. 2. **Continuing education.** At the completion of the first four years of
65.22 licensure, a licensee must provide evidence satisfactory to the board of completion of
65.23 12 additional postgraduate semester credit hours or its equivalent in counseling as
65.24 determined by the board, except that no licensee shall be required to show evidence of
65.25 greater than 60 semester hours or its equivalent. In addition to completing the requisite
65.26 graduate coursework, each licensee shall also complete in the first four years of licensure
65.27 a minimum of 40 hours of continuing education activities approved by the board under
65.28 Minnesota Rules, part 2150.2540. Graduate credit hours successfully completed in the
65.29 first four years of licensure may be applied to both the graduate credit requirement and to
65.30 the requirement for 40 hours of continuing education activities. A licensee may receive 15
65.31 continuing education hours per semester credit hour or ten continuing education hours
65.32 per quarter credit hour. Thereafter, at the time of renewal, each licensee shall provide
65.33 evidence satisfactory to the board that the licensee has completed during each two-year
65.34 period at least the equivalent of 40 clock hours of professional postdegree continuing

66.1 education in programs approved by the board and continues to be qualified to practice
66.2 under sections 148B.50 to 148B.593.

66.3 Sec. 7. Minnesota Statutes 2010, section 148B.54, subdivision 3, is amended to read:

66.4 Subd. 3. **Relicensure following termination.** An individual whose license was
66.5 terminated ~~prior to August 1, 2010,~~ and who can demonstrate completion of the graduate
66.6 credit requirement in subdivision 2, does not need to comply with the continuing education
66.7 requirement of Minnesota Rules, part 2150.2520, subpart 4, or with the continuing
66.8 education requirements for relicensure following termination in Minnesota Rules, part
66.9 2150.0130, subpart 2. This section does not apply to an individual whose license has
66.10 been canceled.

66.11 Sec. 8. Minnesota Statutes 2010, section 148E.060, subdivision 1, is amended to read:

66.12 Subdivision 1. **Students and other persons not currently licensed in another**
66.13 **jurisdiction.** (a) The board may issue a temporary license to practice social work to an
66.14 applicant who is not licensed or credentialed to practice social work in any jurisdiction
66.15 but has:

- 66.16 (1) applied for a license under section 148E.055;
- 66.17 (2) applied for a temporary license on a form provided by the board;
- 66.18 (3) submitted a form provided by the board authorizing the board to complete a
66.19 criminal background check;
- 66.20 (4) passed the applicable licensure examination provided for in section 148E.055;
- 66.21 (5) attested on a form provided by the board that the applicant has completed the
66.22 requirements for a baccalaureate or graduate degree in social work from a program
66.23 accredited by the Council on Social Work Education, the Canadian Association of Schools
66.24 of Social Work, or a similar ~~accreditation~~ accrediting body designated by the board, or a
66.25 doctorate in social work from an accredited university; and
- 66.26 (6) not engaged in conduct that was or would be in violation of the standards of
66.27 practice specified in sections 148E.195 to 148E.240. If the applicant has engaged in
66.28 conduct that was or would be in violation of the standards of practice, the board may take
66.29 action according to sections 148E.255 to 148E.270.

66.30 (b) A temporary license issued under this subdivision expires after six months.

66.31 **EFFECTIVE DATE.** This section is effective August 1, 2011.

66.32 Sec. 9. Minnesota Statutes 2010, section 148E.060, subdivision 2, is amended to read:

Subd. 2. **Emergency situations and persons currently licensed in another jurisdiction.** (a) The board may issue a temporary license to practice social work to an applicant who is licensed or credentialed to practice social work in another jurisdiction, may or may not have applied for a license under section 148E.055, and has:

(1) applied for a temporary license on a form provided by the board;

(2) submitted a form provided by the board authorizing the board to complete a criminal background check;

(3) submitted evidence satisfactory to the board that the applicant is currently licensed or credentialed to practice social work in another jurisdiction;

(4) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar ~~accreditation~~ accrediting body designated by the board, or a doctorate in social work from an accredited university; and

(5) not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(b) A temporary license issued under this subdivision expires after six months.

EFFECTIVE DATE. This section is effective August 1, 2011.

Sec. 10. Minnesota Statutes 2010, section 148E.060, is amended by adding a subdivision to read:

Subd. 2a. **Programs in candidacy status.** (a) The board may issue a temporary license to practice social work to an applicant who has completed the requirements for a baccalaureate or graduate degree in social work from a program in candidacy status with the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board, and has:

(1) applied for a license under section 148E.055;

(2) applied for a temporary license on a form provided by the board;

(3) submitted a form provided by the board authorizing the board to complete a criminal background check;

(4) passed the applicable licensure examination provided for in section 148E.055;

and

(5) not engaged in conduct that is in violation of the standards of practice specified in sections 148E.195 to 148E.240. If the applicant has engaged in conduct that is in

violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(b) A temporary license issued under this subdivision expires after 12 months but may be extended at the board's discretion upon a showing that the social work program remains in good standing with the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board. If the board receives notice from the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board that the social work program is not in good standing, or that the accreditation will not be granted to the social work program, the temporary license is immediately revoked.

EFFECTIVE DATE. This section is effective August 1, 2011.

Sec. 11. Minnesota Statutes 2010, section 148E.060, subdivision 3, is amended to read:

Subd. 3. **Teachers.** (a) The board may issue a temporary license to practice social work to an applicant whose permanent residence is outside the United States, who is teaching social work at an academic institution in Minnesota for a period not to exceed 12 months, who may or may not have applied for a license under section 148E.055, and who has:

(1) applied for a temporary license on a form provided by the board;

(2) submitted a form provided by the board authorizing the board to complete a criminal background check;

(3) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or graduate degree in social work; and

(4) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(b) A temporary license issued under this subdivision expires after 12 months.

EFFECTIVE DATE. This section is effective August 1, 2011.

Sec. 12. Minnesota Statutes 2010, section 148E.060, subdivision 5, is amended to read:

Subd. 5. **Temporary license term.** ~~(a)~~ A temporary license is valid until expiration, or until the board issues or denies the license according to section 148E.055, or until

69.1 the board revokes the temporary license, whichever comes first. A temporary license is
69.2 nonrenewable.

69.3 ~~(b) A temporary license issued according to subdivision 1 or 2 expires after six~~
69.4 ~~months.~~

69.5 ~~(c) A temporary license issued according to subdivision 3 expires after 12 months.~~

69.6 **EFFECTIVE DATE.** This section is effective August 1, 2011.

69.7 Sec. 13. Minnesota Statutes 2010, section 148E.120, is amended to read:

69.8 **148E.120 REQUIREMENTS OF SUPERVISORS.**

69.9 Subdivision 1. **Supervisors licensed as social workers.** (a) Except as provided in
69.10 ~~paragraph (d)~~ subdivision 2, to be eligible to provide supervision under this section, a
69.11 social worker must:

69.12 (1) have completed 30 hours of training in supervision through coursework from
69.13 an accredited college or university, or through continuing education in compliance with
69.14 sections 148E.130 to 148E.170;

69.15 (2) be competent in the activities being supervised; and

69.16 (3) attest, on a form provided by the board, that the social worker has met the
69.17 applicable requirements specified in this section and sections 148E.100 to 148E.115. The
69.18 board may audit the information provided to determine compliance with the requirements
69.19 of this section.

69.20 (b) A licensed independent clinical social worker providing clinical licensing
69.21 supervision to a licensed graduate social worker or a licensed independent social worker
69.22 must have at least 2,000 hours of experience in authorized social work practice, including
69.23 1,000 hours of experience in clinical practice after obtaining a licensed independent
69.24 clinical social worker license.

69.25 (c) A licensed social worker, licensed graduate social worker, licensed independent
69.26 social worker, or licensed independent clinical social worker providing nonclinical
69.27 licensing supervision must have completed the supervised practice requirements specified
69.28 in section 148E.100, 148E.105, 148E.106, 148E.110, or 148E.115, as applicable.

69.29 ~~(d) If the board determines that supervision is not obtainable from an individual~~
69.30 ~~meeting the requirements specified in paragraph (a), the board may approve an alternate~~
69.31 ~~supervisor according to subdivision 2.~~

69.32 Subd. 2. **Alternate supervisors.** (a) ~~The board may approve an alternate supervisor~~
69.33 ~~if.~~ The board may approve an alternate supervisor as determined in this subdivision. The
69.34 board shall approve up to 25 percent of the required supervision hours by a licensed mental

health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

~~(1) the board determines that supervision is not obtainable according to paragraph (b);~~

~~(2) the licensee requests in the supervision plan submitted according to section 148E.125, subdivision 1, that an alternate supervisor conduct the supervision;~~

~~(3) the licensee describes the proposed supervision and the name and qualifications of the proposed alternate supervisor; and~~

~~(4) the requirements of paragraph (d) are met.~~

~~(b) The board may determine that supervision is not obtainable if:~~

~~(1) the licensee provides documentation as an attachment to the supervision plan submitted according to section 148E.125, subdivision 1, that the licensee has conducted a thorough search for a supervisor meeting the applicable licensure requirements specified in sections 148E.100 to 148E.115;~~

~~(2) the licensee demonstrates to the board's satisfaction that the search was unsuccessful; and~~

~~(3) the licensee describes the extent of the search and the names and locations of the persons and organizations contacted.~~

~~(c) The requirements specified in paragraph (b) do not apply to obtaining licensing supervision for social work practice if the board determines that there are five or fewer supervisors meeting the applicable licensure requirements in sections 148E.100 to 148E.115 in the county where the licensee practices social work.~~

~~(d) An alternate supervisor must:~~

~~(1) be an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;~~

~~(2) be a social worker engaged in authorized practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115; or~~

~~(3) be a licensed marriage and family therapist or a mental health professional as established by section 245.462, subdivision 18, or 245.4871, subdivision 27, or an equivalent mental health professional, as determined by the board, who is licensed or credentialed by a state, territorial, provincial, or foreign licensing agency.~~

~~(e) In order to qualify to provide clinical supervision of a licensed graduate social worker or licensed independent social worker engaged in clinical practice, the alternate~~

~~supervisor must be a mental health professional as established by section 245.462, subdivision 18, or 245.4871, subdivision 27, or an equivalent mental health professional, as determined by the board, who is licensed or credentialed by a state, territorial, provincial, or foreign licensing agency.~~

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115;
or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

EFFECTIVE DATE. This section is effective August 1, 2011.

Sec. 14. Minnesota Statutes 2010, section 150A.02, is amended to read:

150A.02 BOARD OF DENTISTRY.

Subdivision 1. **Generally.** There is hereby created a Board of Dentistry whose duty it shall be to carry out the purposes and enforce the provisions of sections 150A.01 to 150A.12. The board shall consist of two public members as defined by section 214.02, and the following dental professionals who are licensed and reside in Minnesota: five qualified ~~resident~~ dentists, one qualified ~~resident~~ licensed dental assistant, and one qualified ~~resident~~ dental hygienist appointed by the governor. One qualified dentist must be involved with the education, employment, or utilization of a dental therapist or an advanced dental therapist. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in sections 214.07 to 214.09. The provision of staff, administrative services and office space; the review and processing of board complaints; the setting of board fees; and other provisions relating to board operations shall be as provided in chapter 214. Each board member who is a dentist, licensed dental assistant, or dental hygienist shall have been lawfully in active practice in this state for five years immediately preceding appointment; and no board member shall be eligible for appointment to more than two consecutive four-year terms, and members serving on the board at the time of the enactment hereof shall be eligible to reappointment provided they shall not have served more than nine consecutive years at the expiration of the term to which they are to be appointed. At least 90 days prior to the expiration of the terms of dentists, licensed dental assistants, or dental hygienists, the Minnesota Dental Association, Minnesota Dental Assistants Association, or the Minnesota State Dental Hygiene Association shall recommend to the governor for each term expiring not less than two dentists, two licensed dental assistants, or two dental hygienists, respectively, who are qualified to serve on the board, and from the list so recommended the governor may appoint members to the board for the term of four years, the appointments to be made within 30 days after the expiration of the terms. Within 60 days after the occurrence of a dentist, licensed dental assistant, or dental hygienist vacancy, prior to the expiration of the term, in the board, the Minnesota Dental Association, the Minnesota Dental Assistants Association, or the Minnesota State Dental Hygiene Association shall recommend to the governor not less than two dentists, two licensed dental assistants, or two dental hygienists, who are qualified to serve on the board and from the list so recommended the governor, within 30 days after receiving such list of dentists, may appoint one member to the board for the unexpired term occasioned by such vacancy. Any appointment to fill a vacancy shall be made within 90 days after the

73.1 occurrence of such vacancy. ~~The first four-year term of the dental hygienist and of the~~
73.2 ~~licensed dental assistant shall commence on the first Monday in January, 1977.~~

73.3 Sec. 15. Minnesota Statutes 2010, section 150A.06, subdivision 1c, is amended to read:

73.4 Subd. 1c. **Specialty dentists.** (a) The board may grant a specialty license in the
73.5 specialty areas of dentistry that are recognized by the American Dental Association.

73.6 (b) An applicant for a specialty license shall:

73.7 (1) have successfully completed a postdoctoral specialty education program
73.8 accredited by the Commission on Dental Accreditation of the American Dental
73.9 Association, or have announced a limitation of practice before 1967;

73.10 (2) have been certified by a specialty examining board approved by the Minnesota
73.11 Board of Dentistry, or provide evidence of having passed a clinical examination for
73.12 licensure required for practice in any state or Canadian province, or in the case of oral and
73.13 maxillofacial surgeons only, have a Minnesota medical license in good standing;

73.14 (3) have been in active practice or a postdoctoral specialty education program or
73.15 United States government service at least 2,000 hours in the 36 months prior to applying
73.16 for a specialty license;

73.17 (4) if requested by the board, be interviewed by a committee of the board, which
73.18 may include the assistance of specialists in the evaluation process, and satisfactorily
73.19 respond to questions designed to determine the applicant's knowledge of dental subjects
73.20 and ability to practice;

73.21 (5) if requested by the board, present complete records on a sample of patients
73.22 treated by the applicant. The sample must be drawn from patients treated by the applicant
73.23 during the 36 months preceding the date of application. The number of records shall be
73.24 established by the board. The records shall be reasonably representative of the treatment
73.25 typically provided by the applicant;

73.26 (6) at board discretion, pass a board-approved English proficiency test if English is
73.27 not the applicant's primary language;

73.28 (7) pass all components of the National ~~Dental~~ Board Dental Examinations;

73.29 (8) pass the Minnesota Board of Dentistry jurisprudence examination;

73.30 (9) abide by professional ethical conduct requirements; and

73.31 (10) meet all other requirements prescribed by the Board of Dentistry.

73.32 (c) The application must include:

73.33 (1) a completed application furnished by the board;

(2) at least two character references from two different dentists, one of whom must be a dentist practicing in the same specialty area, and the other the director of the specialty program attended;

(3) a licensed physician's statement attesting to the applicant's physical and mental condition;

(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's visual acuity;

(5) a nonrefundable fee; and

(6) a notarized, unmounted passport-type photograph, three inches by three inches, taken not more than six months before the date of application.

(d) A specialty dentist holding a specialty license is limited to practicing in the dentist's designated specialty area. The scope of practice must be defined by each national specialty board recognized by the American Dental Association.

(e) A specialty dentist holding a general dentist license is limited to practicing in the dentist's designated specialty area if the dentist has announced a limitation of practice. The scope of practice must be defined by each national specialty board recognized by the American Dental Association.

(f) All specialty dentists who have fulfilled the specialty dentist requirements and who intend to limit their practice to a particular specialty area may apply for a specialty license.

Sec. 16. Minnesota Statutes 2010, section 150A.06, subdivision 1d, is amended to read:

Subd. 1d. **Dental therapists.** A person of good moral character who has graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the American Dental Association Commission on Dental Accreditation or another board-approved national accreditation organization may apply for licensure.

The applicant must submit an application and fee as prescribed by the board and a diploma or certificate from a dental therapy education program. Prior to being licensed, the applicant must pass a comprehensive, competency-based clinical examination that is approved by the board and administered independently of an institution providing dental therapy education. The clinical examinations for competencies for dental therapy and advanced dental therapy must be comparable to those administered to dental students for the same competencies. The applicant must also pass an examination testing the applicant's knowledge of the Minnesota laws and rules relating to the practice of dentistry. An applicant who has failed the clinical examination twice is ineligible to retake the

75.1 clinical examination until further education and training are obtained as specified by the
75.2 board. A separate, nonrefundable fee may be charged for each time a person applies.
75.3 An applicant who passes the examination in compliance with subdivision 2b, abides by
75.4 professional ethical conduct requirements, and meets all the other requirements of the
75.5 board shall be licensed as a dental therapist.

75.6 Sec. 17. Minnesota Statutes 2010, section 150A.06, subdivision 3, is amended to read:

75.7 Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists
75.8 or dental hygienists, except that pertaining to the law of Minnesota relating to dentistry
75.9 and the rules of the board, may, at the discretion of the board, be waived for an applicant
75.10 who presents a certificate of ~~qualification from~~ having passed all components of the
75.11 National Board of Dental Examiners Examinations or evidence of having maintained an
75.12 adequate scholastic standing as determined by the board, in dental school as to dentists, or
75.13 dental hygiene school as to dental hygienists.

75.14 (b) The board shall waive the clinical examination required for licensure for any
75.15 dentist applicant who is a graduate of a dental school accredited by the Commission
75.16 on Dental Accreditation of the American Dental Association, who has ~~successfully~~
75.17 ~~completed~~ passed all components of the ~~National Dental Board Examination~~ Dental
75.18 Examinations, and who has satisfactorily completed a Minnesota-based postdoctoral
75.19 general dentistry residency program (GPR) or an advanced education in general dentistry
75.20 (AEGD) program after January 1, 2004. The postdoctoral program must be accredited
75.21 by the Commission on Dental Accreditation of the American Dental Association, be of
75.22 at least one year's duration, and include an outcome assessment evaluation assessing
75.23 the resident's competence to practice dentistry. The board may require the applicant to
75.24 submit any information deemed necessary by the board to determine whether the waiver is
75.25 applicable. The board may waive the clinical examination for an applicant who meets the
75.26 requirements of this paragraph and has satisfactorily completed an accredited postdoctoral
75.27 general dentistry residency program located outside of Minnesota.

75.28 Sec. 18. Minnesota Statutes 2010, section 150A.06, subdivision 4, is amended to read:

75.29 Subd. 4. **Licensure by credentials.** (a) Any dentist or dental hygienist may, upon
75.30 application and payment of a fee established by the board, apply for licensure based on
75.31 the applicant's performance record in lieu of passing an examination approved by the
75.32 board according to section 150A.03, subdivision 1, and be interviewed by the board to
75.33 determine if the applicant:

75.34 (1) has passed all components of the National Board Dental Examinations;

(1) (2) has been in active practice at least 2,000 hours within 36 months of the application date, or passed a board-approved reentry program within 36 months of the application date;

(2) (3) currently has a license in another state or Canadian province and is not subject to any pending or final disciplinary action, or if not currently licensed, previously had a license in another state or Canadian province in good standing that was not subject to any final or pending disciplinary action at the time of surrender;

(3) (4) is of good moral character and abides by professional ethical conduct requirements;

(4) (5) at board discretion, has passed a board-approved English proficiency test if English is not the applicant's primary language; and

(5) (6) meets other credentialing requirements specified in board rule.

(b) An applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 1 or 2 must be licensed to practice the applicant's profession.

(c) If the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 1 or 2, the application must be denied. When denying a license, the board may notify the applicant of any specific remedy that the applicant could take which, when passed, would qualify the applicant for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 1 or 2.

(d) A candidate whose application has been denied may appeal the decision to the board according to subdivision 4a.

Sec. 19. Minnesota Statutes 2010, section 150A.06, subdivision 6, is amended to read:

Subd. 6. **Display of name and certificates.** (a) The initial license and subsequent renewal, ~~or current registration certificate,~~ of every dentist, a dental therapist, dental hygienist, or dental assistant shall be conspicuously displayed in every office in which that person practices, in plain sight of patients. When available from the board, the board shall allow the display of a wallet-sized initial license and wallet-sized subsequent renewal certificate only at nonprimary practice locations instead of displaying an original-sized initial license and subsequent renewal certificate.

(b) Near or on the entrance door to every office where dentistry is practiced, the name of each dentist practicing there, as inscribed on the current license certificate, shall be displayed in plain sight.

Sec. 20. Minnesota Statutes 2010, section 150A.09, subdivision 3, is amended to read:

77.1 Subd. 3. **Current address, change of address.** Every dentist, dental therapist,
77.2 dental hygienist, and dental assistant shall maintain with the board a correct and current
77.3 mailing address and electronic mail address. For dentists engaged in the practice of
77.4 dentistry, the postal address shall be that of the location of the primary dental practice.
77.5 Within 30 days after changing postal or electronic mail addresses, every dentist, dental
77.6 therapist, dental hygienist, and dental assistant shall provide the board written notice of
77.7 the new address either personally or by first class mail.

77.8 Sec. 21. Minnesota Statutes 2010, section 150A.105, subdivision 7, is amended to read:

77.9 Subd. 7. **Use of dental assistants.** (a) A licensed dental therapist may supervise
77.10 dental assistants to the extent permitted in the collaborative management agreement and
77.11 according to section 150A.10, subdivision 2.

77.12 (b) Notwithstanding paragraph (a), a licensed dental therapist is limited to
77.13 supervising no more than four ~~registered~~ licensed dental assistants or ~~nonregistered~~
77.14 nonlicensed dental assistants at any one practice setting.

77.15 Sec. 22. Minnesota Statutes 2010, section 150A.106, subdivision 1, is amended to read:

77.16 Subdivision 1. **General.** In order to be certified by the board to practice as an
77.17 advanced dental therapist, a person must:

77.18 (1) complete a dental therapy education program;

77.19 (2) pass an examination to demonstrate competency under the dental therapy scope
77.20 of practice;

77.21 (3) be licensed as a dental therapist;

77.22 (4) complete 2,000 hours of dental therapy clinical practice under direct or indirect
77.23 supervision;

77.24 (5) graduate from a master's advanced dental therapy education program;

77.25 (6) pass a board-approved certification examination, comparable to those
77.26 administered to dental students, to demonstrate competency under the advanced scope of
77.27 practice; and

77.28 (7) submit an application and fee for certification as prescribed by the board.

77.29 Sec. 23. Minnesota Statutes 2010, section 150A.14, is amended to read:

77.30 **150A.14 IMMUNITY.**

77.31 Subdivision 1. **Reporting immunity.** A person, health care facility, business, or
77.32 organization is immune from civil liability or criminal prosecution for submitting a report
77.33 in good faith to the board under section 150A.13, or for cooperating with an investigation

of a report or with staff of the board relative to violations or alleged violations of section 150A.08. Reports are confidential data on individuals under section 13.02, subdivision 3, and are privileged communications.

Subd. 2. **Program Investigation immunity.** (a) Members of the board, persons employed by the board, and board consultants retained by the board are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under ~~section 150A.13~~ sections 150A.02 to 150A.21, 214.10, and 214.103.

(b) For purposes of this section, a member of the board or a consultant described in paragraph (a) is considered a state employee under section 3.736, subdivision 9.

Sec. 24. Minnesota Statutes 2010, section 214.09, is amended by adding a subdivision to read:

Subd. 5. **Health-related boards.** No current member of a health-related licensing board may seek a paid employment position with that board.

Sec. 25. Minnesota Statutes 2010, section 214.103, is amended to read:

214.103 HEALTH-RELATED LICENSING BOARDS; COMPLAINT, INVESTIGATION, AND HEARING.

Subdivision 1. **Application.** For purposes of this section, "board" means "health-related licensing board" and does not include the non-health-related licensing boards. Nothing in this section supersedes section 214.10, subdivisions 2a, 3, 8, and 9, as they apply to the health-related licensing boards.

Subd. 1a. **Notifications and resolution.** (a) No more than 14 calendar days after receiving a complaint regarding a licensee, the board shall notify the complainant that the board has received the complaint and shall provide the complainant with the written description of the board's complaint process. The board shall periodically, but no less than every 120 days, notify the complainant of the status of the complaint consistent with section 13.41.

(b) Except as provided in paragraph (d), no more than 60 calendar days after receiving a complaint regarding a licensee, the board must notify the licensee that the board has received a complaint and inform the licensee of:

(1) the substance of the complaint;

(2) the sections of the law that have allegedly been violated;

(3) the sections of the professional rules that have allegedly been violated; and

(4) whether an investigation is being conducted.

79.1 (c) The board shall periodically, but not less than every 120 days, notify the licensee
79.2 of the status of the complaint consistent with section 13.41.

79.3 (d) Paragraphs (b) and (c) do not apply if the board determines that such notice
79.4 would compromise the board's investigation and that such notice cannot reasonably be
79.5 accomplished within this time.

79.6 (e) No more than one year after receiving a complaint regarding a licensee, the
79.7 board must resolve or dismiss the complaint unless the board determines that resolving or
79.8 dismissing the complaint cannot reasonably be accomplished in this time and is not in
79.9 the public interest.

79.10 (f) Failure to make notifications or to resolve the complaint within the time
79.11 established in this subdivision shall not deprive the board of jurisdiction to complete the
79.12 investigation or to take corrective, disciplinary, or other action against the licensee that is
79.13 authorized by law. Such a failure by the board shall not be the basis for a licensee's request
79.14 for the board to dismiss a complaint, and shall not be considered by an administrative law
79.15 judge, the board, or any reviewing court.

79.16 Subd. 2. **Receipt of complaint.** The boards shall receive and resolve complaints
79.17 or other communications, whether oral or written, against regulated persons. Before
79.18 resolving an oral complaint, the executive director or a board member designated by the
79.19 board to review complaints ~~may~~ shall require the complainant to state the complaint in
79.20 writing or authorize transcribing the complaint. The executive director or the designated
79.21 board member shall determine whether the complaint alleges or implies a violation of
79.22 a statute or rule which the board is empowered to enforce. The executive director or
79.23 the designated board member may consult with the designee of the attorney general as
79.24 to a board's jurisdiction over a complaint. If the executive director or the designated
79.25 board member determines that it is necessary, the executive director may seek additional
79.26 information to determine whether the complaint is jurisdictional or to clarify the nature
79.27 of the allegations by obtaining records or other written material, obtaining a handwriting
79.28 sample from the regulated person, clarifying the alleged facts with the complainant, and
79.29 requesting a written response from the subject of the complaint.

79.30 Subd. 3. **Referral to other agencies.** The executive director shall forward to
79.31 another governmental agency any complaints received by the board which do not relate
79.32 to the board's jurisdiction but which relate to matters within the jurisdiction of another
79.33 governmental agency. The agency shall advise the executive director of the disposition
79.34 of the complaint. A complaint or other information received by another governmental
79.35 agency relating to a statute or rule which a board is empowered to enforce must be
79.36 forwarded to the executive director of the board to be processed in accordance with this

section. Governmental agencies may coordinate and conduct joint investigations of complaints that involve more than one governmental agency.

Subd. 4. **Role of the attorney general.** The executive director or the designated board member shall forward a complaint and any additional information to the designee of the attorney general when the executive director or the designated board member determines that a complaint is jurisdictional and:

(1) requires investigation before the executive director or the designated board member may resolve the complaint;

(2) that attempts at resolution for disciplinary action or the initiation of a contested case hearing is appropriate;

(3) that an agreement for corrective action is warranted; or

(4) that the complaint should be dismissed, consistent with subdivision 8.

Subd. 5. **Investigation by attorney general.** (a) If the executive director or the designated board member determines that investigation is necessary before resolving the complaint, the executive director shall forward the complaint and any additional information to the designee of the attorney general. The designee of the attorney general shall evaluate the communications forwarded and investigate as appropriate.

(b) The designee of the attorney general may also investigate any other complaint forwarded under subdivision 3 when the designee of the attorney general determines that investigation is necessary.

(c) In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director or the designated board member. The designee may also consult with or seek the assistance of other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation.

(d) Upon completion of the investigation, the designee shall forward the investigative report to the executive director with recommendations for further consideration or dismissal.

Subd. 6. **Attempts at resolution.** (a) At any time after receipt of a complaint, the executive director or the designated board member may attempt to resolve the complaint with the regulated person. The available means for resolution include a conference or any other written or oral communication with the regulated person. A conference may be held for the purposes of investigation, negotiation, education, or conciliation. Neither the executive director nor any member of a board's staff shall be a voting member in any attempts at resolutions which may result in disciplinary or corrective action. The results of attempts at resolution with the regulated person may include a recommendation to

the board for disciplinary action, an agreement between the executive director or the designated board member and the regulated person for corrective action, or the dismissal of a complaint. If attempts at resolution are not in the public interest ~~or are not satisfactory to the executive director or the designated board member~~, then the executive director or the designated board member may initiate a contested case hearing may be initiated.

(1) The designee of the attorney general shall represent the board in all attempts at resolution which the executive director or the designated board member anticipate may result in disciplinary action. A stipulation between the executive director or the designated board member and the regulated person shall be presented to the board for the board's consideration. An approved stipulation and resulting order shall become public data.

(2) The designee of the attorney general shall represent the board upon the request of the executive director or the designated board member in all attempts at resolution which the executive director or the designated board member anticipate may result in corrective action. Any agreement between the executive director or the designated board member and the regulated person for corrective action shall be in writing and shall be reviewed by the designee of the attorney general prior to its execution. The agreement for corrective action shall provide for dismissal of the complaint upon successful completion by the regulated person of the corrective action.

(b) Upon receipt of a complaint alleging sexual contact or sexual conduct with a client, the board must forward the complaint to the designee of the attorney general for an investigation. If, after it is investigated, the complaint appears to provide a basis for disciplinary action, the board shall resolve the complaint by disciplinary action or initiate a contested case hearing. Notwithstanding paragraph (a), clause (2), a board may not take corrective action or dismiss a complaint alleging sexual contact or sexual conduct with a client unless, in the opinion of the executive director, the designated board member, and the designee of the attorney general, there is insufficient evidence to justify disciplinary action.

Subd. 7. Contested case hearing. If the executive director or the designated board member determines that attempts at resolution of a complaint are not in the public interest ~~or are not satisfactory to the executive director or the designated board member~~, the executive director or the designated board member, after consultation with the designee of the attorney general, and the concurrence of a second board member, may initiate a contested case hearing under chapter 14. The designated board member or any board member who was consulted during the course of an investigation may participate at the contested case hearing. A designated or consulted board member may not deliberate or vote in any proceeding before the board pertaining to the case.

Subd. 8. **Dismissal and reopening of a complaint.** (a) A complaint may not be dismissed without the concurrence of at least two board members and, upon the request of the complainant, a review by a representative of the attorney general's office. The designee of the attorney general must review before dismissal any complaints which allege any violation of chapter 609, any conduct which would be required to be reported under section 626.556 or 626.557, any sexual contact or sexual conduct with a client, any violation of a federal law, any actual or potential inability to practice the regulated profession or occupation by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental or physical condition, any violation of state medical assistance laws, or any disciplinary action related to credentialing in another jurisdiction or country which was based on the same or related conduct specified in this subdivision.

(b) The board may reopen a dismissed complaint if the board receives newly discovered information that was not available to the board during the initial investigation of the complaint, or if the board receives a new complaint that indicates a pattern of behavior or conduct.

Subd. 9. **Information to complainant.** A board shall furnish to a person who made a complaint a written description of the board's complaint process, and actions of the board relating to the complaint.

Subd. 10. **Prohibited participation by board member.** A board member who has actual bias or a current or former direct financial or professional connection with a regulated person may not vote in board actions relating to the regulated person.

Sec. 26. **[214.107] CONVICTION OF A FELONY-LEVEL CRIMINAL SEXUAL CONDUCT OFFENSE.**

Subdivision 1. **Applicability.** This section applies to the health-related licensing boards, as defined in section 214.01, subdivision 2, except the Board of Medical Practice; the Board of Chiropractic Examiners; the Board of Barber Examiners; the Board of Cosmetologist Examiners; and professions credentialed by the Minnesota Department of Health: (1) speech-language pathologists and audiologists; (2) hearing instrument dispensers; and (3) occupational therapists and occupational therapy assistants.

Subd. 2. **Issuing and renewing a credential to practice.** (a) Except as provided in paragraph (f), a credentialing authority listed in subdivision 1 shall not issue or renew a credential to practice to any person who has been convicted on or after August 1, 2011, of any of the provisions of section 609.342, subdivision 1; 609.343, subdivision 1; 609.344, subdivision 1, paragraphs (c) to (o); or 609.345, subdivision 1, paragraphs (b) to (o).

(b) A credentialing authority listed in subdivision 1 shall not issue or renew a credential to practice to any person who has been convicted in any other state or country on or after August 1, 2011, of an offense where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a).

(c) A credential to practice is automatically revoked if the credentialed person is convicted of an offense listed in paragraph (a).

(d) A credential to practice that has been denied or revoked under this section is not subject to chapter 364.

(e) For purposes of this section, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

(f) A credentialing authority listed in subdivision 1 may establish criteria whereby an individual convicted of an offense listed in paragraph (a) of this subdivision may become credentialed provided that the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for credentialing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant was released from any incarceration or supervisory jurisdiction related to the offense.

A credentialing authority listed in subdivision 1 shall not consider an application under this paragraph if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

EFFECTIVE DATE. This section is effective for credentials issued or renewed on or after August 1, 2011.

Sec. 27. [214.108] HEALTH-RELATED LICENSING BOARDS; LICENSEE GUIDANCE.

A health-related licensing board may offer guidance to current licensees about the application of laws and rules the board is empowered to enforce. This guidance shall not bind any court or other adjudicatory body.

Sec. 28. [214.109] RECORD KEEPING.

(a) A board may take administrative action against a regulated person whose records do not meet the standards of professional practice. Records that are fraudulent or could result in patient harm may be handled through disciplinary or other corrective action.

(b) For the first offense, a board shall issue a warning to the regulated person that identifies the specific record-keeping deficiencies. The board may require the regulated person to attend a remedial class.

(c) For a second offense, a board shall require additional training as determined by the board and impose a \$50 penalty on the regulated person.

(d) For a third offense, a board shall require additional training as determined by the board and impose a \$100 penalty on the regulated person.

(e) Action under this section shall not be considered disciplinary action.

Sec. 29. Minnesota Statutes 2010, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.21, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving.

This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Board of Teaching or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.

(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.

(f) This chapter does not apply to a person who has been denied a license to practice nursing by the board or whose license has been revoked by the board pursuant to section 148.192.

(g) This chapter does not apply to any person who has been denied a credential to practice or whose credential to practice has been revoked by a credentialing authority in accordance with section 214.107.

EFFECTIVE DATE. This section is effective for credentials issued or renewed on or after August 1, 2011.

Sec. 30. Laws 2010, chapter 349, section 1, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for ~~new~~ licenses issued or renewed on or after August 1, 2010.

Sec. 31. Laws 2010, chapter 349, section 2, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for ~~new~~ licenses issued or renewed on or after August 1, 2010.

Sec. 32. **WORKING GROUP; PSYCHIATRIC MEDICATIONS.**

(a) The commissioner of health shall convene a working group composed of the executive directors of the Boards of Medical Practice, Psychology, Social Work, and Behavioral Health and Therapy and one representative from each professional association to make recommendations on the feasibility of developing collaborative agreements between psychiatrists and psychologists, social workers, and licensed professional clinical counselors for administration and management of psychiatric medications.

(b) The executive directors shall take the lead in setting the agenda, convening subsequent meetings, and presenting a written report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. The report and recommendations for legislation shall be submitted no later than January 1, 2012.

(c) The working group is not subject to the provisions of section 15.059.

Sec. 33. **REPORT.**

The executive directors of the health-related licensing boards shall issue a report to the legislature with recommendations for use of nondisciplinary cease and desist letters which can be issued to licensees when the board receives an allegation against a licensee, but the allegation does not rise to the level of a complaint, does not involve patient harm, and does not involve fraud. This report shall be issued no later than December 15, 2011.

Sec. 34. **REVISOR'S INSTRUCTION.**

In each practice act regulated by a credentialing authority listed in Minnesota Statutes, section 214.107, the revisor shall insert the following as either a new section or new subdivision:

Applicants for a credential to practice and individuals renewing a credential to practice are subject to the provisions of the conviction of felony-level criminal sexual conduct offenses in section 214.107.

Sec. 35. **REPEALER.**

Minnesota Rules, parts 6310.3100, subpart 2; 6310.3600; and 6310.3700, subpart 1, are repealed.

ARTICLE 4

MISCELLANEOUS

Section 1. Minnesota Statutes 2010, section 3.98, is amended by adding a subdivision to read:

Subd. 5. **Health note.** The commissioner of health, in consultation with other state agencies, shall develop a report and recommendations for the legislature for a process through which a health impact review of proposed legislation may be requested by a legislative committee chair and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services finance and policy issues to estimate the impact of the proposed legislation on costs of health care for public employees, state health care programs, private employers, local governments, or Minnesota individuals and families, including costs related to the impact of the legislation on the health status of the state or a community. The commissioner may consult with local and private public health organizations and other persons or organizations in the development of the report and recommendations. The report and recommendations shall be provided to the legislature by January 15, 2012.

Sec. 2. Minnesota Statutes 2010, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family day care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31; ~~or~~

(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2003, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2003, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

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

Subd. 33. **Combined application form; referral of veterans.** The commissioner shall modify the combined application form to add a question asking applicants: "Are you a United States military veteran?" The commissioner shall ensure that all applicants who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any benefits for which they may be eligible.

Sec. 4. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision to read:

Subd. 3a. **Spousal contribution.** (a) For purposes of this subdivision, the following terms have the meanings given:

89.1 (1) "commissioner" means the commissioner of human services;

89.2 (2) "community spouse" means the spouse, who lives in the community, of an
89.3 individual receiving long-term care services in a long-term care facility or home care
89.4 services pursuant to the Medicaid waiver for elderly services under section 256B.0915
89.5 or the alternative care program under section 256B.0913. A community spouse does not
89.6 include a spouse living in the community who receives a monthly income allowance
89.7 under section 256B.058, subdivision 2, or who receives home care services or home
89.8 and community-based services under section 256B.0915, 256B.092, or 256B.49, or the
89.9 alternative care program under section 256B.0913;

89.10 (3) "cost of care" means the actual fee-for-service costs or capitated payments for
89.11 the long-term care spouse;

89.12 (4) "department" means the Department of Human Services;

89.13 (5) "disabled child" means a blind or permanently and totally disabled son or
89.14 daughter of any age as defined in the Supplemental Security Income program or the state
89.15 medical review team;

89.16 (6) "income" means earned and unearned income, attributable to the community
89.17 spouse, used to calculate the adjusted gross income on the prior year's income tax return.
89.18 Evidence of income includes, but is not limited to, W-2 and 1099 forms; and

89.19 (7) "long-term care spouse" means the spouse who is receiving long-term care
89.20 services in a long-term care facility or home care services pursuant to the Medicaid
89.21 waiver for elderly services under section 256B.0915 or the alternative care program under
89.22 section 256B.0913.

89.23 (b) The community spouse of a long-term care spouse who receives medical
89.24 assistance or alternative care services has an obligation to contribute to the cost of care.
89.25 The community spouse must pay a monthly fee on a sliding fee scale based on the
89.26 community spouse's income. If a minor or disabled child resides with and receives care
89.27 from the community spouse, then no fee shall be assessed.

89.28 (c) For a community spouse with an income equal to or greater than 250 percent of
89.29 the federal poverty guidelines for a family of two and less than 545 percent of the federal
89.30 poverty guidelines for a family of two, the spousal contribution shall be determined using
89.31 a sliding fee scale established by the commissioner that begins at 7.5 percent of the
89.32 community spouse's income and increases to 15 percent for those with an income of up to
89.33 545 percent of the federal poverty guidelines for a family of two.

89.34 (d) For a community spouse with an income equal to or greater than 545 percent of
89.35 the federal poverty guidelines for a family of two and less than 750 percent of the federal
89.36 poverty guidelines for a family of two, the spousal contribution shall be determined using

90.1 a sliding fee scale established by the commissioner that begins at 15 percent of the
90.2 community spouse's income and increases to 25 percent for those with an income of up to
90.3 750 percent of the federal poverty guidelines for a family of two.

90.4 (e) For a community spouse with an income equal to or greater than 750 percent of
90.5 the federal poverty guidelines for a family of two and less than 975 percent of the federal
90.6 poverty guidelines for a family of two, the spousal contribution shall be determined using
90.7 a sliding fee scale established by the commissioner that begins at 25 percent of the
90.8 community spouse's income and increases to 33 percent for those with an income of up to
90.9 975 percent of the federal poverty guidelines for a family of two.

90.10 (f) For a community spouse with an income equal to or greater than 975 percent of
90.11 the federal poverty guidelines for a family of two, the spousal contribution shall be 33
90.12 percent of the community spouse's income.

90.13 (g) The spousal contribution shall be explained in writing at the time eligibility for
90.14 medical assistance or alternative care is being determined. In addition to explaining the
90.15 formula used to determine the fee, the commissioner shall provide written information
90.16 describing how to request a variance for undue hardship, how a contribution may be
90.17 reviewed or redetermined, the right to appeal a contribution determination, and that
90.18 the consequences for not complying with a request to provide information shall be an
90.19 assessment against the community spouse for the full cost of care for the long-term care
90.20 spouse.

90.21 (h) The contribution shall be assessed for each month the long-term care spouse
90.22 has a community spouse and is eligible for medical assistance payment of long-term
90.23 care services or alternative care.

90.24 (i) The spousal contribution shall be reviewed at least once every 12 months and
90.25 when there is a loss or gain in income in excess of ten percent. Thirty days prior to a
90.26 review or redetermination, written notice must be provided to the community spouse
90.27 and must contain the amount the spouse is required to contribute, notice of the right to
90.28 redetermination and appeal, and the telephone number of the division at the department
90.29 that is responsible for redetermination and review. If, after review, the contribution amount
90.30 is to be adjusted, the commissioner shall mail a written notice to the community spouse 30
90.31 days in advance of the effective date of the change in the amount of the contribution.

90.32 (1) The spouse shall notify the commissioner within 30 days of a gain or loss in
90.33 income in excess of ten percent and provide the department supporting documentation to
90.34 verify the need for redetermination of the fee.

91.1 (2) When a spouse requests a review or redetermination of the contribution amount,
91.2 a request for information shall be sent to the spouse within ten calendar days after the
91.3 commissioner receives the request for review.

91.4 (3) No action shall be taken on a review or redetermination until the required
91.5 information is received by the commissioner.

91.6 (4) The review of the spousal contribution shall be completed within ten days after
91.7 the commissioner receives completed information that verifies a loss or gain in income
91.8 in excess of ten percent.

91.9 (5) An increase in the contribution amount is effective in the month in which the
91.10 increase in spousal income occurs.

91.11 (6) A decrease in the contribution amount is effective in the month the spouse
91.12 verifies the reduction in income, retroactive to no longer than six months.

91.13 (j) In no case shall the spousal contribution exceed the amount of medical assistance
91.14 expended or the cost of alternative care services for the care of the long-term care spouse.
91.15 Annually, upon redetermination, or at termination of eligibility, the total amount of
91.16 medical assistance paid or costs of alternative care for the care of the long-term care spouse
91.17 and the total amount of the spousal contribution shall be compared. If the total amount of
91.18 the spousal contribution exceeds the total amount of medical assistance expended or cost
91.19 of alternative care, then the department shall reimburse the community spouse the excess
91.20 amount if the long-term care spouse is no longer receiving services, or apply the excess
91.21 amount to the spousal contribution due until the excess amount is exhausted.

91.22 (k) A community spouse may request a variance by submitting a written request
91.23 and supporting documentation that payment of the calculated contribution would cause
91.24 an undue hardship. An undue hardship is defined as the inability to pay the calculated
91.25 contribution due to medical expenses incurred by the community spouse. Documentation
91.26 must include proof of medical expenses incurred by the community spouse since the last
91.27 annual redetermination of the contribution amount that are not reimbursable by any public
91.28 or private source, and are a type, regardless of amount, that would be allowable as a
91.29 federal tax deduction under the Internal Revenue Code.

91.30 (1) A spouse who requests a variance from a notice of an increase in the amount
91.31 of spousal contribution shall continue to make monthly payments at the lower amount
91.32 pending determination of the variance request. A spouse who requests a variance from
91.33 the initial determination shall not be required to make a payment pending determination
91.34 of the variance request. Payments made pending outcome of the variance request that
91.35 result in overpayment must be returned to the spouse, if the community spouse is no
91.36 longer receiving services, or applied to the spousal contribution in the current year. If the

92.1 variance is denied, the spouse shall pay the additional amount due from the effective date
92.2 of the increase or the total amount due from the effective date of the original notice of
92.3 determination of the spousal contribution.

92.4 (2) A spouse who is granted a variance shall sign a written agreement in which the
92.5 spouse agrees to report to the commissioner any changes in circumstances that gave rise
92.6 to the undue hardship variance.

92.7 (3) When the commissioner receives a request for a variance, written notice of a
92.8 grant or denial of the variance shall be mailed to the spouse within 30 calendar days
92.9 after the commissioner receives the financial information required in this clause. The
92.10 granting of a variance will necessitate a written agreement between the spouse and the
92.11 commissioner with regard to the specific terms of the variance. The variance will not
92.12 become effective until the written agreement is signed by the spouse. If the commissioner
92.13 denies in whole or in part the request for a variance, the denial notice shall set forth in
92.14 writing the reasons for the denial that address the specific hardship and right to appeal.

92.15 (4) If a variance is granted, the term of the variance shall not exceed 12 months
92.16 unless otherwise determined by the commissioner.

92.17 (5) Undue hardship does not include action taken by a spouse which divested or
92.18 diverted income in order to avoid being assessed a spousal contribution.

92.19 (l) A spouse aggrieved by an action under this subdivision has the right to appeal
92.20 under subdivision 4. If the spouse appeals on or before the effective date of an increase in
92.21 the spousal fee, the spouse shall continue to make payments to the commissioner in the
92.22 lower amount while the appeal is pending. A spouse appealing an initial determination
92.23 of a spousal contribution shall not be required to make monthly payments pending an
92.24 appeal decision. Payments made that result in an overpayment shall be reimbursed to the
92.25 spouse if the long-term care spouse is no longer receiving services, or applied to the
92.26 spousal contribution remaining in the current year. If the commissioner's determination is
92.27 affirmed, the community spouse shall pay within 90 calendar days of the order the total
92.28 amount due from the effective date of the original notice of determination of the spousal
92.29 contribution. The commissioner's order is binding on the spouse and the department and
92.30 shall be implemented subject to section 256.045, subdivision 7. No additional notice is
92.31 required to enforce the commissioner's order.

92.32 (m) If the commissioner finds that notice of the payment obligation was given to
92.33 the community spouse and the spouse was determined to be able to pay, but that the
92.34 spouse failed or refused to pay, a cause of action exists against the community spouse
92.35 for that portion of medical assistance payment of long-term care services or alternative
92.36 care services granted after notice was given to the community spouse. The action may

93.1 be brought by the commissioner in the county where assistance was granted for the
93.2 assistance together with the costs of disbursements incurred due to the action. In addition
93.3 to granting the commissioner a money judgment, the court may, upon a motion or order to
93.4 show cause, order continuing contributions by a community spouse found able to repay
93.5 the commissioner. The order shall be effective only for the period of time during which
93.6 a contribution shall be assessed.

93.7 Sec. 5. Minnesota Statutes 2010, section 326B.175, is amended to read:

93.8 **326B.175 ELEVATORS, ENTRANCES SEALED.**

93.9 Except as provided in section 326B.188, it shall be the duty of the department and
93.10 the licensing authority of any municipality which adopts any such ordinance whenever
93.11 it finds any such elevator under its jurisdiction in use in violation of any provision of
93.12 sections 326B.163 to 326B.178 to seal the entrances of such elevator and attach a notice
93.13 forbidding the use of such elevator until the provisions thereof are complied with.

93.14 Sec. 6. **[326B.188] COMPLIANCE WITH ELEVATOR CODE CHANGES.**

93.15 (a) This section applies to code requirements for existing elevators and related
93.16 devices under Minnesota Rules, chapter 1307, where the deadline set by law for meeting
93.17 the code requirements is January 29, 2012, or later.

93.18 (b) If the department or municipality conducting elevator inspections within its
93.19 jurisdiction notifies the owner of an existing elevator or related device of the code
93.20 requirements before the effective date of this section, the owner may submit a compliance
93.21 plan by December 30, 2011. If the department or municipality does not notify the owner
93.22 of an existing elevator or related device of the code requirements before the effective
93.23 date of this section, the department or municipality shall notify the owner of the code
93.24 requirements and permit the owner to submit a compliance plan by December 30, 2011, or
93.25 within 60 days after the date of notification, whichever is later.

93.26 (c) Any compliance plan submitted under this section must result in compliance with
93.27 the code requirements by the later of January 29, 2012, or three years after submission of
93.28 the compliance plan. Elevators and related devices that are not in compliance with the
93.29 code requirements by the later of January 29, 2012, or three years after the submission of
93.30 the compliance plan may be taken out of service as provided in section 326B.175.

93.31 Sec. 7. **DEVELOPMENTAL DISABILITY WAIVERED SERVICES.**

93.32 Subdivision 1. **Purpose.** All individuals in the state of Minnesota who are eligible
93.33 for developmental disability waived services are entitled to receive adequate services,

94.1 within the limits of available funding, to ensure their basic needs for housing, food, health,
94.2 and safety are met.

94.3 Subd. 2. **Instructions to commissioner.** (a) No later than November 1, 2011,
94.4 the commissioner of human services shall convene a workgroup to define the essential
94.5 services required to adequately meet the needs of individuals who receive developmental
94.6 disability waived services. The commissioner shall identify the essential services in
94.7 each of the following tiers:

94.8 (1) tier 1, services and costs associated with safety, food, housing, and health care;

94.9 (2) tier 2, services and costs associated with enhancements toward self-sufficiency;

94.10 and

94.11 (3) tier 3, services and costs associated with quality of life improvements.

94.12 (b) The commissioner, or designee, and a representative designated by the counties
94.13 shall cochair the workgroup. The workgroup shall consider Tier 1 services to be the most
94.14 important and of highest priority for available funds, and may choose to implement a policy
94.15 that all waiver-eligible individuals receive Tier 1 services within the limits of available
94.16 funding before services from Tier 2 or 3 are offered to waiver-eligible individuals.

94.17 Sec. 8. **ANALYSIS OF PROGRAMS AND THEIR EFFECT ON MARRIAGES;**
94.18 **REPORT.**

94.19 (a) The commissioner of human services shall conduct an analysis of how current
94.20 human services programs affect the motivation and capacity of individuals to form and
94.21 sustain marriages in which to raise children. Programs to be examined in this marriage
94.22 impact analysis may include, but are not limited to, medical assistance, MinnesotaCare,
94.23 Minnesota family investment program, child protection, child support enforcement, and
94.24 child welfare services.

94.25 (b) Before January 1, 2012, the commissioner shall submit a report to the legislature
94.26 describing the results of this analysis and outline proposals to improve the ability of
94.27 human services programs to help people who are interested in marriage to form and
94.28 sustain marriages in which to raise children. The commissioner shall ensure that experts
94.29 on marriage are consulted on the process of conducting the analysis and writing the report.

94.30 Sec. 9. **INSTRUCTIONS TO COMMISSIONER.**

94.31 To offset the cost of implementing Minnesota Statutes, section 256B.14, subdivision
94.32 3a, the commissioner of human services shall collect from each county its proportionate
94.33 share of the cost based on population of the county. At the end of each fiscal year, the
94.34 commissioner shall divide ten percent of all collections made under Minnesota Statutes,

95.1 section 256B.14, subdivision 3a, between the counties based on the population of the
95.2 county.

95.3 Sec. 10. **LEGISLATIVE APPROVAL FOR FEDERAL FUNDS.**

95.4 The commissioners of human services and health shall not expend any funding
95.5 received through federal grants or subsequent renewal of federal grants without the
95.6 approval of three of the four chairs and ranking minority members of the legislative
95.7 committees with jurisdiction over health and human services finance.

95.8 **ARTICLE 5**

95.9 **HEALTH LICENSING FEES**

95.10 Section 1. Minnesota Statutes 2010, section 148.07, subdivision 1, is amended to read:

95.11 Subdivision 1. **Renewal fees.** All persons practicing chiropractic within this state,
95.12 or licensed so to do, shall pay, on or before the date of expiration of their licenses, to the
95.13 Board of Chiropractic Examiners a renewal fee set ~~by the board~~ in accordance with section
95.14 16A.1283, with a penalty ~~set by the board~~ for each month or portion thereof for which a
95.15 license fee is in arrears and upon payment of the renewal and upon compliance with all the
95.16 rules of the board, shall be entitled to renewal of their license.

95.17 Sec. 2. Minnesota Statutes 2010, section 148.108, is amended by adding a subdivision
95.18 to read:

95.19 Subd. 4. **Animal chiropractic.** (a) Animal chiropractic registration fee is \$125.
95.20 (b) Animal chiropractic registration renewal fee is \$75.
95.21 (c) Animal chiropractic inactive renewal fee is \$25.

95.22 Sec. 3. Minnesota Statutes 2010, section 148.191, subdivision 2, is amended to read:

95.23 Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise
95.24 rules not inconsistent with the law, as may be necessary to enable it to carry into effect the
95.25 provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula
95.26 and standards for schools and courses preparing persons for licensure under sections
95.27 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses
95.28 at such times as it may deem necessary. It shall approve such schools and courses as
95.29 meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine,
95.30 license, and renew the license of duly qualified applicants. It shall hold examinations
95.31 at least once in each year at such time and place as it may determine. It shall by rule
95.32 adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for

registration and renewal of registration as defined in section 148.231. It shall maintain a record of all persons licensed by the board to practice professional or practical nursing and all registered nurses who hold Minnesota licensure and registration and are certified as advanced practice registered nurses. It shall cause the prosecution of all persons violating sections 148.171 to 148.285 and have power to incur such necessary expense therefor.

It shall register public health nurses who meet educational and other requirements established by the board by rule, including payment of a fee. ~~Prior to the adoption of rules, the board shall use the same procedures used by the Department of Health to certify public health nurses.~~ It shall have power to issue subpoenas, and to compel the attendance of witnesses and the production of all necessary documents and other evidentiary material. Any board member may administer oaths to witnesses, or take their affirmation. It shall keep a record of all its proceedings.

(b) The board shall have access to hospital, nursing home, and other medical records of a patient cared for by a nurse under review. If the board does not have a written consent from a patient permitting access to the patient's records, the nurse or facility shall delete any data in the record that identifies the patient before providing it to the board. The board shall have access to such other records as reasonably requested by the board to assist the board in its investigation. Nothing herein may be construed to allow access to any records protected by section 145.64. The board shall maintain any records obtained pursuant to this paragraph as investigative data under chapter 13.

(c) The board may accept and expend grants or gifts of money or in-kind services from a person, a public or private entity, or any other source for purposes consistent with the board's role and within the scope of its statutory authority.

(d) The board may accept registration fees for meetings and conferences conducted for the purposes of board activities that are within the scope of its authority.

Sec. 4. Minnesota Statutes 2010, section 148.212, subdivision 1, is amended to read:

Subdivision 1. **Issuance.** Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation or disciplinary action, nor disqualified for any other reason, under the following circumstances:

~~(a) The applicant for licensure by examination under section 148.211, subdivision 1, has graduated from an approved nursing program within the 60 days preceding board receipt of an affidavit of graduation or transcript and has been authorized by the board to~~

~~write the licensure examination for the first time in the United States. The permit holder must practice professional or practical nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days whichever occurs first.~~

~~(b)~~ The applicant for licensure by endorsement under section 148.211, subdivision 2, is currently licensed to practice professional or practical nursing in another state, territory, or Canadian province. The permit is valid from submission of a proper request until the date of board action on the application or for 60 days, whichever comes first.

~~(e)~~ (b) The applicant for licensure by endorsement under section 148.211, subdivision 2, or for reregistration under section 148.231, subdivision 5, is currently registered in a formal, structured refresher course or its equivalent for nurses that includes clinical practice.

~~(d) The applicant for licensure by examination under section 148.211, subdivision 1, who graduated from a nursing program in a country other than the United States or Canada has completed all requirements for licensure except registering for and taking the nurse licensure examination for the first time in the United States. The permit holder must practice professional nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days, whichever occurs first.~~

Sec. 5. Minnesota Statutes 2010, section 148.231, is amended to read:

148.231 REGISTRATION; FAILURE TO REGISTER; REREGISTRATION; VERIFICATION.

Subdivision 1. **Registration.** Every person licensed to practice professional or practical nursing must maintain with the board a current registration for practice as a registered nurse or licensed practical nurse which must be renewed at regular intervals established by the board by rule. No ~~certificate~~ of registration shall be issued by the board to a nurse until the nurse has submitted satisfactory evidence of compliance with the procedures and minimum requirements established by the board.

The fee for periodic registration for practice as a nurse shall be determined by the board by rule law. ~~A penalty fee shall be added for any application received after the required date as specified by the board by rule.~~ Upon receipt of the application and the required fees, the board shall verify the application and the evidence of completion of continuing education requirements in effect, and thereupon issue to the nurse ~~a certificate of registration~~ for the next renewal period.

Subd. 4. **Failure to register.** Any person licensed under the provisions of sections 148.171 to 148.285 who fails to register within the required period shall not be entitled to practice nursing in this state as a registered nurse or licensed practical nurse.

Subd. 5. **Reregistration.** A person whose registration has lapsed desiring to resume practice shall make application for reregistration, submit satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the ~~registration~~ reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, ~~the~~ the registration ~~certificate~~ shall be issued to the person who shall immediately be placed on the practicing list as a registered nurse or licensed practical nurse.

Subd. 6. **Verification.** A person licensed under the provisions of sections 148.171 to 148.285 who requests the board to verify a Minnesota license to another state, territory, or country or to an agency, facility, school, or institution shall pay a fee ~~to the board~~ for each verification.

Sec. 6. **[148.242] FEES.**

The fees specified in section 148.243 are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 7. **[148.243] FEE AMOUNTS.**

Subdivision 1. **Licensure by examination.** The fee for licensure by examination is \$105.

Subd. 2. **Reexamination fee.** The reexamination fee is \$60.

Subd. 3. **Licensure by endorsement.** The fee for licensure by endorsement is \$105.

Subd. 4. **Registration renewal.** The fee for registration renewal is \$85.

Subd. 5. **Reregistration.** The fee for reregistration is \$105.

Subd. 6. **Replacement license.** The fee for a replacement license is \$20.

Subd. 7. **Public health nurse certification.** The fee for public health nurse certification is \$30.

Subd. 8. **Drug Enforcement Administration verification for Advanced Practice Registered Nurse (APRN).** The Drug Enforcement Administration verification for APRN is \$50.

Subd. 9. **Licensure verification other than through Nursys.** The fee for verification of licensure status other than through Nursys verification is \$20.

Subd. 10. **Verification of examination scores.** The fee for verification of examination scores is \$20.

Subd. 11. **Microfilmed licensure application materials.** The fee for a copy of microfilmed licensure application materials is \$20.

Subd. 12. **Nursing business registration; initial application.** The fee for the initial application for nursing business registration is \$100.

Subd. 13. **Nursing business registration; annual application.** The fee for the annual application for nursing business registration is \$25.

Subd. 14. **Practicing without current registration.** The fee for practicing without current registration is two times the amount of the current registration renewal fee for any part of the first calendar month, plus the current registration renewal fee for any part of any subsequent month up to 24 months.

Subd. 15. **Practicing without current APRN certification.** The fee for practicing without current APRN certification is \$200 for the first month or any part thereof, plus \$100 for each subsequent month or part thereof.

Subd. 16. **Dishonored check fee.** The service fee for a dishonored check is as provided in section 604.113.

Subd. 17. **Border state registry fee.** The initial application fee for border state registration is \$50. Any subsequent notice of employment change to remain or be reinstated on the registry is \$50.

Sec. 8. Minnesota Statutes 2010, section 148B.17, is amended to read:

148B.17 FEES.

~~Subdivision. 1. **Fees; Board of Marriage and Family Therapy.** Each board shall by rule establish~~ The board's fees, including late fees, for licenses and renewals are established so that the total fees collected by the board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.1285. Fees must be credited to ~~accounts~~ the board's account in the state government special revenue fund.

Subd. 2. **Licensure and application fees.** Nonrefundable licensure and application fees charged by the board are as follows:

(1) application fee for national examination is \$220;

(2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is \$110;

(3) initial LMFT license fee is prorated, but cannot exceed \$125;

(4) annual renewal fee for LMFT license is \$125;

(5) late fee for initial Licensed Associate Marriage and Family Therapist LAMFT license renewal is \$50;

- 100.1 (6) application fee for LMFT licensure by reciprocity is \$340;
- 100.2 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT)
- 100.3 license is \$75;
- 100.4 (8) annual renewal fee for LAMFT license is \$75;
- 100.5 (9) late fee for LAMFT renewal is \$50;
- 100.6 (10) fee for reinstatement of license is \$150; and
- 100.7 (11) fee for emeritus status is \$125.
- 100.8 Subd. 3. **Other fees.** Other fees charged by the board are as follows:
- 100.9 (1) sponsor application fee for approval of a continuing education course is \$60;
- 100.10 (2) fee for license verification by mail is \$10;
- 100.11 (3) duplicate license fee is \$25;
- 100.12 (4) duplicate renewal card fee is \$10;
- 100.13 (5) fee for licensee mailing list is \$60;
- 100.14 (6) fee for a rule book is \$10; and
- 100.15 (7) fees as authorized by section 148B.175, subdivision 6, clause (7).

100.16 Sec. 9. Minnesota Statutes 2010, section 148B.33, subdivision 2, is amended to read:

100.17 Subd. 2. **Fee.** Each applicant shall pay a nonrefundable application fee ~~set by~~

100.18 ~~the board~~ under section 148B.17.

100.19 Sec. 10. Minnesota Statutes 2010, section 148B.52, is amended to read:

100.20 **148B.52 DUTIES OF THE BOARD.**

100.21 (a) The Board of Behavioral Health and Therapy shall:

100.22 (1) establish by rule appropriate techniques, including examinations and other

100.23 methods, for determining whether applicants and licensees are qualified under sections

100.24 148B.50 to 148B.593;

100.25 (2) establish by rule standards for professional conduct, including adoption of a

100.26 Code of Professional Ethics and requirements for continuing education and supervision;

100.27 (3) issue licenses to individuals qualified under sections 148B.50 to 148B.593;

100.28 (4) establish by rule standards for initial education including coursework for

100.29 licensure and content of professional education;

100.30 (5) establish, maintain, and publish annually a register of current licensees and

100.31 approved supervisors;

100.32 (6) establish initial and renewal application and examination fees sufficient to cover

100.33 operating expenses of the board and its agents in accordance with section 16A.1283;

(7) educate the public about the existence and content of the laws and rules for licensed professional counselors to enable consumers to file complaints against licensees who may have violated the rules; and

(8) periodically evaluate its rules in order to refine the standards for licensing professional counselors and to improve the methods used to enforce the board's standards.

(b) The board may appoint a professional discipline committee for each occupational licensure regulated by the board, and may appoint a board member as chair. The professional discipline committee shall consist of five members representative of the licensed occupation and shall provide recommendations to the board with regard to rule techniques, standards, procedures, and related issues specific to the licensed occupation.

Sec. 11. Minnesota Statutes 2010, section 150A.091, subdivision 2, is amended to read:

Subd. 2. **Application fees.** Each applicant shall submit with a license, advanced dental therapist certificate, or permit application a nonrefundable fee in the following amounts in order to administratively process an application:

(1) dentist, \$140;

(2) full faculty dentist, \$140;

~~(2)~~ (3) limited faculty dentist, \$140;

~~(3)~~ (4) resident dentist or dental provider, \$55;

(5) advanced dental therapist, \$100;

~~(4)~~ (6) dental therapist, \$100;

~~(5)~~ (7) dental hygienist, \$55;

~~(6)~~ (8) licensed dental assistant, \$55; and

~~(7)~~ (9) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, \$15.

Sec. 12. Minnesota Statutes 2010, section 150A.091, subdivision 3, is amended to read:

Subd. 3. **Initial license or permit fees.** Along with the application fee, each of the following applicants shall submit a separate prorated initial license or permit fee. The prorated initial fee shall be established by the board based on the number of months of the applicant's initial term as described in Minnesota Rules, part 3100.1700, subpart 1a, not to exceed the following monthly fee amounts:

(1) dentist or full faculty dentist, \$14 times the number of months of the initial term;

(2) dental therapist, \$10 times the number of months of the initial term;

(3) dental hygienist, \$5 times the number of months of the initial term;

(4) licensed dental assistant, \$3 times the number of months of the initial term; and

102.1 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,
102.2 subpart 3, \$1 times the number of months of the initial term.

102.3 Sec. 13. Minnesota Statutes 2010, section 150A.091, subdivision 4, is amended to read:

102.4 Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit
102.5 with an annual license renewal application a fee established by the board not to exceed
102.6 the following amounts:

- 102.7 (1) limited faculty dentist, \$168; and
102.8 (2) resident dentist or dental provider, \$59.

102.9 Sec. 14. Minnesota Statutes 2010, section 150A.091, subdivision 5, is amended to read:

102.10 Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall
102.11 submit with a biennial license or permit renewal application a fee as established by the
102.12 board, not to exceed the following amounts:

- 102.13 (1) dentist or full faculty dentist, \$336;
102.14 (2) dental therapist, \$180;
102.15 (3) dental hygienist, \$118;
102.16 (4) licensed dental assistant, \$80; and
102.17 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,
102.18 subpart 3, \$24.

102.19 Sec. 15. Minnesota Statutes 2010, section 150A.091, subdivision 8, is amended to read:

102.20 Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with
102.21 a request for issuance of a duplicate of the original license, or of an annual or biennial
102.22 renewal certificate for a license or permit, a fee in the following amounts:

- 102.23 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental
102.24 assistant license, \$35; and
102.25 (2) annual or biennial renewal certificates, \$10.

102.26 Sec. 16. Minnesota Statutes 2010, section 150A.091, is amended by adding a
102.27 subdivision to read:

102.28 Subd. 16. **Failure of professional development portfolio audit.** A licensee shall
102.29 submit a fee as established by the board not to exceed the amount of \$250 after failing
102.30 two consecutive professional development portfolio audits and, thereafter, for each failed
102.31 professional development portfolio audit under Minnesota Rules, part 3100.5300.

Sec. 17. [151.065] FEE AMOUNTS.

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

- (1) pharmacist licensed by examination, \$130;
- (2) pharmacist licensed by reciprocity, \$225;
- (3) pharmacy intern, \$30;
- (4) pharmacy technician, \$30;
- (5) pharmacy, \$190;
- (6) drug wholesaler, legend drugs only, \$200;
- (7) drug wholesaler, legend and nonlegend drugs, \$200;
- (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;
- (9) drug wholesaler, medical gases, \$150;
- (10) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;
- (11) drug manufacturer, legend drugs only, \$200;
- (12) drug manufacturer, legend and nonlegend drugs, \$200;
- (13) drug manufacturer, nonlegend or veterinary legend drugs, \$175;
- (14) drug manufacturer, medical gases, \$150;
- (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;
- (16) medical gas distributor, \$75;
- (17) controlled substance researcher, \$50; and
- (18) pharmacy professional corporation, \$100.

Subd. 2. **Original license fee.** The pharmacist original licensure fee, \$130.

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

- (1) pharmacist, \$130;
- (2) pharmacy technician, \$30;
- (3) pharmacy, \$190;
- (4) drug wholesaler, legend drugs only, \$200;
- (5) drug wholesaler, legend and nonlegend drugs, \$200;
- (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;
- (7) drug wholesaler, medical gases, \$150;
- (8) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;
- (9) drug manufacturer, legend drugs only, \$200;
- (10) drug manufacturer, legend and nonlegend drugs, \$200;
- (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$175;
- (12) drug manufacturer, medical gases, \$150;

104.1 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;

104.2 (14) medical gas distributor, \$75;

104.3 (15) controlled substance researcher, \$50; and

104.4 (16) pharmacy professional corporation, \$45.

104.5 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses
104.6 and certificates are as follows:

104.7 (1) intern affidavit, \$15;

104.8 (2) duplicate small license, \$15; and

104.9 (3) duplicate large certificate, \$25.

104.10 Subd. 5. **Late fees.** All annual renewal fees are subject to a 50 percent late fee if
104.11 the renewal fee and application are not received by the board prior to the date specified
104.12 by the board.

104.13 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's
104.14 license to lapse may reinstate the license with board approval and upon payment of any
104.15 fees and late fees in arrears, up to a maximum of \$1,000.

104.16 (b) A pharmacy technician who has allowed the technician's registration to lapse
104.17 may reinstate the registration with board approval and upon payment of any fees and late
104.18 fees in arrears, up to a maximum of \$90.

104.19 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical
104.20 gas distributor who has allowed the license of the establishment to lapse may reinstate the
104.21 license with board approval and upon payment of any fees and late fees in arrears.

104.22 (d) A controlled substance researcher who has allowed the researcher's registration
104.23 to lapse may reinstate the registration with board approval and upon payment of any fees
104.24 and late fees in arrears.

104.25 (e) A pharmacist owner of a professional corporation who has allowed the
104.26 corporation's registration to lapse may reinstate the registration with board approval and
104.27 upon payment of any fees and late fees in arrears.

104.28 Sec. 18. Minnesota Statutes 2010, section 151.07, is amended to read:

104.29 **151.07 MEETINGS; EXAMINATION FEE.**

104.30 The board shall meet at times as may be necessary and as it may determine to
104.31 examine applicants for licensure and to transact its other business, giving reasonable
104.32 notice of all examinations by mail to known applicants therefor. The secretary shall record
104.33 the names of all persons licensed by the board, together with the grounds upon which
104.34 the right of each to licensure was claimed. The fee for examination shall be in ~~such~~ the

105.1 amount ~~as the board may determine~~ specified in section 151.065, which fee may in the
105.2 discretion of the board be returned to applicants not taking the examination.

105.3 Sec. 19. Minnesota Statutes 2010, section 151.101, is amended to read:

105.4 **151.101 INTERNSHIP.**

105.5 Upon payment of the fee specified in section 151.065, the board may ~~license~~ register
105.6 as an intern any natural persons who have satisfied the board that they are of good moral
105.7 character, not physically or mentally unfit, and who have successfully completed the
105.8 educational requirements for intern ~~licensure~~ registration prescribed by the board. The
105.9 board shall prescribe standards and requirements for interns, pharmacist-preceptors, and
105.10 internship training but may not require more than one year of such training.

105.11 The board in its discretion may accept internship experience obtained in another
105.12 state provided the internship requirements in such other state are in the opinion of the
105.13 board equivalent to those herein provided.

105.14 Sec. 20. Minnesota Statutes 2010, section 151.102, is amended by adding a subdivision
105.15 to read:

105.16 Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy
105.17 technician unless all applicable fees specified in section 151.065 have been paid.

105.18 Sec. 21. Minnesota Statutes 2010, section 151.12, is amended to read:

105.19 **151.12 RECIPROCITY; LICENSURE.**

105.20 The board may in its discretion grant licensure without examination to any
105.21 pharmacist licensed by the Board of Pharmacy or a similar board of another state which
105.22 accords similar recognition to licensees of this state; provided, the requirements for
105.23 licensure in such other state are in the opinion of the board equivalent to those herein
105.24 provided. The fee for licensure shall be in ~~such the amount as the board may determine by~~
105.25 rule specified in section 151.065.

105.26 Sec. 22. Minnesota Statutes 2010, section 151.13, subdivision 1, is amended to read:

105.27 Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist
105.28 shall pay to the board a the annual renewal fee to be fixed by it specified in section
105.29 151.065. The board may promulgate by rule a charge to be assessed for the delinquent
105.30 payment of a fee. the late fee specified in section 151.065 if the renewal fee and
105.31 application are not received by the board prior to the date specified by the board. It shall
105.32 be unlawful for any person licensed as a pharmacist who refuses or fails to pay ~~such any~~

106.1 applicable renewal or late fee to practice pharmacy in this state. Every certificate and
106.2 license shall expire at the time therein prescribed.

106.3 Sec. 23. Minnesota Statutes 2010, section 151.19, is amended to read:

106.4 **151.19 REGISTRATION; FEES.**

106.5 Subdivision 1. **Pharmacy registration.** The board shall require and provide for the
106.6 annual registration of every pharmacy now or hereafter doing business within this state.
106.7 Upon the payment of ~~a~~ any applicable fee to be set by the board specified in section
106.8 151.065, the board shall issue a registration certificate in such form as it may prescribe to
106.9 such persons as may be qualified by law to conduct a pharmacy. Such certificate shall be
106.10 displayed in a conspicuous place in the pharmacy for which it is issued and expire on the
106.11 30th day of June following the date of issue. It shall be unlawful for any person to conduct
106.12 a pharmacy unless such certificate has been issued to the person by the board.

106.13 Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an
106.14 annual nonresident special pharmacy registration for all pharmacies located outside of this
106.15 state that regularly dispense medications for Minnesota residents and mail, ship, or deliver
106.16 prescription medications into this state. Nonresident special pharmacy registration shall
106.17 be granted by the board upon payment of any applicable fee specified in section 151.065
106.18 and the disclosure and certification by a pharmacy:

106.19 (1) that it is licensed in the state in which the dispensing facility is located and from
106.20 which the drugs are dispensed;

106.21 (2) the location, names, and titles of all principal corporate officers and all
106.22 pharmacists who are dispensing drugs to residents of this state;

106.23 (3) that it complies with all lawful directions and requests for information from
106.24 the Board of Pharmacy of all states in which it is licensed or registered, except that it
106.25 shall respond directly to all communications from the board concerning emergency
106.26 circumstances arising from the dispensing of drugs to residents of this state;

106.27 (4) that it maintains its records of drugs dispensed to residents of this state so that the
106.28 records are readily retrievable from the records of other drugs dispensed;

106.29 (5) that it cooperates with the board in providing information to the Board of
106.30 Pharmacy of the state in which it is licensed concerning matters related to the dispensing
106.31 of drugs to residents of this state;

106.32 (6) that during its regular hours of operation, but not less than six days per week, for
106.33 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
106.34 communication between patients in this state and a pharmacist at the pharmacy who has

access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(7) that, upon request of a resident of a long-term care facility located within the state of Minnesota, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with the provisions of section 151.415, subdivision 5.

Subd. 3. **Sale of federally restricted medical gases.** The board shall require and provide for the annual registration of every person or establishment not licensed as a pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted medical gases. Upon the payment of ~~a~~ any applicable fee to be set by the board specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to those persons or places that may be qualified to sell or distribute federally restricted medical gases. The certificate shall be displayed in a conspicuous place in the business for which it is issued and expire on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.

Sec. 24. Minnesota Statutes 2010, section 151.25, is amended to read:

151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.

The board shall require and provide for the annual registration of every person engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes, now or hereafter doing business with accounts in this state. Upon a payment of ~~a~~ any applicable fee as set by the board specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such manufacturer. Such registration certificate shall be displayed in a conspicuous place in such manufacturer's or wholesaler's place of business for which it is issued and expire on the date set by the board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals, or poisons for medicinal purposes unless such a certificate has been issued to the person by the board. It shall be unlawful for any person engaged in the manufacture of drugs, medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell legend drugs to other than a pharmacy, except as provided in this chapter.

Sec. 25. Minnesota Statutes 2010, section 151.47, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** All wholesale drug distributors are subject to the requirements in paragraphs (a) to (f).

108.1 (a) No person or distribution outlet shall act as a wholesale drug distributor without
108.2 first obtaining a license from the board and paying ~~the required~~ any applicable fee
108.3 specified in section 151.065.

108.4 (b) No license shall be issued or renewed for a wholesale drug distributor to operate
108.5 unless the applicant agrees to operate in a manner prescribed by federal and state law and
108.6 according to the rules adopted by the board.

108.7 (c) The board may require a separate license for each facility directly or indirectly
108.8 owned or operated by the same business entity within the state, or for a parent entity
108.9 with divisions, subsidiaries, or affiliate companies within the state, when operations
108.10 are conducted at more than one location and joint ownership and control exists among
108.11 all the entities.

108.12 (d) As a condition for receiving and retaining a wholesale drug distributor license
108.13 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has
108.14 and will continuously maintain:

108.15 (1) adequate storage conditions and facilities;

108.16 (2) minimum liability and other insurance as may be required under any applicable
108.17 federal or state law;

108.18 (3) a viable security system that includes an after hours central alarm, or comparable
108.19 entry detection capability; restricted access to the premises; comprehensive employment
108.20 applicant screening; and safeguards against all forms of employee theft;

108.21 (4) a system of records describing all wholesale drug distributor activities set forth
108.22 in section 151.44 for at least the most recent two-year period, which shall be reasonably
108.23 accessible as defined by board regulations in any inspection authorized by the board;

108.24 (5) principals and persons, including officers, directors, primary shareholders,
108.25 and key management executives, who must at all times demonstrate and maintain their
108.26 capability of conducting business in conformity with sound financial practices as well
108.27 as state and federal law;

108.28 (6) complete, updated information, to be provided to the board as a condition for
108.29 obtaining and retaining a license, about each wholesale drug distributor to be licensed,
108.30 including all pertinent corporate licensee information, if applicable, or other ownership,
108.31 principal, key personnel, and facilities information found to be necessary by the board;

108.32 (7) written policies and procedures that assure reasonable wholesale drug distributor
108.33 preparation for, protection against, and handling of any facility security or operation
108.34 problems, including, but not limited to, those caused by natural disaster or government
108.35 emergency, inventory inaccuracies or product shipping and receiving, outdated product

109.1 or other unauthorized product control, appropriate disposition of returned goods, and
109.2 product recalls;

109.3 (8) sufficient inspection procedures for all incoming and outgoing product
109.4 shipments; and

109.5 (9) operations in compliance with all federal requirements applicable to wholesale
109.6 drug distribution.

109.7 (e) An agent or employee of any licensed wholesale drug distributor need not seek
109.8 licensure under this section.

109.9 (f) A wholesale drug distributor shall file with the board an annual report, in a
109.10 form and on the date prescribed by the board, identifying all payments, honoraria,
109.11 reimbursement or other compensation authorized under section 151.461, clauses (3) to
109.12 (5), paid to practitioners in Minnesota during the preceding calendar year. The report
109.13 shall identify the nature and value of any payments totaling \$100 or more, to a particular
109.14 practitioner during the year, and shall identify the practitioner. Reports filed under this
109.15 provision are public data.

109.16 Sec. 26. Minnesota Statutes 2010, section 151.48, is amended to read:

109.17 **151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.**

109.18 (a) It is unlawful for an out-of-state wholesale drug distributor to conduct business
109.19 in the state without first obtaining a license from the board and paying ~~the required~~ any
109.20 applicable fee specified in section 151.065.

109.21 (b) Application for an out-of-state wholesale drug distributor license under this
109.22 section shall be made on a form furnished by the board.

109.23 (c) No person acting as principal or agent for any out-of-state wholesale drug
109.24 distributor may sell or distribute drugs in the state unless the distributor has obtained
109.25 a license.

109.26 (d) The board may adopt regulations that permit out-of-state wholesale drug
109.27 distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state
109.28 wholesale drug distributor:

109.29 (1) possesses a valid license granted by another state under legal standards
109.30 comparable to those that must be met by a wholesale drug distributor of this state as
109.31 prerequisites for obtaining a license under the laws of this state; and

109.32 (2) can show that the other state would extend reciprocal treatment under its own
109.33 laws to a wholesale drug distributor of this state.

109.34 Sec. 27. Minnesota Statutes 2010, section 152.12, subdivision 3, is amended to read:

Subd. 3. **Research project use of controlled substances.** Any qualified person may use controlled substances in the course of a bona fide research project but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed and administered by a person lawfully authorized to do so. Every person who engages in research involving the use of such substances shall apply annually for registration by the state Board of Pharmacy and shall pay any applicable fee specified in section 151.065, provided that such registration shall not be required if the person is covered by and has complied with federal laws covering such research projects.

ARTICLE 6

HEALTH CARE

Section 1. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) the premium for the number one qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) \$1,000 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a \$1,000 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(b) the premium for the number two qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) \$500 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a \$500 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(c) the premiums for the plans with a \$2,000, \$5,000, or \$10,000 annual deductible shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

111.1 (1) \$2,000, \$5,000, or \$10,000 annual deductible individual plans, respectively, in
111.2 force in Minnesota; and

111.3 (2) individual health maintenance organization contracts of coverage with a \$2,000,
111.4 \$5,000, or \$10,000 annual deductible, respectively, which are in force in Minnesota; or

111.5 (3) other plans of coverage similar to plans offered by the association based on
111.6 generally accepted actuarial principles;

111.7 (d) the premium for each type of Medicare supplement plan required to be offered
111.8 by the association pursuant to section 62E.12 shall range from a minimum of 101 percent
111.9 to a maximum of 125 percent of the weighted average of rates charged by those insurers
111.10 and health maintenance organizations with individuals enrolled in:

111.11 (1) Medicare supplement plans in force in Minnesota;

111.12 (2) health maintenance organization Medicare supplement contracts of coverage
111.13 which are in force in Minnesota; and

111.14 (3) other plans of coverage similar to plans offered by the association based on
111.15 generally accepted actuarial principles; ~~and~~

111.16 (e) the charge for health maintenance organization coverage shall be based on
111.17 generally accepted actuarial principles; and

111.18 (f) the premium for a high-deductible, basic plan offered under section 62E.121 shall
111.19 range from a minimum of 101 percent to a maximum of 125 percent of the weighted
111.20 average of rates charged by those insurers and health maintenance organizations offering
111.21 comparable plans outside of the Minnesota Comprehensive Health Association.

111.22 The list of insurers and health maintenance organizations whose rates are used to
111.23 establish the premium for coverage offered by the association pursuant to paragraphs (a)
111.24 to (d) and (f) shall be established by the commissioner on the basis of information which
111.25 shall be provided to the association by all insurers and health maintenance organizations
111.26 annually at the commissioner's request. This information shall include the number of
111.27 individuals covered by each type of plan or contract specified in paragraphs (a) to (d) and
111.28 (f) that is sold, issued, and renewed by the insurers and health maintenance organizations,
111.29 including those plans or contracts available only on a renewal basis. The information shall
111.30 also include the rates charged for each type of plan or contract.

111.31 In establishing premiums pursuant to this section, the association shall utilize
111.32 generally accepted actuarial principles, provided that the association shall not discriminate
111.33 in charging premiums based upon sex. In order to compute a weighted average for each
111.34 type of plan or contract specified under paragraphs (a) to (d) and (f), the association
111.35 shall, using the information collected pursuant to this subdivision, list insurers and health
111.36 maintenance organizations in rank order of the total number of individuals covered by

each insurer or health maintenance organization. The association shall then compute a weighted average of the rates charged for coverage by all the insurers and health maintenance organizations by:

(1) multiplying the numbers of individuals covered by each insurer or health maintenance organization by the rates charged for coverage;

(2) separately summing both the number of individuals covered by all the insurers and health maintenance organizations and all the products computed under clause (1); and

(3) dividing the total of the products computed under clause (1) by the total number of individuals covered.

The association may elect to use a sample of information from the insurers and health maintenance organizations for purposes of computing a weighted average. In no case, however, may a sample used by the association to compute a weighted average include information from fewer than the two insurers or health maintenance organizations highest in rank order.

Sec. 2. [62E.121] HIGH-DEDUCTIBLE, BASIC PLAN.

Subdivision 1. **Required offering.** The Minnesota Comprehensive Health Association shall offer a high-deductible, basic plan that meets the requirements specified in this section. The high-deductible, basic plan is a one-person plan. Any dependents must be covered separately.

Subd. 2. **Annual deductible; out-of-pocket maximum.** (a) The plan shall provide the following in-network annual deductible options: \$3,000, \$6,000, \$9,000, and \$12,000. The in-network annual out-of-pocket maximum for each annual deductible option shall be \$1,000 greater than the amount of the annual deductible.

(b) The deductible is subject to an annual increase based on the change in the Consumer Price Index (CPI).

Subd. 3. **Office visits for nonpreventive care.** The following co-payments shall apply for each of the first three office visits per calendar year for nonpreventive care:

(1) \$30 per visit for the \$3,000 annual deductible option;

(2) \$40 per visit for the \$6,000 annual deductible option;

(3) \$50 per visit for the \$9,000 annual deductible option; and

(4) \$60 per visit for the \$12,000 annual deductible option.

For the fourth and subsequent visits during the calendar year, 80 percent coverage is provided under all deductible options, after the deductible is met.

Subd. 4. **Preventive care.** One hundred percent coverage is provided for preventive care, and no co-payment, coinsurance, or deductible requirements apply.

113.1 Subd. 5. **Prescription drugs.** A \$10 co-payment applies to preferred generic drugs.
113.2 Preferred brand-name drugs require an enrollee payment of 100 percent of the health
113.3 plan's discounted rate.

113.4 Subd. 6. **Convenience care center visits.** A \$20 co-payment applies for the first
113.5 three convenience care center visits during a calendar year. For the fourth and subsequent
113.6 visits during a calendar year, 80 percent coverage is provided after the deductible is met.

113.7 Subd. 7. **Urgent care center visits.** A \$100 co-payment applies for the first urgent
113.8 care center visit during a calendar year. For the second and subsequent visits during a
113.9 calendar year, 80 percent coverage is provided after the deductible is met.

113.10 Subd. 8. **Emergency room visits.** A \$200 co-payment applies for the first
113.11 emergency room visit during a calendar year. For the second and subsequent visits during
113.12 a calendar year, 80 percent coverage is provided after the deductible is met.

113.13 Subd. 9. **Lab and x-ray; hospital services; ambulance; surgery.** Lab and x-ray
113.14 services, hospital services, ambulance services, and surgery are covered at 80 percent
113.15 after the deductible is met.

113.16 Subd. 10. **Eyewear.** The health plan pays up to \$50 per calendar year for eyewear.

113.17 Subd. 11. **Maternity.** Maternity, labor and delivery, and postpartum care are not
113.18 covered. One hundred percent coverage is provided for prenatal care and no deductible
113.19 applies.

113.20 Subd. 12. **Other eligible health care services.** Other eligible health care services
113.21 are covered at 80 percent after the deductible is met.

113.22 Subd. 13. **Option to remove mental health and substance abuse coverage.**
113.23 Enrollees have the option of removing mental health and substance abuse coverage in
113.24 exchange for a reduced premium.

113.25 Subd. 14. **Option to upgrade prescription drug coverage.** Enrollees have
113.26 the option to upgrade prescription drug coverage to include coverage for preferred
113.27 brand-name drugs with a \$50 co-payment and coverage for nonpreferred drugs with a
113.28 \$100 co-payment in exchange for an increased premium.

113.29 Subd. 15. **Out-of-network services.** (a) The out-of-network annual deductible is
113.30 double the in-network annual deductible.

113.31 (b) There is no out-of-pocket maximum for out-of-network services.

113.32 (c) Benefits for out-of-network services are covered at 60 percent after the deductible
113.33 is met.

113.34 (d) The lifetime maximum benefit for out-of-network services is \$1,000,000.

113.35 Subd. 16. **Services not covered.** Services not covered include: custodial care
113.36 or rest care; most dental services; cosmetic services; refractive eye surgery; infertility

114.1 services; and services that are investigational, not medically necessary, or received while
114.2 on military duty.

114.3 Sec. 3. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision
114.4 to read:

114.5 Subd. 4f. **Waiver of preexisting conditions for persons covered by healthy**
114.6 **Minnesota contribution program.** A person may enroll in the comprehensive plan with
114.7 a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for
114.8 the healthy Minnesota contribution program, and has been denied coverage as described
114.9 under section 256L.031, subdivision 6.

114.10 Sec. 4. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

114.11 Subd. 9. **Growth limits; federal programs.** The commissioners of health and
114.12 human services shall establish a rate methodology for Medicare and Medicaid risk-based
114.13 contracting with health plan companies that is consistent with statewide growth limits.
114.14 ~~The methodology shall be presented for review by the Minnesota Health Care Commission~~
114.15 ~~and the Legislative Commission on Health Care Access prior to the submission of a~~
114.16 ~~waiver request to the Centers for Medicare and Medicaid Services and subsequent~~
114.17 ~~implementation of the methodology.~~

114.18 Sec. 5. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

114.19 Subd. 9. **Review of eligible providers.** The commissioner and the Medical
114.20 Education and Research Costs Advisory Committee may review provider groups included
114.21 in the definition of a clinical medical education program to assure that the distribution of
114.22 the funds continue to be consistent with the purpose of this section. The results of any
114.23 such reviews must be reported to the ~~Legislative Commission on Health Care Access~~
114.24 chairs and ranking minority members of the legislative committees with jurisdiction over
114.25 health care policy and finance.

114.26 Sec. 6. **[62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL**
114.27 **ERRORS PROHIBITED.**

114.28 A health care provider shall not bill a patient, and shall not be reimbursed, for
114.29 any operation, treatment, or other care that is provided to reverse, correct, or otherwise
114.30 minimize the affects of an adverse health care event, as described in section 144.7065,
114.31 subdivisions 2 to 7, for which that health care provider is responsible.

Sec. 7. Minnesota Statutes 2010, section 62Q.32, is amended to read:

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed. ~~The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the Legislative Commission on Health Care Access by January 15, 1996.~~

Sec. 8. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) By no later than October 15, 2010, the commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(c) By no later than January 1, 2011, the commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use,

condition-specific quality of care, and the condition-specific results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:

(1) clearly indicate the reason they believe the data used to calculate the peer group system results are not accurate;

(2) provide evidence and documentation to support the reason that data was not accurate; and

(3) cooperate with the commissioner, including allowing the commissioner access to data necessary and relevant to resolving the dispute.

If a provider does not meet the requirements of this paragraph, a provider's appeal shall be considered withdrawn. The commissioner shall not publish results for a specific provider under paragraph (e) or (f) while that provider has an unresolved appeal.

(e) Beginning January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing information under paragraph (e) or (f), the commissioner shall ensure the scientific validity and reliability of the results according to the standards described in paragraph (h). If additional time is needed to establish the scientific validity and reliability of the results, the commissioner may delay the dissemination of data to providers under paragraph (b) or (c), or the publication of information under paragraph (e) or (f). If the delay is more than 60 days, the commissioner shall report in writing to the ~~Legislative Commission on~~

117.1 ~~Health Care Access~~ chairs and ranking minority members of the legislative committees
117.2 with jurisdiction over health care policy and finance the following information:

117.3 (1) the reason for the delay;

117.4 (2) the actions being taken to resolve the delay and establish the scientific validity
117.5 and reliability of the results; and

117.6 (3) the new dates by which the results shall be disseminated.

117.7 If there is a delay under this paragraph, the commissioner must disseminate the
117.8 information to providers under paragraph (b) or (c) at least 90 days before publishing
117.9 results under paragraph (e) or (f).

117.10 (h) The commissioner's assurance of valid and reliable clinic and hospital peer
117.11 grouping performance results shall include, at a minimum, the following:

117.12 (1) use of the best available evidence, research, and methodologies; and

117.13 (2) establishment of an explicit minimum reliability threshold developed in
117.14 collaboration with the subjects of the data and the users of the data, at a level not below
117.15 nationally accepted standards where such standards exist.

117.16 In achieving these thresholds, the commissioner shall not aggregate clinics that are not
117.17 part of the same system or practice group. The commissioner shall consult with and solicit
117.18 feedback from representatives of physician clinics and hospitals during the peer grouping
117.19 data analysis process to obtain input on the methodological options prior to final analysis
117.20 and on the design, development, and testing of provider reports.

117.21 Sec. 9. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

117.22 Subd. 9. **Uses of information.** (a) ~~By no later~~ As coverage is offered, sold, issued,
117.23 or renewed, but not less than 12 months after the commissioner publishes the information
117.24 in subdivision 3, paragraph (e):

117.25 (1) the commissioner of management and budget shall use the information and
117.26 methods developed under subdivision 3 to strengthen incentives for members of the state
117.27 employee group insurance program to use high-quality, low-cost providers;

117.28 (2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer
117.29 health benefits to their employees must offer plans that differentiate providers on their
117.30 cost and quality performance and create incentives for members to use better-performing
117.31 providers;

117.32 (3) all health plan companies shall use the information and methods developed
117.33 under subdivision 3 to develop products that encourage consumers to use high-quality,
117.34 low-cost providers; and

118.1 (4) health plan companies that issue health plans in the individual market or the
118.2 small employer market must offer at least one health plan that uses the information
118.3 developed under subdivision 3 to establish financial incentives for consumers to choose
118.4 higher-quality, lower-cost providers through enrollee cost-sharing or selective provider
118.5 networks.

118.6 (b) By January 1, 2011, the commissioner of health shall report to the governor
118.7 and the legislature on recommendations to encourage health plan companies to promote
118.8 widespread adoption of products that encourage the use of high-quality, low-cost providers.
118.9 The commissioner's recommendations may include tax incentives, public reporting of
118.10 health plan performance, regulatory incentives or changes, and other strategies.

118.11 Sec. 10. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:

118.12 Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner
118.13 of health shall submit to the ~~Legislative Commission on Health Care Access~~ chairs and
118.14 ranking minority members of the legislative committees with jurisdiction over health care
118.15 policy and finance periodic progress reports on the implementation of this chapter and
118.16 sections 256B.0751 to 256B.0754.

118.17 Sec. 11. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
118.18 to read:

118.19 Subd. 33. **Contingency contract fees.** When the commissioner enters into
118.20 a contingency-based contract for the purpose of recovering medical assistance or
118.21 MinnesotaCare funds, the commissioner may retain that portion of the recovered funds
118.22 equal to the amount of the contingency fee.

118.23 Sec. 12. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
118.24 to read:

118.25 Subd. 34. **Elimination of certain provider reporting requirements; sunset of**
118.26 **new requirements.** (a) Notwithstanding any other law, rule, or provision to the contrary,
118.27 effective July 1, 2012, the commissioner shall cease collecting from health care providers
118.28 and purchasers all reports and data related to health care costs, quality, utilization, access,
118.29 patient encounters, and disease surveillance and public health, and related to provider
118.30 licensure, monitoring, finances, and regulation, unless the reports or data are necessary for
118.31 federal compliance. For purposes of this subdivision, the term "health care providers and
118.32 purchasers" has the meaning provided in section 62J.03, subdivision 8, except that it also
118.33 includes nursing homes, health plan companies as defined in section 62Q.01, subdivision

119.1 4, and managed care and county-based purchasing plans delivering services under sections
119.2 256B.69 and 256B.692.

119.3 (b) The commissioner shall present to the 2012 legislature draft legislation to repeal,
119.4 effective July 1, 2012, the provider reporting requirements identified under paragraph (a)
119.5 that are not necessary for federal compliance.

119.6 (c) The commissioner may establish new provider reporting requirements to take
119.7 effect on or after July 1, 2012. These new reporting requirements must sunset five years
119.8 from their effective date, unless they are renewed by the commissioner. All new provider
119.9 reporting requirements and requests for their renewal shall not take effect unless they
119.10 are enacted in state law.

119.11 Sec. 13. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

119.12 Subd. 2b. **Operating payment rates.** In determining operating payment rates for
119.13 admissions occurring on or after the rate year beginning January 1, 1991, and every two
119.14 years after, or more frequently as determined by the commissioner, the commissioner
119.15 shall obtain operating data from an updated base year and establish operating payment
119.16 rates per admission for each hospital based on the cost-finding methods and allowable
119.17 costs of the Medicare program in effect during the base year. Rates under the general
119.18 assistance medical care, medical assistance, and MinnesotaCare programs shall not be
119.19 rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months
119.20 of the rebased period beginning January 1, 2009. For the first 24 months of the rebased
119.21 period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota
119.22 long-term hospital shall be rebased effective January 1, 2011, based on its most recent
119.23 Medicare cost report ending on or before September 1, 2008, with the provisions under
119.24 subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent
119.25 rate setting periods in which the base years are updated, a Minnesota long-term hospital's
119.26 base year shall remain within the same period as other hospitals. ~~Effective January 1,~~
119.27 ~~2013, rates shall be rebased at full value~~ Rates must not be rebased to more current data
119.28 for the first six months of the rebased period beginning January 1, 2013. The base year
119.29 operating payment rate per admission is standardized by the case mix index and adjusted
119.30 by the hospital cost index, relative values, and disproportionate population adjustment.
119.31 The cost and charge data used to establish operating rates shall only reflect inpatient
119.32 services covered by medical assistance and shall not include property cost information
119.33 and costs recognized in outlier payments.

119.34 Sec. 14. Minnesota Statutes 2010, section 256.969, subdivision 3a, is amended to read:

120.1 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
120.2 assistance program must not be submitted until the recipient is discharged. However,
120.3 the commissioner shall establish monthly interim payments for inpatient hospitals that
120.4 have individual patient lengths of stay over 30 days regardless of diagnostic category.
120.5 Except as provided in section 256.9693, medical assistance reimbursement for treatment
120.6 of mental illness shall be reimbursed based on diagnostic classifications. Individual
120.7 hospital payments established under this section and sections 256.9685, 256.9686, and
120.8 256.9695, in addition to third-party and recipient liability, for discharges occurring during
120.9 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
120.10 inpatient services paid for the same period of time to the hospital. This payment limitation
120.11 shall be calculated separately for medical assistance and general assistance medical
120.12 care services. The limitation on general assistance medical care shall be effective for
120.13 admissions occurring on or after July 1, 1991. Services that have rates established under
120.14 subdivision 11 or 12, must be limited separately from other services. After consulting with
120.15 the affected hospitals, the commissioner may consider related hospitals one entity and
120.16 may merge the payment rates while maintaining separate provider numbers. The operating
120.17 and property base rates per admission or per day shall be derived from the best Medicare
120.18 and claims data available when rates are established. The commissioner shall determine
120.19 the best Medicare and claims data, taking into consideration variables of recency of the
120.20 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
120.21 The commissioner shall notify hospitals of payment rates by December 1 of the year
120.22 preceding the rate year. The rate setting data must reflect the admissions data used to
120.23 establish relative values. Base year changes from 1981 to the base year established for the
120.24 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
120.25 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
120.26 1. The commissioner may adjust base year cost, relative value, and case mix index data
120.27 to exclude the costs of services that have been discontinued by the October 1 of the year
120.28 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
120.29 that encompass portions of two or more rate years shall have payments established based
120.30 on payment rates in effect at the time of admission unless the date of admission preceded
120.31 the rate year in effect by six months or more. In this case, operating payment rates for
120.32 services rendered during the rate year in effect and established based on the date of
120.33 admission shall be adjusted to the rate year in effect by the hospital cost index.

120.34 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
120.35 payment, before third-party liability and spenddown, made to hospitals for inpatient
120.36 services is reduced by .5 percent from the current statutory rates.

121.1 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
121.2 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
121.3 before third-party liability and spenddown, is reduced five percent from the current
121.4 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
121.5 facilities defined under subdivision 16 are excluded from this paragraph.

121.6 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
121.7 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
121.8 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
121.9 from the current statutory rates. Mental health services within diagnosis related groups
121.10 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
121.11 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
121.12 assistance does not include general assistance medical care. Payments made to managed
121.13 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
121.14 this reduction.

121.15 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
121.16 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
121.17 to hospitals for inpatient services before third-party liability and spenddown, is reduced
121.18 3.46 percent from the current statutory rates. Mental health services with diagnosis related
121.19 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
121.20 paragraph. Payments made to managed care plans shall be reduced for services provided
121.21 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

121.22 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
121.23 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
121.24 to hospitals for inpatient services before third-party liability and spenddown, is reduced
121.25 1.9 percent from the current statutory rates. Mental health services with diagnosis related
121.26 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
121.27 paragraph. Payments made to managed care plans shall be reduced for services provided
121.28 on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

121.29 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
121.30 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
121.31 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
121.32 from the current statutory rates. Mental health services with diagnosis related groups
121.33 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
121.34 Payments made to managed care plans shall be reduced for services provided on or after
121.35 July 1, 2011, to reflect this reduction.

122.1 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
122.2 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
122.3 hospitals for inpatient services before third-party liability and spenddown, is reduced
122.4 one percent from the current statutory rates. Facilities defined under subdivision 16 are
122.5 excluded from this paragraph. Payments made to managed care plans shall be reduced for
122.6 services provided on or after October 1, 2009, to reflect this reduction.

122.7 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
122.8 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
122.9 hospitals for inpatient services before third-party liability and spenddown, is reduced
122.10 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
122.11 excluded from this paragraph. Payments made to managed care plans shall be reduced for
122.12 services provided on or after January 1, 2011, to reflect this reduction.

122.13 (j) In addition to the reductions in paragraphs (b), (c), (d), (g), (h), and (i), the total
122.14 payment for medical assistance fee-for-service admissions occurring on or after July 1,
122.15 2011, through June 30, 2013, made to hospitals for inpatient services before third-party
122.16 liability and spenddown, is reduced by 7.04 percent from the current statutory rates.
122.17 Inpatient hospital fee-for-service payments to hospitals located in the seven-county
122.18 metropolitan area that are not government-owned with a disproportionate population
122.19 adjustment under section 256.969, subdivision 9, paragraph (b), that is greater than 17
122.20 percent on January 1, 2011, are excluded from this reduction. Payments made to managed
122.21 care plans shall be reduced for services provided on or after January 1, 2012, through June
122.22 30, 2013, to reflect the full 24-month reduction in fee-for-service rates.

122.23 Sec. 15. Minnesota Statutes 2010, section 256.969, is amended by adding a subdivision
122.24 to read:

122.25 Subd. 31. **Initiatives to reduce incidence of low birth-weight.** The commissioner
122.26 shall require hospitals with a level III neonatal intensive care unit located in the
122.27 seven-county metropolitan area, as a condition of contract, to implement strategies
122.28 to reduce the incidence of low birth-weight in geographic areas identified by the
122.29 commissioner as having a higher than average incidence of low birth-weight, with special
122.30 emphasis on areas within a one-mile radius of the hospital. These strategies may focus on
122.31 smoking prevention and cessation, ensuring that pregnant women get adequate nutrition,
122.32 and addressing demographic, social, and environmental risk factors. The strategies must
122.33 coordinate health care with social services and the local public health system, and offer
122.34 patient education through appropriate means. The commissioner shall require hospitals to
122.35 submit proposed initiatives for approval to the commissioner by January 1, 2012, and the

123.1 commissioner shall require hospitals to implement approved initiatives by July 1, 2012.
123.2 The commissioner shall evaluate the strategies adopted to reduce low birth-weight, and
123.3 shall require hospitals to submit outcome and other data necessary for the evaluation.

123.4 Sec. 16. Minnesota Statutes 2010, section 256B.04, subdivision 18, is amended to read:

123.5 Subd. 18. **Applications for medical assistance.** (a) The state agency may
123.6 take applications for medical assistance and conduct eligibility determinations for
123.7 MinnesotaCare enrollees.

123.8 (b) The commissioner of human services shall modify the Minnesota health care
123.9 programs application form to add a question asking applicants: "Are you a United States
123.10 military veteran?"

123.11 Sec. 17. Minnesota Statutes 2010, section 256B.05, is amended by adding a
123.12 subdivision to read:

123.13 Subd. 5. **Technical assistance.** The commissioner shall provide technical assistance
123.14 to county agencies in processing complex medical assistance applications, including but
123.15 not limited to applications for long-term care services. The commissioner shall provide
123.16 this technical assistance using existing financial resources.

123.17 Sec. 18. Minnesota Statutes 2010, section 256B.055, subdivision 15, is amended to
123.18 read:

123.19 Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a
123.20 person who is:

123.21 (1) at least age 21 and under age 65;

123.22 (2) not pregnant;

123.23 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII
123.24 of the Social Security Act;

123.25 (4) not an adult in a family with children as defined in section 256L.01, subdivision
123.26 3a; and

123.27 (5) not described in another subdivision of this section.

123.28 (b) If the federal government eliminates the federal Medicaid match or reduces the
123.29 federal Medicaid matching rate beyond any adjustment required as part of the annual
123.30 recalculation of the state's overall Medicaid matching rate for persons eligible under this
123.31 subdivision, the commissioner shall eliminate coverage for persons enrolled under this
123.32 subdivision and suspend new enrollment under this subdivision effective on the date
123.33 of the elimination or reduction.

124.1 **EFFECTIVE DATE.** This section is effective the day following final enactment
124.2 and expires January 1, 2014.

124.3 Sec. 19. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

124.4 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
124.5 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
124.6 other persons residing lawfully in the United States. Citizens or nationals of the United
124.7 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
124.8 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
124.9 Public Law 109-171.

124.10 (b) "Qualified noncitizen" means a person who meets one of the following
124.11 immigration criteria:

124.12 (1) admitted for lawful permanent residence according to United States Code, title 8;

124.13 (2) admitted to the United States as a refugee according to United States Code,
124.14 title 8, section 1157;

124.15 (3) granted asylum according to United States Code, title 8, section 1158;

124.16 (4) granted withholding of deportation according to United States Code, title 8,
124.17 section 1253(h);

124.18 (5) paroled for a period of at least one year according to United States Code, title 8,
124.19 section 1182(d)(5);

124.20 (6) granted conditional entrant status according to United States Code, title 8,
124.21 section 1153(a)(7);

124.22 (7) determined to be a battered noncitizen by the United States Attorney General
124.23 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
124.24 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

124.25 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
124.26 States Attorney General according to the Illegal Immigration Reform and Immigrant
124.27 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
124.28 Public Law 104-200; or

124.29 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
124.30 Law 96-422, the Refugee Education Assistance Act of 1980.

124.31 (c) All qualified noncitizens who were residing in the United States before August
124.32 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
124.33 medical assistance with federal financial participation.

125.1 (d) All qualified noncitizens who entered the United States on or after August 22,
125.2 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
125.3 medical assistance with federal financial participation through November 30, 1996.

125.4 Beginning December 1, 1996, qualified noncitizens who entered the United States
125.5 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
125.6 chapter are eligible for medical assistance with federal participation for five years if they
125.7 meet one of the following criteria:

125.8 (i) refugees admitted to the United States according to United States Code, title 8,
125.9 section 1157;

125.10 (ii) persons granted asylum according to United States Code, title 8, section 1158;

125.11 (iii) persons granted withholding of deportation according to United States Code,
125.12 title 8, section 1253(h);

125.13 (iv) veterans of the United States armed forces with an honorable discharge for
125.14 a reason other than noncitizen status, their spouses and unmarried minor dependent
125.15 children; or

125.16 (v) persons on active duty in the United States armed forces, other than for training,
125.17 their spouses and unmarried minor dependent children.

125.18 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
125.19 criteria in items (i) to (v) are eligible for medical assistance without federal financial
125.20 participation as described in paragraph (j).

125.21 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
125.22 women who are noncitizens described in paragraph (b) or (e), are eligible for medical
125.23 assistance with federal financial participation as provided by the federal Children's Health
125.24 Insurance Program Reauthorization Act of 2009, Public Law 111-3.

125.25 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
125.26 are lawfully present in the United States, as defined in Code of Federal Regulations, title
125.27 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
125.28 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
125.29 with the United States Citizenship and Immigration Services to pursue any applicable
125.30 immigration status, including citizenship, that would qualify them for medical assistance
125.31 with federal financial participation.

125.32 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
125.33 for medical assistance with federal financial participation through December 31, 1996.

125.34 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
125.35 medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition, ~~except for organ transplants and related care and services and routine prenatal care.~~

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i)(1) Notwithstanding paragraph (h), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and that are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

- 127.1 (viii) dialysis;
- 127.2 (ix) chemotherapy or therapeutic radiation services;
- 127.3 (x) rehabilitation services;
- 127.4 (xi) physical, occupational, or speech therapy;
- 127.5 (xii) transportation services;
- 127.6 (xiii) case management;
- 127.7 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 127.8 (xv) dental services;
- 127.9 (xvi) hospice care;
- 127.10 (xvii) audiology services and hearing aids;
- 127.11 (xviii) podiatry services;
- 127.12 (xix) chiropractic services;
- 127.13 (xx) immunizations;
- 127.14 (xxi) vision services and eyeglasses;
- 127.15 (xxii) waiver services;
- 127.16 (xxiii) individualized education programs; or
- 127.17 (xxiv) chemical dependency treatment.

127.18 ~~(j)~~ (j) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
127.19 nonimmigrants, or lawfully present as designated in paragraph (e) and who are not
127.20 covered by a group health plan or health insurance coverage according to Code of
127.21 Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility
127.22 requirements of this chapter, are eligible for medical assistance through the period of
127.23 pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal
127.24 funds are available under title XXI of the Social Security Act, and the state children's
127.25 health insurance program.

127.26 ~~(k)~~ (k) Qualified noncitizens as described in paragraph (d), and all other noncitizens
127.27 lawfully residing in the United States as described in paragraph (e), who are ineligible
127.28 for medical assistance with federal financial participation and who otherwise meet the
127.29 eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
127.30 assistance without federal financial participation. Qualified noncitizens as described
127.31 in paragraph (d) are only eligible for medical assistance without federal financial
127.32 participation for five years from their date of entry into the United States.

127.33 ~~(l)~~ (l) Beginning October 1, 2003, persons who are receiving care and rehabilitation
127.34 services from a nonprofit center established to serve victims of torture and are otherwise
127.35 ineligible for medical assistance under this chapter are eligible for medical assistance
127.36 without federal financial participation. These individuals are eligible only for the period

128.1 during which they are receiving services from the center. Individuals eligible under this
128.2 paragraph shall not be required to participate in prepaid medical assistance.

128.3 Sec. 20. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
128.4 subdivision to read:

128.5 Subd. 1b. **Care coordination services provided through pediatric hospitals.**

128.6 (a) Medical assistance covers care coordination services provided by certain pediatric
128.7 hospitals to children with high-cost medical conditions and children at risk of recurrent
128.8 hospitalization for acute or chronic illnesses. There must be Level I and Level II pediatric
128.9 care coordination services.

128.10 (b) Level I pediatric care coordination services are provided by advanced practice
128.11 nurses employed by or under contract with pediatric hospitals that have a neonatal
128.12 intensive care unit and are either recipients of payments to support the training of residents
128.13 from an approved graduate medical residency program under United States Code, title
128.14 42, section 256e, or the major pediatric teaching hospital affiliate of the University of
128.15 Minnesota Medical School, and that meet the criteria in this subdivision.

128.16 (c) The services in paragraph (b) must be available through in-home video telehealth
128.17 management and other methods, and must be designed to improve patient outcomes
128.18 and reduce unnecessary hospital and emergency room utilization. The services must
128.19 streamline communication, reduce redundancy, and eliminate unnecessary documentation
128.20 through the use of a Web-accessible, uniform document that contains critical patient care
128.21 management information, and which is accessible to all providers with patient consent.
128.22 The commissioner shall develop the uniform document and associated Web site and shall
128.23 implement procedures to assess patient outcomes and evaluate the effectiveness of the
128.24 care coordination services provided under this subdivision.

128.25 (d) Medical assistance also covers, as durable medical equipment, computers,
128.26 webcams, and other technology necessary to allow in-home video telehealth management.

128.27 (e) For purposes of paragraph (b), a child has a high-cost medical condition if
128.28 inpatient hospital expenses for that child related to complex or chronic illnesses or
128.29 conditions for the most recent calendar year exceeded \$100,000, or if the expenses for that
128.30 child are projected to exceed \$100,000 for the current calendar year. For purposes of this
128.31 subdivision, a child is at risk of recurrent hospitalization if the child was hospitalized three
128.32 or more times for acute or chronic illness in the most recent calendar year.

128.33 (f) For purposes of paragraph (b), "care coordination" means collaboration between
128.34 the advanced practice nurse and primary care physicians and specialists to manage
128.35 care and reduce hospitalizations, patient case management, development of medical

129.1 management plans for chronic illnesses and recurrent acute illnesses, oversight and
129.2 coordination of all aspects of care in partnership with families, organization of medical
129.3 information into a summary of critical information, coordination and appropriate
129.4 sequencing of tests and multiple appointments, information and assistance with accessing
129.5 resources, and telephone triage for acute illnesses or problems.

129.6 (g) The commissioner shall adjust managed care and county-based purchasing plan
129.7 capitation rates to reflect savings from the coverage of this service.

129.8 (h) Level II pediatric care coordination services are provided by registered nurses
129.9 employed by or under contract with a pediatric hospital that has been designated as
129.10 an essential community provider under section 62Q.19, subdivision 1, clause (4), and
129.11 has been a recipient of payments to support the training of residents from an approved
129.12 graduate medical residency program pursuant to United States Code, title 42, section
129.13 256e, and that meets the following criteria:

129.14 (1) the services must be provided through telehealth management and other methods,
129.15 be available on a regular schedule seven days per week, and be designed to provide
129.16 collaboration in patient care as provided by the patient's family, primary care providers,
129.17 and the hospital and specialized physicians;

129.18 (2) for purposes of this paragraph, a child has a high-cost medical condition if the
129.19 child has a serious chronic physical disability caused by a congenital anomaly, birth
129.20 injury or traumatic injury, complications which can be expected to cause further injury,
129.21 hospitalization, or death, but that can be effectively addressed through ongoing family
129.22 and primary care supported by communication of ongoing care information and care
129.23 coordination; and

129.24 (3) for purposes of this paragraph, "care coordination" means the ready availability
129.25 of telehealth management services to support collaboration through a registered nurse
129.26 between a child's family, the primary care professional that is available to care for the
129.27 child, and appropriate professionals to address urgent questions about and minimize the
129.28 consequences of medical complications, develop medical management plans for complex
129.29 conditions, and avoid serious health consequences and hospitalizations to treat such
129.30 complications.

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

129.32 Sec. 21. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
129.33 subdivision to read:

129.34 **Subd. 3q. Evidence-based childbirth program.** (a) The commissioner shall
129.35 implement a program to reduce the number of elective inductions of labor prior to 39

weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

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

Sec. 22. Minnesota Statutes 2010, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. ~~Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises.~~ Authorization determinations must be communicated within three working days. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist ~~who is not on the premises~~ shall be reimbursed at 65 percent of the physical therapist rate.

Sec. 23. Minnesota Statutes 2010, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or reevaluations. ~~Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises.~~ Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist ~~who is not on the premises~~ shall be reimbursed at 65 percent of the occupational therapist rate.

Sec. 24. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to read:

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater number of visits is obtained.

132.1 Sec. 25. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
132.2 subdivision to read:

132.3 Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined
132.4 in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by
132.5 another Minnesota licensed practitioner for whom acupuncture is within the practitioner's
132.6 scope of practice and who has specific acupuncture training or credentialing.

132.7 Sec. 26. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to
132.8 read:

132.9 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
132.10 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
132.11 the maximum allowable cost set by the federal government or by the commissioner plus
132.12 the fixed dispensing fee; or the usual and customary price charged to the public. The
132.13 amount of payment basis must be reduced to reflect all discount amounts applied to the
132.14 charge by any provider/insurer agreement or contract for submitted charges to medical
132.15 assistance programs. The net submitted charge may not be greater than the patient liability
132.16 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee
132.17 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per
132.18 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral
132.19 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral
132.20 nutritional products dispensed in quantities greater than one liter. Actual acquisition cost
132.21 includes quantity and other special discounts except time and cash discounts. ~~Effective~~
132.22 ~~July 1, 2009,~~ The actual acquisition cost of a drug shall be estimated by the commissioner;
132.23 ~~at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic~~
132.24 ~~factor drugs shall be estimated at the average wholesale price minus 30 percent. wholesale~~
132.25 acquisition cost plus four percent for independently owned pharmacies located in a
132.26 designated rural area within Minnesota, and at wholesale acquisition cost plus two percent
132.27 for all other pharmacies. A pharmacy is "independently owned" if it is one of four or
132.28 fewer pharmacies under the same ownership nationally. A "designated rural area" means
132.29 an area defined as a small rural area or isolated rural area according to the four-category
132.30 classification of the Rural Urban Commuting Area system developed for the United States
132.31 Health Resources and Services Administration. Wholesale acquisition cost is defined as
132.32 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers
132.33 in the United States, not including prompt pay or other discounts, rebates, or reductions
132.34 in price, for the most recent month for which information is available, as reported in
132.35 wholesale price guides or other publications of drug or biological pricing data. The

133.1 maximum allowable cost of a multisource drug may be set by the commissioner and it
133.2 shall be comparable to, but no higher than, the maximum amount paid by other third-party
133.3 payors in this state who have maximum allowable cost programs. Establishment of the
133.4 amount of payment for drugs shall not be subject to the requirements of the Administrative
133.5 Procedure Act.

133.6 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
133.7 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
133.8 facilities when a unit dose blister card system, approved by the department, is used. Under
133.9 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
133.10 The National Drug Code (NDC) from the drug container used to fill the blister card must
133.11 be identified on the claim to the department. The unit dose blister card containing the
133.12 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
133.13 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
133.14 will be required to credit the department for the actual acquisition cost of all unused
133.15 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
133.16 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
133.17 dispensed in a quantity that is less than a 30-day supply.

133.18 (c) Whenever a maximum allowable cost has been set for a multisource drug,
133.19 payment shall be on the basis of the maximum allowable cost established by the
133.20 commissioner unless prior authorization for the brand name product has been granted
133.21 according to the criteria established by the Drug Formulary Committee as required by
133.22 subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on
133.23 the prescription in a manner consistent with section 151.21, subdivision 2.

133.24 (d) The basis for determining the amount of payment for drugs administered in an
133.25 outpatient setting shall be the lower of the usual and customary cost submitted by the
133.26 provider or ~~the amount established for Medicare by the~~ 106 percent of the average sales
133.27 price as determined by the United States Department of Health and Human Services
133.28 pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales
133.29 price is unavailable, the amount of payment must be lower of the usual and customary cost
133.30 submitted by the provider or the wholesale acquisition cost.

133.31 (e) The commissioner may negotiate lower reimbursement rates for specialty
133.32 pharmacy products than the rates specified in paragraph (a). The commissioner may
133.33 require individuals enrolled in the health care programs administered by the department
133.34 to obtain specialty pharmacy products from providers with whom the commissioner has
133.35 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
133.36 used by a small number of recipients or recipients with complex and chronic diseases

that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective July 1, 2011, or upon federal approval, whichever is later.

Sec. 27. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking ~~four~~ three or more prescriptions to treat or prevent ~~two~~ one or more chronic medical conditions; ~~or~~ or a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

- (1) performing or obtaining necessary assessments of the patient's health status;
- (2) formulating a medication treatment plan;
- (3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
- (4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, ~~excluding~~ including long-term care ~~and settings~~, group homes, ~~if the service is ordered by the provider-directed care coordination team~~ and facilities providing assisted living services; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located

within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 28. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) an ambulance, as defined in section 144E.001, subdivision 2;

(2) special transportation; or

(3) common carrier including, but not limited to, bus, taxicab, other commercial carrier, or private automobile.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation providers shall perform driver-assisted services for eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance

137.1 with admittance of the individual to the medical facility, and assistance in passenger
137.2 securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation
137.3 providers must obtain written documentation from the health care service provider who
137.4 is serving the recipient being transported, identifying the time that the recipient arrived.
137.5 Special transportation providers may not bill for separate base rates for the continuation of
137.6 a trip beyond the original destination. Special transportation providers must take recipients
137.7 to the nearest appropriate health care provider, using the most direct route. The minimum
137.8 medical assistance reimbursement rates for special transportation services are:

137.9 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to
137.10 eligible persons who need a wheelchair-accessible van;

137.11 (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to
137.12 eligible persons who do not need a wheelchair-accessible van; and

137.13 (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
137.14 special transportation services to eligible persons who need a stretcher-accessible vehicle;

137.15 (2) the base rates for special transportation services in areas defined under RUCA
137.16 to be super rural shall be equal to the reimbursement rate established in clause (1) plus
137.17 11.3 percent; and

137.18 (3) for special transportation services in areas defined under RUCA to be rural
137.19 or super rural areas:

137.20 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
137.21 percent of the respective mileage rate in clause (1); and

137.22 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
137.23 112.5 percent of the respective mileage rate in clause (1).

137.24 (c) For purposes of reimbursement rates for special transportation services under
137.25 paragraph (b), the zip code of the recipient's place of residence shall determine whether
137.26 the urban, rural, or super rural reimbursement rate applies.

137.27 (d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"
137.28 means a census-tract based classification system under which a geographical area is
137.29 determined to be urban, rural, or super rural.

137.30 (e) Effective for services provided on or after July 1, 2011, nonemergency
137.31 transportation rates, including special transportation, taxi, and other commercial carriers,
137.32 are reduced 4.5 percent. Payments made to managed care plans and county-based
137.33 purchasing plans must be reduced for services provided on or after January 1, 2012,
137.34 to reflect this reduction.

138.1 Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to
138.2 read:

138.3 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers
138.4 ambulance services. Providers shall bill ambulance services according to Medicare
138.5 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
138.6 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
138.7 services shall be paid at the Medicare reimbursement rate or at the medical assistance
138.8 payment rate in effect on July 1, 2000, whichever is greater.

138.9 (b) Effective for services provided on or after July 1, 2011, ambulance services
138.10 payment rates are reduced 4.5 percent. Payments made to managed care plans and
138.11 county-based purchasing plans must be reduced for services provided on or after January
138.12 1, 2012, to reflect this reduction.

138.13 Sec. 30. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to
138.14 read:

138.15 Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the
138.16 state agency, medical assistance covers ~~costs of~~ the most appropriate and cost-effective
138.17 form of transportation incurred by any ambulatory eligible person for obtaining
138.18 nonemergency medical care.

138.19 Sec. 31. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
138.20 subdivision to read:

138.21 Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise
138.22 allowed under this subdivision or required under federal or state regulations, the
138.23 commissioner must not consider a request for authorization of a service when the recipient
138.24 has coverage from a third-party payer unless the provider requesting authorization has
138.25 made a good faith effort to receive payment or authorization from the third-party payer.
138.26 A good faith effort is established by supplying with the authorization request to the
138.27 commissioner the following:

138.28 (1) a determination of payment for the service from the third-party payer, a
138.29 determination of authorization for the service from the third-party payer, or a verification
138.30 of noncoverage of the service by the third-party payer; and

138.31 (2) the information or records required by the department to document the reason for
138.32 the determination or to validate noncoverage from the third-party payer.

138.33 (b) A provider requesting authorization for services covered by Medicare is not
138.34 required to bill Medicare before requesting authorization from the commissioner if the

139.1 provider has reason to believe that a service covered by Medicare is not eligible for
139.2 payment. The provider must document that, because of recent claim experiences with
139.3 Medicare or because of written communication from Medicare, coverage is not available
139.4 for the service.

139.5 (c) Authorization is not required if a third-party payer has made payment that is
139.6 equal to or greater than 60 percent of the maximum payment amount for the service
139.7 allowed under medical assistance.

139.8 Sec. 32. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to
139.9 read:

139.10 Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical
139.11 assistance covers augmentative and alternative communication systems consisting of
139.12 electronic or nonelectronic devices and the related components necessary to enable a
139.13 person with severe expressive communication limitations to produce or transmit messages
139.14 or symbols in a manner that compensates for that disability.

139.15 ~~(b) Until the volume of systems purchased increases to allow a discount price, the~~
139.16 ~~commissioner shall reimburse augmentative and alternative communication manufacturers~~
139.17 ~~and vendors at the manufacturer's suggested retail price for augmentative and alternative~~
139.18 ~~communication systems and related components. The commissioner shall separately~~
139.19 ~~reimburse providers for purchasing and integrating individual communication systems~~
139.20 ~~which are unavailable as a package from an augmentative and alternative communication~~
139.21 ~~vendor. Augmentative and alternative communication systems must be paid the lower~~
139.22 ~~of the:~~

139.23 (1) submitted charge; or

139.24 (2)(i) manufacturer's suggested retail price minus 20 percent for providers that are
139.25 manufacturers of augmentative and alternative communication systems; or

139.26 (ii) manufacturer's invoice charge plus 20 percent for providers that are not
139.27 manufacturers of augmentative and alternative communication systems.

139.28 (c) Reimbursement rates established by this purchasing program are not subject to
139.29 Minnesota Rules, part 9505.0445, item S or T.

139.30 Sec. 33. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
139.31 subdivision to read:

139.32 Subd. 55. **Payment for multiple services provided on same day.** The
139.33 commissioner shall not prohibit payment, including any supplemental payments, for
139.34 mental health services or dental services provided to a patient by a clinic or health care

140.1 professional solely because the mental health services or dental services were provided on
140.2 the same day as other covered health care services furnished by the same provider.

140.3 Sec. 34. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
140.4 subdivision to read:

140.5 Subd. 56. **Medical care coordination.** (a) Medical assistance covers in-reach
140.6 community-based care coordination that is performed in a hospital emergency department
140.7 as an eligible procedure under a state health care program or private insurance for a
140.8 frequent user. A frequent user is defined as an individual who has frequented the hospital
140.9 emergency department for services three or more times in the previous four consecutive
140.10 months. In-reach community-based care coordination includes navigating services to
140.11 address a client's mental health, chemical health, social, economic, and housing needs,
140.12 or any other activity targeted at reducing the incidence of emergency room and other
140.13 nonmedically necessary health care utilization.

140.14 (b) Reimbursement must be made in 15-minute increments under current Medicaid
140.15 mental health social work reimbursement methodology and allowed for up to 60 days
140.16 posthospital discharge based upon the specific identified emergency department visit or
140.17 inpatient admitting event. A frequent user who is participating in care coordination within
140.18 a health care home framework is ineligible for reimbursement under this subdivision.
140.19 Eligible in-reach care coordinators must hold a minimum of a bachelor's degree in social
140.20 work, public health, corrections, or related field. The commissioner shall submit any
140.21 necessary application for waivers to the Centers for Medicare and Medicaid Services to
140.22 implement this subdivision.

140.23 (c) For the purposes of this subdivision, "in-reach community-based care
140.24 coordination" means the practice of a community-based worker with training, knowledge,
140.25 skills, and ability to access a continuum of services, including housing, transportation,
140.26 chemical and mental health treatment, employment, and peer support services, by working
140.27 with an organization's staff to transition an individual back into the individual's living
140.28 environment. In-reach community-based care coordination includes working with the
140.29 individual during their discharge and for up to a defined amount of time in the individual's
140.30 living environment, reducing the individual's need for readmittance.

140.31 Sec. 35. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
140.32 subdivision to read:

140.33 Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services
140.34 provided on or after January 1, 2012, medical assistance payment for an enrollee's cost

141.1 sharing associated with Medicare Part B is limited to an amount up to the medical
141.2 assistance total allowed, when the medical assistance rate exceeds the amount paid by
141.3 Medicare.

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

141.5 Sec. 36. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
141.6 subdivision to read:

141.7 **Subd. 58. Early and periodic screening, diagnosis, and treatment services.**
141.8 Medical assistance covers early and periodic screening, diagnosis, and treatment services
141.9 (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate
141.10 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

141.11 Sec. 37. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
141.12 subdivision to read:

141.13 **Subd. 59. Services provided by advanced dental therapists and dental**
141.14 **therapists.** Medical assistance covers services provided by advanced dental therapists
141.15 and dental therapists when provided within the scope of practice identified in sections
141.16 150A.105 and 150A.106.

141.17 Sec. 38. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to
141.18 read:

141.19 Subdivision 1. ~~Co-payments~~ **Cost-sharing.** (a) Except as provided in subdivision
141.20 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing
141.21 for all recipients, effective for services provided on or after October 1, 2003, and before
141.22 January 1, 2009 July 1, 2011:

141.23 (1) \$3 per nonpreventive visit, except as provided in paragraph (c). For purposes
141.24 of this subdivision, a visit means an episode of service which is required because of
141.25 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
141.26 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
141.27 midwife, advanced practice nurse, audiologist, optician, or optometrist;

141.28 (2) \$3 for eyeglasses;

141.29 (3) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room, except
141.30 that this co-payment shall be increased to \$20 upon federal approval; and

141.31 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
141.32 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
141.33 shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:~~

~~(1) \$3.50 for nonemergency visits to a hospital-based emergency room;~~

~~(2) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(3) (6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly co-payments cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on co-payments cost-sharing.~~

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

(c) Effective January 1, 2012, or upon federal approval, whichever is later, the following co-payments for nonpreventive visits shall apply to providers included in provider peer grouping:

(1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is at the 60th percentile or lower for providers of the same type;

(2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county-based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph using a methodology approved by the commissioner. The commissioner shall develop a methodology for calculating the average, risk-adjusted, total annual cost of care for fee-for-service providers.

143.1 (d) The commissioner shall seek any federal waivers and approvals necessary to
143.2 increase the co-payment for nonemergency visits to a hospital-based emergency room
143.3 under paragraph (a), clause (3), and to implement paragraph (c).

143.4 Sec. 39. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to
143.5 read:

143.6 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
143.7 exceptions:

143.8 (1) children under the age of 21;

143.9 (2) pregnant women for services that relate to the pregnancy or any other medical
143.10 condition that may complicate the pregnancy;

143.11 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
143.12 intermediate care facility for the developmentally disabled;

143.13 (4) recipients receiving hospice care;

143.14 (5) 100 percent federally funded services provided by an Indian health service;

143.15 (6) emergency services;

143.16 (7) family planning services;

143.17 (8) services that are paid by Medicare, resulting in the medical assistance program
143.18 paying for the coinsurance and deductible; and

143.19 (9) co-payments that exceed one per day per provider for nonpreventive visits,
143.20 eyeglasses, and nonemergency visits to a hospital-based emergency room.

143.21 Sec. 40. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to
143.22 read:

143.23 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall
143.24 be reduced by the amount of the co-payment or deductible, except that reimbursements
143.25 shall not be reduced:

143.26 (1) once a recipient has reached the \$12 per month maximum ~~or the \$7 per month~~
143.27 ~~maximum effective January 1, 2009~~, for prescription drug co-payments; or

143.28 (2) for a recipient identified by the commissioner under 100 percent of the federal
143.29 poverty guidelines who has met their monthly five percent ~~co-payment~~ cost-sharing limit.

143.30 (b) The provider collects the co-payment or deductible from the recipient. Providers
143.31 may not deny services to recipients who are unable to pay the co-payment or deductible.

143.32 (c) Medical assistance reimbursement to fee-for-service providers and payments to
143.33 managed care plans shall not be increased as a result of the removal of co-payments or
143.34 deductibles effective on or after January 1, 2009.

144.1 Sec. 41. Minnesota Statutes 2010, section 256B.0751, subdivision 1, is amended to
144.2 read:

144.3 Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753,
144.4 the following definitions apply.

144.5 (b) "Commissioner" means the commissioner of human services.

144.6 (c) "Commissioners" means the commissioner of humans services and the
144.7 commissioner of health, acting jointly.

144.8 (d) "Health plan company" has the meaning provided in section 62Q.01, subdivision
144.9 4.

144.10 (e) "Personal clinician" means a physician licensed under chapter 147, a physician
144.11 assistant licensed and practicing under chapter 147A, ~~or~~ a mental health professional
144.12 licensed under section 245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision
144.13 27, clauses (1) to (6), an advanced practice nurse licensed and registered to practice
144.14 under chapter 148, or a chiropractor working in cooperation with a physician, physician
144.15 assistant, or advanced practice nurse.

144.16 (f) "State health care program" means the medical assistance, MinnesotaCare, and
144.17 general assistance medical care programs.

144.18 Sec. 42. Minnesota Statutes 2010, section 256B.0751, subdivision 2, is amended to
144.19 read:

144.20 Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009,
144.21 the commissioners of health and human services shall develop and implement standards
144.22 of certification for health care homes for state health care programs. In developing these
144.23 standards, the commissioners shall consider existing standards developed by national
144.24 independent accrediting and medical home organizations. The standards developed by the
144.25 commissioners must meet the following criteria:

144.26 (1) emphasize, enhance, and encourage the use of primary care, and include
144.27 the use of primary care physicians, advanced practice nurses, ~~and~~ mental health
144.28 professionals, physician assistants, and chiropractors as personal clinicians but permitting
144.29 multidisciplinary teams of other health professionals;

144.30 (2) focus on delivering high-quality, efficient, and effective health care services
144.31 and providing, arranging, or coordinating related social and public health services and
144.32 other services that directly affect an individual's health, access to services, quality and
144.33 outcomes, and patient satisfaction;

144.34 (3) encourage patient-centered care and services, including active participation by
144.35 the patient and family or a legal guardian, or a health care agent as defined in chapter

145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of ~~clinical~~ professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care and wellness plans for their patients with complex or chronic conditions, including an assessment of health risks ~~and~~ chronic conditions, and socioeconomic factors affecting health and treatment;

(6) enable and encourage utilization of a range of qualified health care professionals and other professionals or services related to the health and treatment of the patient, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience, with appropriate adjustments for socioeconomic factors;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment and service options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Sec. 43. Minnesota Statutes 2010, section 256B.0751, subdivision 3, is amended to read:

Subd. 3. Requirements for clinicians certified as health care homes. (a) A personal clinician ~~or~~ a primary care clinic, or community mental health center eligible for payment under section 256B.0625, subdivision 5, may be certified as a health care home.

146.1 If a primary care clinic or mental health center is certified, all of the primary care clinic's
146.2 or mental health center's clinicians who may provide care to persons enrolled with the
146.3 health care home must meet the criteria of a health care home. In order to be certified as
146.4 a health care home, a clinician ~~or~~ clinic, or community mental health center must meet
146.5 the standards set by the commissioners in accordance with this section. Certification as
146.6 a health care home is voluntary. In order to maintain their status as health care homes,
146.7 clinicians or clinics must renew their certification annually.

146.8 (b) Clinicians ~~or~~ clinics, or mental health centers certified as health care homes must
146.9 offer their health care home services to all their patients with complex or chronic health
146.10 conditions who are interested in participation.

146.11 (c) Health care homes must participate in the health care home collaborative
146.12 established under subdivision 5.

146.13 Sec. 44. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to
146.14 read:

146.15 Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this
146.16 section shall preclude the continued development of existing medical or health care
146.17 home projects currently operating or under development by the commissioner of human
146.18 services or preclude the commissioner from establishing alternative models and payment
146.19 mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs
146.20 under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term
146.21 care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and
146.22 medical assistance, are in the waiting period for Medicare, or who have other primary
146.23 coverage.

146.24 (b) The commissioner of health shall modify the health care homes application for
146.25 certification to add an item allowing an applicant to indicate status as a federally qualified
146.26 health center or a federally qualified health center look-alike, as defined in section
146.27 145.9269, subdivision 1. The commissioner shall certify as a health care home each
146.28 applicant that indicates this status on a completed application for certification, without
146.29 requiring the applicant to meet the standards in Minnesota Rules, part 4764.0040. In order
146.30 to retain certification, a federally qualified health center or federally qualified health center
146.31 look-alike certified under this paragraph must seek annual recertification by submitting a
146.32 letter of intent stating its desire to be recertified but is not required to meet the standards
146.33 for recertification in Minnesota Rules, part 4764.0040.

146.34 (c) The commissioner of health shall waive health care home certification
146.35 requirements if an applicant demonstrates that compliance with a certification requirement

147.1 will create a major financial hardship or is not feasible, and the applicant establishes an
147.2 alternative way to accomplish the objectives of the certification requirement.

147.3 Sec. 45. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
147.4 subdivision to read:

147.5 Subd. 8. **Coordination with local services.** The health care home and the county
147.6 shall coordinate care and services provided to patients enrolled with a health care home
147.7 who have complex medical or socioeconomic needs or a disability, and who need and are
147.8 eligible for additional local services administered by counties, including but not limited
147.9 to waived services, mental health services, social services, public health services,
147.10 transportation, and housing. The coordination of care and services must be as provided in
147.11 the plan established by the patient and health care home.

147.12 Sec. 46. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
147.13 subdivision to read:

147.14 Subd. 9. **Patient choice of health care home.** Notwithstanding section 256B.69,
147.15 subdivisions 4 and 23, and subject to any necessary federal approval, the commissioner
147.16 may require a patient enrolled in a state health care program through a managed care
147.17 plan, county-based purchasing plan, fee-for-service, or demonstration project under
147.18 section 256B.0755 to select a health care home and agree to receive primary care and
147.19 care coordination services through the health care home as a condition of enrollment in
147.20 the state health care program. The patient must be allowed to choose from among all
147.21 available qualified health care providers, including an essential community provider as
147.22 defined in section 62Q.19, if the provider is certified as a health care home and agrees to
147.23 accept the terms, conditions, and payment rates for participation in the managed care plan,
147.24 county-based purchasing plan, fee-for-service program, or demonstration project, except
147.25 that reimbursement to federally qualified health centers and federally qualified health
147.26 center look-alikes as defined in section 145.9269 must comply with federal law.

147.27 Sec. 47. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
147.28 subdivision to read:

147.29 Subd. 10. **Engagement of patients and communities in health care home.** The
147.30 commissioner of health shall require health care homes to demonstrate that their health
147.31 care home patients, and the racial and ethnic communities of current or potential patients,
147.32 participate in evaluating the health care home and recommending improvements and
147.33 changes to the health care home's methods and procedures in order to improve health,

148.1 quality, and patient satisfaction for patients from those communities. The commissioner
148.2 shall consult with racial and ethnic communities to determine whether the requirements of
148.3 this section and rules adopted under it are barriers to effective health care home methods
148.4 and procedures for serving patients of racial and ethnic communities.

148.5 Sec. 48. Minnesota Statutes 2010, section 256B.0753, is amended by adding a
148.6 subdivision to read:

148.7 Subd. 4. **Waiver recipients.** A health care home shall receive the highest care
148.8 coordination payment established under section 256B.0753 for providing services to an
148.9 enrollee receiving home and community-based waiver services.

148.10 Sec. 49. Minnesota Statutes 2010, section 256B.0754, is amended by adding a
148.11 subdivision to read:

148.12 Subd. 3. **Primary care provider tiering.** (a) The commissioner shall establish
148.13 a tiering system for all providers participating in Minnesota health care programs.
148.14 The tiering system must differentiate providers on the basis of their ability to provide
148.15 cost-effective, quality care and must incorporate the provider peer grouping measures
148.16 established under section 62U.04. The tier assignments must be established annually based
148.17 on the most recent peer grouping measures available. Differentiation of tier assignments
148.18 must be statistically valid. The commissioner may set specific quality standards for
148.19 providers designated as high-performing providers under this subdivision.

148.20 (b) The commissioner may adjust the rates paid to providers within each tier group
148.21 established under paragraph (a) on an annual basis. Adjustments to rates shall not include
148.22 the rate paid for care coordination services to certified health care homes under section
148.23 256B.0753. Providers designated high-performing providers under paragraph (c) are not
148.24 eligible for rate increases unless the provider also meets the cost and quality criteria
148.25 associated with that tier level.

148.26 (c) Health care homes certified under section 256B.0751, rural health clinics, and
148.27 federally qualified health care clinics are designated as high-performing providers under
148.28 this subdivision.

148.29 (d) Providers reimbursed on a cost basis are subject to rate adjustments under this
148.30 section.

148.31 (e) The commissioner may phase in the tiering system by service type.

148.32 **EFFECTIVE DATE.** This section is effective one year from the public release of
148.33 provider peer grouping measures under Minnesota Statutes, section 62U.04, or upon
148.34 federal approval, whichever is later.

149.1 Sec. 50. Minnesota Statutes 2010, section 256B.0755, subdivision 4, is amended to
149.2 read:

149.3 Subd. 4. **Payment system.** (a) In developing a payment system for health care
149.4 delivery systems, the commissioner shall establish a total cost of care benchmark or a
149.5 risk/gain sharing payment model to be paid for services provided to the recipients enrolled
149.6 in a health care delivery system.

149.7 (b) The payment system may include incentive payments to health care delivery
149.8 systems that meet or exceed annual quality and performance targets realized through
149.9 the coordination of care.

149.10 (c) An amount equal to the savings realized to the general fund as a result of the
149.11 demonstration project shall be transferred each fiscal year to the health care access fund.

149.12 (d) The total cost of care benchmark for demonstration projects must be no
149.13 greater than the capitation rate that would have been paid to a managed care plan for a
149.14 substantially similar enrollee population based on the per-member per-month rate in
149.15 effect on December 31, 2010. The commissioner shall adjust benchmark payment rates
149.16 for demonstration projects as necessary to reflect the higher level of service and cost
149.17 necessary to serve a patient population with a higher incidence of socioeconomic barriers
149.18 and complexity, and shall make corresponding reductions in payment rates for projects
149.19 with a lower concentration of patients with socioeconomic barriers and complexity.

149.20 Sec. 51. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
149.21 subdivision to read:

149.22 Subd. 8. **Coordination with local services.** The health care home and the county
149.23 shall coordinate care and services provided to patients enrolled in a demonstration project
149.24 who have complex medical or socioeconomic needs or a disability, and who need and are
149.25 eligible for additional local services administered by counties, including but not limited
149.26 to waived services, mental health services, social services, public health services,
149.27 transportation, or housing. The coordination of care and services must be as provided in
149.28 the plan established by the patient and primary care provider or health care home.

149.29 Sec. 52. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
149.30 subdivision to read:

149.31 Subd. 9. **Rural demonstration projects.** For demonstration projects serving
149.32 rural areas, the commissioner shall consult with rural hospitals, primary care providers,
149.33 county boards, health plans, and other key stakeholders primarily domiciled in the
149.34 service area regarding the development and approval of alternative rural health care

150.1 delivery demonstration projects under this section. In addition to organizations eligible
150.2 to establish a demonstration project under subdivision 1, a rural demonstration project
150.3 may be established by a county public health or social services agency or a county-based
150.4 purchasing plan. In a rural area where multiple, competing provider-based demonstration
150.5 projects are not possible, the commissioner shall not approve more than one demonstration
150.6 project to serve the primary geographic area and shall follow the applicable procedures
150.7 and requirements in section 256B.692 regarding participation of county boards in
150.8 reviewing and approving demonstration project proposals.

150.9 Sec. 53. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
150.10 subdivision to read:

150.11 Subd. 10. **Patient choice of qualified provider.** The commissioner shall implement
150.12 and approve demonstration projects in a manner that allows a patient to choose a primary
150.13 care provider and health care home from among all available qualified options. The
150.14 commissioner may require the patient to remain with the chosen provider, health care
150.15 home, or demonstration project organization for a period of time determined by the
150.16 commissioner. The commissioner shall implement the demonstration projects in a manner
150.17 that ensures that a patient has the option of receiving services, including health care home
150.18 services, through a provider designated as an essential community provider under section
150.19 62Q.19. Demonstration projects and essential community providers must comply with
150.20 section 62Q.19, subdivisions 3 to 7, for purposes of participation of providers in the
150.21 demonstration project, except that reimbursement to federally qualified health centers
150.22 and federally qualified health center look-alikes as defined in section 145.9269 must be
150.23 in compliance with federal law.

150.24 Sec. 54. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
150.25 subdivision to read:

150.26 Subd. 11. **Patient and community engagement.** As a condition of approval of
150.27 a demonstration project, the commissioner shall require the applicant to demonstrate
150.28 that consumers and communities to be served under the project were consulted with and
150.29 engaged in the process of developing the project proposal. The proposal must identify the
150.30 needs and preferences of consumers and communities that were identified through this
150.31 process of consultation and engagement. The consumers and communities consulted with
150.32 and engaged in the development of the proposal must generally reflect the demographics,
150.33 race, and ethnicity of those likely to be served under the demonstration project, with a
150.34 special focus on those who experience the greatest health disparities. The commissioner

151.1 shall require that demonstration project providers continue to consult with and engage
151.2 consumers and communities during implementation and operation of the demonstration
151.3 project.

151.4 Sec. 55. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
151.5 subdivision to read:

151.6 Subd. 12. **Care coordination system.** The commissioner of human services, in
151.7 consultation with the commissioner of health, shall convene an advisory committee of
151.8 small, independent, rural, and safety net primary care clinics, community hospitals,
151.9 mental health centers, dental clinics, and other providers to advise the commissioner
151.10 on the establishment of a system that will allow providers participating in payment
151.11 reform demonstration projects established under this section and section 256B.0756 to
151.12 effectively coordinate and deliver care to patients. In consultation with the advisory
151.13 committee, the commissioner shall develop a plan for the care coordination system, issue a
151.14 request for proposals, and contract with a vendor or vendors to establish and maintain the
151.15 technology for the care coordination system. Using appropriations made for this purpose,
151.16 the commissioner shall fund the planning, development, and establishment of the system.
151.17 Ongoing costs must be covered by payments made by the providers who use the system.

151.18 Sec. 56. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
151.19 subdivision to read:

151.20 Subd. 13. **Approval and implementation.** Beginning January 1, 2012, the
151.21 commissioner of human services shall approve payment reform projects authorized under
151.22 this section for medical assistance and MinnesotaCare. The commissioner may approve
151.23 projects for persons enrolled in fee-for-service programs and may require managed care
151.24 plans and county-based purchasing plans to contract with a demonstration project provider
151.25 on the same terms, conditions, and payment arrangements as are established by the
151.26 commissioner for fee-for-service programs.

151.27 Sec. 57. Minnesota Statutes 2010, section 256B.0756, is amended to read:

151.28 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

151.29 (a) The commissioner, upon federal approval of a new waiver request or amendment
151.30 of an existing demonstration, may establish a pilot program in Hennepin County or
151.31 Ramsey County, or both, to test alternative and innovative integrated health care delivery
151.32 networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

(h) A demonstration project established under this section must meet the requirements of section 256B.0755, subdivisions 8, 9, 10, and 11.

Sec. 58. [256B.0758] PREGNANCY CARE HOMES.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Pregnancy care home" means a health care home certified by the commissioner of health under section 256B.0751 that provides pregnancy care services in a way that is patient-centered, outcome-driven, comprehensive, and coordinated, and meets the standards specified and developed under subdivision 3.

(c) "Pregnancy care services" means prenatal care, consultative perinatal services, intrapartum and postpartum care, and well-baby care for the first week.

(d) "State health care program" means the medical assistance and MinnesotaCare programs.

Subd. 2. Development and implementation of standards. (a) The commissioners of human services and health shall develop and implement standards of certification of pregnancy care homes for state health care programs. In developing standards, the commissioners shall consult with representatives of the American College of Nurse Midwives, the American Congress of OB/GYN, the American Academy of Family Practice, the American Academy of Pediatrics, and relevant local consumer groups.

Subd. 3. Criteria for development of standards. (a) A pregnancy care home must meet the general health care home standards developed by the commissioners under section 256B.0751, subdivision 2, paragraph (a), clauses (1) to (4), (6), and (8) to (10), and must also meet specific standards for pregnancy care homes. The specific standards for pregnancy care homes developed by the commissioners must meet the criteria specified in this subdivision.

(b) A pregnancy care home must provide pregnancy care services. Nonpregnancy complications, such as preexisting illness, shall be covered by medical assistance outside of the pregnancy care home. During a pregnancy episode, the pregnancy care home must coordinate necessary nonpregnancy health care services with the mother's primary care provider or another appropriate provider.

(c) Each pregnancy care home must have adequate malpractice insurance that meets the standards specified by the commissioners.

(d) A pregnancy care home may provide pregnancy services through any health care professional licensed to provide the service in Minnesota, including but not limited to licensed traditional midwives, certified nurse midwives, family practitioners, obstetricians, perinatologists, neonatologists, and other advanced practice registered nurses.

(e) Pregnancy care within a pregnancy care home may be provided at any Minnesota facility licensed to provide pregnancy care and birth, including but not limited to freestanding birth centers, integrated birth centers, and hospitals. Each pregnancy care home must offer the option of midwife-directed pregnancy care services in a licensed integrated or freestanding birth center.

(f) A pregnancy care home must have a governing board comprised of at least eight members. One-half of the governing board members must be providers licensed to attend births.

(g) Each pregnancy care home must have a formal consultative relationship with at least one level III perinatal center to provide care for mothers and babies who develop pregnancy complications.

(h) Each pregnancy care home must comply with state and federal requirements for the use of interoperable electronic medical records.

(i) Each pregnancy care home must submit annual reports to the commissioners of human services and health that document:

(1) all relevant pregnancy care outcomes and patient satisfaction measures; and

(2) the financial status of the pregnancy care home.

All reports are public data under section 13.02.

(j) Each pregnancy care home must offer culturally competent care coordination services in a manner that is consistent with health care home requirements.

(k) For the purposes of developing and implementing the standards in this subdivision, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 4. **Certification process.** Providers seeking certification as a pregnancy care home must apply to the commissioner of health. Providers certified by the commissioner of health may provide pregnancy care services through pregnancy care homes beginning July 1, 2012. Certification as a pregnancy care home is voluntary, except that beginning July 1, 2014, all nonemergency pregnancy care services covered under state health care programs must be provided through providers certified as pregnancy care homes.

Subd. 5. **Payments to pregnancy care homes.** (a) The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides a single per-person payment to pregnancy care homes to cover all pregnancy care services provided to each mother and infant enrolled in a state health care program. Pregnancy care homes receiving payments under this subdivision remain eligible for care coordination payments under section 256B.0753.

(b) Payment amounts for pregnancy care homes shall be uniform statewide and determined annually by the commissioner, based initially upon a specified percentage of the calculated average cost of care for mothers and infants under state health care programs for the three most recent fiscal years for which cost information is available. Beginning July 1, 2014, statewide payment amounts for pregnancy care homes shall be determined annually by the commissioner by adjusting the current payment amount by a measure of medical inflation selected by the commissioner that best represents the change in the cost of pregnancy-related services provided to patients covered by private sector health coverage.

(c) Pregnancy care home payments must initially be made for pregnancy care services provided to pregnant women who are not high risk, beginning July 1, 2012. Beginning January 1, 2013, the commissioner shall phase in higher payments for high-risk pregnancy categories so that beginning July 1, 2014, pregnancy care services for all low-risk and high-risk pregnancies are reimbursed under this subdivision.

Sec. 59. [256B.0759] CARE COORDINATION FOR ENROLLEES.

Subdivision 1. **Qualified enrollee.** For purposes of this section, a "qualified enrollee" means: (1) a medical assistance enrollee eligible under this chapter; or (2) a MinnesotaCare enrollee eligible under chapter 256L.

Subd. 2. **Selection of primary care provider.** The commissioner shall require qualified enrollees who do not have a designated medical condition to select a primary care provider and agree to receive primary care services from that provider as a condition of medical assistance or MinnesotaCare enrollment.

Subd. 3. **Selection of health care home; care coordination.** (a) The commissioner shall require qualified enrollees who have a medical condition designated by the commissioner to select a health care home certified under section 256B.0751 and agree to receive primary care and care coordination services through that health care home as a condition of medical assistance or MinnesotaCare enrollment. For purposes of this subdivision, the commissioner shall designate medical conditions with a high likelihood of inappropriate inpatient hospital admissions for which care coordination and prior authorization of admissions are expected to improve the quality of care and lead to costs savings for state health care programs.

(b) The commissioner shall include on Minnesota health care program enrollment cards a designation as to whether an enrollee meets the criteria in paragraph (a). In order to receive medical assistance or MinnesotaCare payment for nonemergency inpatient hospital admissions for enrollees meeting the criteria in paragraph (a), a hospital must receive prior authorization from the enrollee's health care home.

EFFECTIVE DATE. This section is effective January 1, 2012, for MinnesotaCare enrollees not eligible for a federal match, and is effective January 1, 2012, or upon federal approval, whichever is later, for medical assistance enrollees and for MinnesotaCare enrollees eligible for a federal match.

Sec. 60. [256B.0760] ELECTIVE SURGERY.

Subdivision 1. **Payment prohibition.** The commissioner, in consultation with health care providers, health care homes certified under section 256B.0751, managed

156.1 care plans providing services under section 256B.69, and county-based purchasing plans
156.2 providing services under section 256B.692, shall identify elective or nonemergency
156.3 surgical procedures for which less invasive and less costly alternative treatment methods
156.4 are available, and shall prohibit payment for these elective or nonemergency surgical
156.5 procedures if the alternative treatment methods have not first been evaluated for use
156.6 and, if appropriate, provided to the enrollee.

156.7 Subd. 2. **Implementation.** The commissioner shall implement the payment
156.8 prohibitions in paragraph (a) for fee-for-service medical assistance providers by January
156.9 1, 2012, and shall require managed care and county-based purchasing plans to implement
156.10 the payment prohibitions in paragraph (a) for providers employed or under contract for
156.11 services provided to medical assistance and MinnesotaCare enrollees beginning January
156.12 1, 2012.

156.13 Subd. 3. **Reduction in capitation rates.** The commissioner shall reduce medical
156.14 assistance and MinnesotaCare capitation rates to managed care and county-based
156.15 purchasing plans beginning January 1, 2012, to reflect cost-savings to plans resulting from
156.16 implementation of the payment prohibitions required by this subdivision.

156.17 Sec. 61. Minnesota Statutes 2010, section 256B.37, subdivision 5, is amended to read:

156.18 Subd. 5. **Private benefits to be used first.** Private accident and health care
156.19 coverage, including Medicare for medical services and coverage provided through the
156.20 United States Department of Veterans Affairs, is primary coverage and must be exhausted
156.21 before medical assistance or alternative care services are paid for medical services
156.22 including home health care, personal care assistance services, hospice, supplies and
156.23 equipment, or services covered under a Centers for Medicare and Medicaid Services
156.24 waiver. When a person who is otherwise eligible for medical assistance has private
156.25 accident or health care coverage, including Medicare or a prepaid health plan or coverage
156.26 provided through the United States Department of Veterans Affairs, the private health care
156.27 benefits available to the person must be used first and to the fullest extent.

156.28 Sec. 62. Minnesota Statutes 2010, section 256B.69, subdivision 3a, is amended to read:

156.29 Subd. 3a. **County authority.** (a) The commissioner, when implementing or
156.30 administering the medical assistance prepayment program within a county, must include
156.31 the county board in the process of development, approval, and issuance of the request for
156.32 proposals to provide services to eligible individuals within the proposed county, including
156.33 proposals for demonstration projects established under section 256B.0755. County boards
156.34 must be given reasonable opportunity to ~~make recommendations regarding~~ assist in

157.1 the development, issuance, review of responses, and changes needed in the request for
157.2 proposals. The commissioner must provide county boards the opportunity to review
157.3 each proposal based on the identification of community needs under chapters 145A and
157.4 256E and county advocacy activities. If a county board finds that a proposal does not
157.5 address certain community needs, the county board and commissioner shall continue
157.6 efforts for improving the proposal and network prior to the approval of the contract.
157.7 The county board shall make ~~recommendations~~ determinations regarding the approval
157.8 of local networks and their operations to ensure adequate local availability and access to
157.9 covered services. The provider or health plan must respond directly to county advocates
157.10 and the state prepaid medical assistance ombudsperson regarding service delivery and
157.11 must be accountable to the state regarding contracts with medical assistance funds. The
157.12 county board ~~may recommend~~ shall decide a maximum number of participating health
157.13 plans including county-based purchasing plans after considering the size of the enrolling
157.14 population; ensuring adequate access and capacity; considering the client and county
157.15 administrative complexity; and considering the need to promote the viability of locally
157.16 developed health plans, managed care plans, or demonstration projects established under
157.17 section 256B.0755. The county board or a single entity representing a group of county
157.18 boards and the commissioner shall mutually select one or more qualified health plans or
157.19 county-based purchasing plans for participation at the time of initial implementation of the
157.20 prepaid medical assistance program or a demonstration project established under section
157.21 256B.0755 in that county or group of counties and at the time of contract renewal. The
157.22 commissioner shall also seek input for contract requirements from the county or single
157.23 entity representing a group of county boards at each contract renewal and incorporate
157.24 those recommendations into the contract negotiation process.

157.25 (b) At the option of the county board, the board may develop contract requirements
157.26 related to the achievement of local public health goals and health care delivery and access
157.27 goals to meet the health needs of medical assistance enrollees. These requirements must
157.28 be reasonably related to the performance of health plan managed care or delivery system
157.29 demonstration project functions and within the scope of the medical assistance benefit
157.30 set. ~~If the county board and the commissioner mutually agree to such requirements, the~~
157.31 ~~department~~ The commissioner shall include such requirements in all ~~health plan~~
157.32 governing the prepaid medical assistance program in that county at initial implementation
157.33 of the program or demonstration project in that county and at the time of contract renewal.
157.34 The county board may participate in the enforcement of the contract ~~provisions related to~~
157.35 ~~local public health goals~~.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a ~~preliminary and final~~ proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans or demonstration projects under section 256B.0755 in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes ~~after taking into account~~ by approving the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract procurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation

159.1 for any decisions of the commissioner not to accept the recommendations of a county or
159.2 group of counties required to be consulted under this section. The report must be provided
159.3 at least 30 days prior to the effective date of a new or renewed prepaid or managed care
159.4 contract in a county.

159.5 (i) This section also applies to other Minnesota health care programs administered
159.6 by the commissioner, including but not limited to the MinnesotaCare program.

159.7 Sec. 63. Minnesota Statutes 2010, section 256B.69, subdivision 4, is amended to read:

159.8 Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to
159.9 determine when limitation of choice may be implemented in the experimental counties.
159.10 The criteria shall ensure that all eligible individuals in the county have continuing access
159.11 to the full range of medical assistance services as specified in subdivision 6.

159.12 (b) The commissioner shall exempt the following persons from participation in the
159.13 project, in addition to those who do not meet the criteria for limitation of choice:

159.14 (1) persons eligible for medical assistance according to section 256B.055,
159.15 subdivision 1;

159.16 (2) persons eligible for medical assistance due to blindness or disability as
159.17 determined by the Social Security Administration or the state medical review team, unless:

159.18 (i) they are 65 years of age or older; or

159.19 (ii) they reside in Itasca County or they reside in a county in which the commissioner
159.20 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social
159.21 Security Act;

159.22 (3) recipients who currently have private coverage through a health maintenance
159.23 organization;

159.24 (4) recipients who are eligible for medical assistance by spending down excess
159.25 income for medical expenses other than the nursing facility per diem expense;

159.26 (5) recipients who receive benefits under the Refugee Assistance Program,
159.27 established under United States Code, title 8, section 1522(e);

159.28 (6) children who are both determined to be severely emotionally disturbed and
159.29 receiving case management services according to section 256B.0625, subdivision 20,
159.30 except children who are eligible for and who decline enrollment in an approved preferred
159.31 integrated network under section 245.4682;

159.32 (7) adults who are both determined to be seriously and persistently mentally ill and
159.33 received case management services according to section 256B.0625, subdivision 20;

159.34 (8) persons eligible for medical assistance according to section 256B.057,
159.35 subdivision 10; and

160.1 (9) persons with access to cost-effective employer-sponsored private health
160.2 insurance or persons enrolled in a non-Medicare individual health plan determined to be
160.3 cost-effective according to section 256B.0625, subdivision 15.

160.4 Children under age 21 who are in foster placement may enroll in the project on an elective
160.5 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an
160.6 elective basis. The commissioner may enroll recipients in the prepaid medical assistance
160.7 program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by
160.8 spending down excess income.

160.9 (c) The commissioner may allow persons with a one-month spenddown who are
160.10 otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay
160.11 their monthly spenddown to the state.

160.12 (d) The commissioner may require those individuals to enroll in the prepaid medical
160.13 assistance program who otherwise would have been excluded under paragraph (b), clauses
160.14 (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

160.15 (e) Before limitation of choice is implemented, eligible individuals shall be notified
160.16 and after notification, shall be allowed to choose only among demonstration providers.
160.17 The commissioner may assign an individual with private coverage through a health
160.18 maintenance organization, to the same health maintenance organization for medical
160.19 assistance coverage, if the health maintenance organization is under contract for medical
160.20 assistance in the individual's county of residence. After initially choosing a provider,
160.21 the recipient is allowed to change that choice only at specified times as allowed by the
160.22 commissioner. If a demonstration provider ends participation in the project for any reason,
160.23 a recipient enrolled with that provider must select a new provider but may change providers
160.24 without cause once more within the first 60 days after enrollment with the second provider.

160.25 (f) An infant born to a woman who is eligible for and receiving medical assistance
160.26 and who is enrolled in the prepaid medical assistance program shall be retroactively
160.27 enrolled to the month of birth in the same managed care plan as the mother once the
160.28 child is enrolled in medical assistance unless the child is determined to be excluded from
160.29 enrollment in a prepaid plan under this section.

160.30 (g) For an eligible individual under the age of 65, in the absence of a specific
160.31 managed care plan choice by the individual, the commissioner shall assign the individual to
160.32 the county-based purchasing plan, if any, in the county of the individual's residence. For an
160.33 eligible individual over the age of 65, the commissioner shall make the default assignment
160.34 on the county-based purchasing plan entering into a contract with the commissioner to
160.35 serve this population and receiving federal approval as a special needs plan.

Sec. 64. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no

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

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

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

(g) Effective for services rendered on or after January 1, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold in this paragraph does not apply to county-based purchasing plans.

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization rates or subsequent hospitalizations within 30 days of a previous

163.1 hospitalization of a patient regardless of the reason for the hospitalization for state health
163.2 care program enrollees by a measurable rate of five percent from the plan's utilization rate
163.3 for state health care program enrollees for the previous calendar year.

163.4 The withheld funds must be returned no sooner than July 1 and no later than July 31
163.5 of the following calendar year if the managed care plan or county-based purchasing plan
163.6 demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization
163.7 rate was achieved.

163.8 The withhold described in this paragraph must continue for each consecutive
163.9 contract period until the plan's subsequent hospitalization rate for state health care
163.10 program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate
163.11 for state health care program enrollees for calendar year 2010. Hospitals shall cooperate
163.12 with the plans in meeting this performance target and shall accept payment withholds that
163.13 must be returned to the hospitals if the performance target is achieved. The commissioner
163.14 shall structure the withhold so that the commissioner returns a portion of the withheld
163.15 funds in amounts commensurate with achieved reductions in utilization less than the
163.16 targeted amount.

163.17 ~~(h)~~ (i) Effective for services rendered on or after January 1, 2011, through December
163.18 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments
163.19 under this section and county-based purchasing plan payments under section 256B.692
163.20 for the prepaid medical assistance program. The withheld funds must be returned no
163.21 sooner than July 1 and no later than July 31 of the following year. The commissioner may
163.22 exclude special demonstration projects under subdivision 23.

163.23 ~~(i)~~ (j) Effective for services rendered on or after January 1, 2012, through December
163.24 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
163.25 under this section and county-based purchasing plan payments under section 256B.692
163.26 for the prepaid medical assistance program. The withheld funds must be returned no
163.27 sooner than July 1 and no later than July 31 of the following year. The commissioner may
163.28 exclude special demonstration projects under subdivision 23.

163.29 ~~(j)~~ (k) Effective for services rendered on or after January 1, 2013, through December
163.30 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
163.31 under this section and county-based purchasing plan payments under section 256B.692
163.32 for the prepaid medical assistance program. The withheld funds must be returned no
163.33 sooner than July 1 and no later than July 31 of the following year. The commissioner may
163.34 exclude special demonstration projects under subdivision 23.

163.35 ~~(k)~~ (l) Effective for services rendered on or after January 1, 2014, the commissioner
163.36 shall withhold three percent of managed care plan payments under this section and

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

164.5 ~~(h)~~ (m) A managed care plan or a county-based purchasing plan under section
164.6 256B.692 may include as admitted assets under section 62D.044 any amount withheld
164.7 under this section that is reasonably expected to be returned.

164.8 ~~(m)~~ (n) Contracts between the commissioner and a prepaid health plan are exempt
164.9 from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
164.10 (a), and 7.

164.11 ~~(n)~~ (o) The return of the withhold under paragraphs (d), (f), and (h) to (k) is not
164.12 subject to the requirements of paragraph (c).

164.13 Sec. 65. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

164.14 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
164.15 services shall transfer each year to the medical education and research fund established
164.16 under section 62J.692, the following:

164.17 (1) an amount equal to the reduction in the prepaid medical assistance payments as
164.18 specified in this clause. Until January 1, 2002, the county medical assistance capitation
164.19 base rate prior to plan specific adjustments and after the regional rate adjustments under
164.20 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
164.21 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
164.22 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
164.23 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
164.24 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
164.25 facility and elderly waiver payments and demonstration project payments operating
164.26 under subdivision 23 are excluded from this reduction. The amount calculated under
164.27 this clause shall not be adjusted for periods already paid due to subsequent changes to
164.28 the capitation payments;

164.29 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
164.30 section;

164.31 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
164.32 paid under this section; and

164.33 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
164.34 under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. Effective July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts otherwise required to be transferred under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the transfers under paragraph (a), clause (1).

(c) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall transfer \$21,714,000 each fiscal year to the medical education and research fund. The balance of the transfers under paragraph (a) shall be transferred to the medical education and research fund no earlier than July 1 of the following fiscal year.

(d) Beginning in fiscal year 2012, the commissioner shall reduce the amount transferred to the medical education research fund under paragraph (a), by \$6,404,000 each fiscal year. This reduction must be applied to the amount available for general distribution under section 62J.692, subdivision 7, clause (5).

Sec. 66. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration

provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) A demonstration provider must accept into its medical assistance and MinnesotaCare provider networks any health care or social service provider that agrees to accept payment, quality assurance, and other contract terms that the demonstration provider applies to other similarly situated providers in its provider network.

EFFECTIVE DATE. This section is effective January 1, 2012, and applies to provider contracts that take effect on or after that date.

Sec. 67. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Provider payment rates.** (a) Each managed care and county-based plan shall, by October 1, 2011, array all providers within each provider type, employed by or under contract with the plan, by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for the most recent reporting year for which data is available, risk-adjusted for enrollee demographics and health status.

(b) Beginning January 1, 2012, and each contract year thereafter, each managed care and county-based purchasing plan shall implement a progressive payment withhold methodology for each provider type, under which the withhold for a provider increases proportionally as the provider's risk-adjusted total annual cost increases, relative to other providers of the same type. For purposes of this paragraph, the risk-adjusted total annual cost of care is the dollar amount calculated under paragraph (a).

(c) At the end of each contract year, each plan shall array all providers within each provider type by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for that contract year, risk-adjusted for enrollee demographics and health status. For each provider whose risk-adjusted total annual cost of care is at or below a benchmark percentile established by the plan, the plan shall return the full amount of any withhold. For each provider whose risk-adjusted total annual cost of care is above the benchmark percentile, the plan shall return only the portion of the withhold sufficient to bring the provider's payment rate to the average for providers within the provider type whose risk-adjusted total annual cost of care is at the benchmark percentile. Each plan shall establish the benchmark percentile at a level that allows the plan to adjust expenditures for provider payments to reflect the reduction in capitation rates under paragraph (f).

(d) Each managed care and county-based purchasing plan must establish an appeals process to allow providers to appeal determinations of risk-adjusted total annual cost of care. Each plan's appeals process must be approved by the commissioner.

(e) The commissioner shall require each plan to submit to the commissioner, in the form and manner specified by the commissioner, all provider payment data and information on the withhold methodology that the commissioner determines is necessary to verify compliance with this subdivision.

(f) The commissioner, for the contract year beginning January 1, 2012, shall reduce plan capitation rates by 12 percent from the rates that would otherwise apply, absent application of this subdivision. The reduced rate shall be the historical base rate for negotiating capitation rates for future contract years. The commissioner may recommend additional reductions in capitation rates for future contract years to the legislature, if the commissioner determines this is necessary to ensure that health care providers under contract with managed care and county-based purchasing plans practice in an efficient manner.

(g) The commissioner of human services, in consultation with the commissioner of health, shall develop and provide to managed care and county-based purchasing plans, by September 1, 2011, standard criteria and definitions necessary for consistent calculation of the total annual risk-adjusted cost of care across plans. The commissioner may use encounter data collected under section 62U.04 to implement this subdivision, and may provide encounter data or analyses to plans. Section 62U.04, subdivision 4, paragraph (b), shall not apply to the commissioners of health and human services for purposes of this subdivision.

(h) For purposes of this subdivision, "provider" means a vendor of medical care as defined in section 256B.02, subdivision 7, for which sufficient encounter data on utilization and costs is available to implement this subdivision.

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

Sec. 68. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 31. Initiatives to reduce incidence of low birth weight. The commissioner shall require managed care and county-based purchasing plans as a condition of contract to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight, with special emphasis on areas within a one-mile radius of hospitals within their provider networks. These strategies may focus on smoking prevention and cessation, ensuring that pregnant women get adequate nutrition, and addressing demographic, social, and environmental risk factors. The strategies must coordinate health care with social services and the local public health system, and offer patient education through

168.1 appropriate means. The commissioner shall require plans to submit proposed initiatives
168.2 for approval to the commissioner by January 1, 2012, and the commissioner shall require
168.3 plans to implement approved initiatives by July 1, 2012. The commissioner shall evaluate
168.4 the strategies adopted to reduce low birth weight and shall require plans to submit outcome
168.5 and other data necessary for the evaluation.

168.6 Sec. 69. Minnesota Statutes 2010, section 256B.69, is amended by adding a
168.7 subdivision to read:

168.8 Subd. 32. **Health education.** The commissioner shall require managed care and
168.9 county-based purchasing plans, as a condition of contract, to provide health education,
168.10 wellness training, and information about the availability and benefits of preventive
168.11 services to all medical assistance and MinnesotaCare enrollees, beginning January 1,
168.12 2012. Plan initiatives developed or implemented to comply with this requirement must be
168.13 approved by the commissioner.

168.14 Sec. 70. Minnesota Statutes 2010, section 256B.692, subdivision 2, is amended to read:

168.15 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and
168.16 62N, a county that elects to purchase medical assistance in return for a fixed sum without
168.17 regard to the frequency or extent of services furnished to any particular enrollee is not
168.18 required to obtain a certificate of authority under chapter 62D or 62N. The county board
168.19 of commissioners is the governing body of a county-based purchasing program. In a
168.20 multicounty arrangement, the governing body is a joint powers board established under
168.21 section 471.59.

168.22 (b) A county that elects to purchase medical assistance services under this section
168.23 must satisfy the commissioner of health that the requirements for assurance of consumer
168.24 protection, provider protection, and, effective January 1, 2010, fiscal solvency of chapter
168.25 62D, applicable to health maintenance organizations will be met according to the
168.26 following schedule:

168.27 (1) for a county-based purchasing plan approved on or before June 30, 2008, the
168.28 plan must have in reserve:

168.29 (i) at least 50 percent of the minimum amount required under chapter 62D as
168.30 of January 1, 2010;

168.31 (ii) at least 75 percent of the minimum amount required under chapter 62D as of
168.32 January 1, 2011;

168.33 (iii) at least 87.5 percent of the minimum amount required under chapter 62D as
168.34 of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. Notwithstanding this paragraph and paragraph (b), a county-based purchasing plan may satisfy its fiscal solvency requirements by obtaining written financial guarantees from participating counties in amounts equivalent to the minimum amounts that would otherwise apply.

A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F;

(2) an annual fee of \$21,500, to be paid by June 15 of each calendar year, beginning in calendar year 2009; and

(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 71. Minnesota Statutes 2010, section 256B.692, subdivision 5, is amended to read:

Subd. 5. County proposals. (a) On or before September 1, 1997, a county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department on or before July 1, 1997. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal on or before July 1, 1998, that demonstrates the ability to meet all the requirements of this section, including beginning enrollment on January 1, 1999, unless a delay has been granted under section 256B.69, subdivision 3a, paragraph (g).

(c) After January 1, 1999, for a county in which the prepaid medical assistance program is in existence, the county board must submit a ~~preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal that meets the requirements of this section~~ six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

(d) The commissioner is not required to terminate contracts for the prepaid medical assistance program that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance program.

Sec. 72. Minnesota Statutes 2010, section 256B.692, subdivision 7, is amended to read:

Subd. 7. Dispute resolution. In the event the commissioner rejects a proposal under subdivision 6, the county board may request the ~~recommendation~~ decision of a

171.1 three-person mediation panel. The commissioner shall resolve all disputes ~~after taking~~
171.2 ~~into account~~ by following the recommendations decision of the mediation panel. The
171.3 panel shall be composed of one designee of the president of the Association of Minnesota
171.4 Counties, one designee of the commissioner of human services, and one person selected
171.5 jointly by the designee of the commissioner of human services and the designee of
171.6 the Association of Minnesota Counties. Within a reasonable period of time before the
171.7 hearing, the panelists must be provided all documents and information relevant to the
171.8 mediation. The parties to the mediation must be given 30 days' notice of a hearing before
171.9 the mediation panel.

171.10 Sec. 73. Minnesota Statutes 2010, section 256B.692, is amended by adding a
171.11 subdivision to read:

171.12 Subd. 11. **Patient choice of qualified provider.** Effective January 1, 2012, a county
171.13 board operating a county-based purchasing plan must ensure that each enrollee has the
171.14 option of choosing a primary care provider or a health care home from all qualified
171.15 providers who agree to accept the terms, conditions, and payment rates offered by the
171.16 plan to similarly situated providers. Notwithstanding this requirement, reimbursement
171.17 to federally qualified health centers and federally qualified health center look-alikes as
171.18 defined in section 145.9269 must be in compliance with federal law.

171.19 Sec. 74. Minnesota Statutes 2010, section 256B.694, is amended to read:

171.20 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
171.21 **CONTRACT.**

171.22 (a) Notwithstanding section 256B.692, subdivision 6, clause (1), paragraph (c),
171.23 the commissioner of human services shall approve a county-based purchasing health
171.24 plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena
171.25 Counties, that requires county-based purchasing on a single-plan basis contract if the
171.26 implementation of the single-plan purchasing proposal does not limit an enrollee's
171.27 provider choice or access to services and all other requirements applicable to health plan
171.28 purchasing are satisfied. The commissioner shall continue to use single-health plan,
171.29 county-based purchasing arrangements for medical assistance and general assistance
171.30 medical care programs and products for the counties that were in single-health plan,
171.31 county-based purchasing arrangements on March 1, 2008. This paragraph does not require
171.32 the commissioner to terminate an existing contract with a noncounty-based purchasing
171.33 plan that had enrollment in a medical assistance program or product in these counties on
171.34 March 1, 2008. This paragraph expires on December 31, 2010, or the effective date

of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled procurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) At the request of a county or group of counties, the commissioner shall ~~consider, and may approve,~~ contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll,~~ enrolled in Minnesota health care programs in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in section 256B.69, subdivision 23, are satisfied. Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

Sec. 75. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

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

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

(5) a dental clinic ~~associated with an oral health or dental education program~~ owned and operated by the University of Minnesota or ~~an institution within~~ the Minnesota State Colleges and Universities system.

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

(d) Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 76. **[256B.7671] PATIENT-CENTERED DECISION-MAKING.**

(a) For purposes of this section, "patient-centered decision-making process" means a process that involves directed interaction with the patient to assist the patient in arriving at an informed objective health care decision regarding the surgical procedure that is both informed and consistent with the patient's preference and values. The interaction may be conducted by a health care provider or through the electronic use of decision aids. If decision aids are used in the process, the aids must meet the criteria established by the International Patients Decision Aids Standards Collaboration or the Cochrane Decision Aid Registry.

(b) Effective January 1, 2012, the commissioner of human services shall require active participation in a patient-centered decision-making process before authorization is approved or payment reimbursement is provided for any of the following:

(1) a surgical procedure for abnormal uterine bleeding, benign prostate enlargement, chronic back pain, early stage of breast and prostate cancers, gastroesophageal reflux disease, hemorrhoids, spinal stenosis, temporomandibular joint dysfunction, ulcerative colitis, urinary incontinence, uterine fibroids, or varicose veins; and

(2) bypass surgery for coronary disease, angioplasty for stable coronary artery disease, or total hip replacement.

(c) A list of the procedures in paragraph (b) shall be published in the State Register by October 1, 2011. The list shall be reviewed no less than every two years by the commissioner, in consultation with the commissioner of health. The commissioner shall hold a public forum and receive public comment prior to any changes to the list in paragraph (b). Any changes made shall be published in the State Register.

(d) Prior to receiving authorization or reimbursement for the procedures identified under this section, a health care provider must certify that the patient has participated in a patient-centered decision-making process. The format for this certification and the process for coordination between providers shall be developed by the Health Services Policy Committee under section 256B.0625, subdivision 3c.

(e) This section does not apply if any of the procedures identified in this section are performed under an emergency situation.

Sec. 77. **[256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE DEMONSTRATION PROJECT.**

Subdivision 1. Establishment and implementation. The commissioner of human services, in consultation with the commissioner of health, shall contract with a Minnesota-based academic and research institution specializing in providing complementary and alternative medicine education and clinical services to establish and implement a five-year demonstration project in conjunction with federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269, to improve the quality and cost-effectiveness of care provided under medical assistance to enrollees with neck and back problems. The demonstration project must maximize the use of complementary and alternative medicine-oriented primary care providers, including but not limited to physicians and chiropractors. The demonstration project must be designed to significantly improve physical and mental health for enrollees who present with neck and back problems while decreasing medical treatment costs. The commissioner, in consultation with the commissioner of health, shall deliver services through the demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

Subd. 2. RFP and project criteria. The commissioner, in consultation with the commissioner of health, shall develop and issue a request for proposal (RFP) for the demonstration project. The RFP must require the academic and research institution selected to demonstrate a proven track record over at least five years of conducting

high-quality, federally funded clinical research. The institution and the federally qualified health centers and federally qualified health center look-alikes shall also:

(1) provide patient education, provider education, and enrollment training components on health and lifestyle issues in order to promote enrollee responsibility for health care decisions, enhance productivity, prepare enrollees to reenter the workforce, and reduce future health care expenditures;

(2) use high-quality and cost-effective integrated disease management that includes the best practices of traditional and complementary and alternative medicine;

(3) incorporate holistic medical care, appropriate nutrition, exercise, medications, and conflict resolution techniques;

(4) include a provider education component that makes use of professional organizations representing chiropractors, nurses, and other primary care providers and provides appropriate educational materials and activities in order to improve the integration of traditional medical care with licensed chiropractic services and other alternative health care services and achieve program enrollment objectives; and

(5) provide to the commissioner the information and data necessary for the commissioner to prepare the annual reports required under subdivision 6.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the commissioner from current enrollees in the prepaid medical assistance program who have, or are determined to be at significant risk of developing, neck and back problems. Participation in the demonstration project shall be voluntary. The commissioner shall seek to enroll, over the term of the demonstration project, ten percent of current and future medical assistance enrollees who have, or are determined to be at significant risk of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic and research institution selected, federally qualified health centers, and federally qualified health center look-alikes to fund all net costs of the demonstration project.

Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner of health, beginning December 15, 2011, and each December 15 thereafter through December 15, 2015, shall report annually to the legislature on the functional and mental improvements of the populations served by the demonstration project, patient satisfaction, and the cost-effectiveness of the program. The reports must also include data on hospital admissions, days in hospital, rates of outpatient surgery and other services, and drug

176.1 utilization. The report, due December 15, 2015, must include recommendations on
176.2 whether the demonstration project should be continued and expanded.

176.3 Sec. 78. **[256B.841] WAIVER APPLICATION AND PROCESS.**

176.4 Subdivision 1. **Intent.** It is the intent of the legislature that medical assistance be:

176.5 (1) a sustainable, cost-effective, person-centered, and opportunity-driven program
176.6 utilizing competitive and value-based purchasing to maximize available service options;
176.7 and

176.8 (2) a results-oriented system of coordinated care that focuses on independence
176.9 and choice, promotes accountability and transparency, encourages and rewards healthy
176.10 outcomes and responsible choices, and promotes efficiency.

176.11 Subd. 2. **Waiver application.** (a) By September 1, 2011, the commissioner of
176.12 human services shall apply for a waiver and any necessary state plan amendments from
176.13 the secretary of the United States Department of Health and Human Services, including,
176.14 but not limited to, a waiver of the appropriate sections of title XIX of the federal Social
176.15 Security Act, United States Code, title 42, section 1396 et seq., or other provisions of
176.16 federal law that provide program flexibility and under which Minnesota will operate all
176.17 facets of the state's medical assistance program.

176.18 (b) The commissioner of human services shall provide the legislative committees
176.19 with jurisdiction over health and human services finance and policy with the waiver
176.20 application and financial and other related materials, at least ten days prior to submitting
176.21 the application and materials to the federal Centers for Medicare and Medicaid Services.

176.22 (c) If the state's waiver application is approved, the commissioner of human services
176.23 shall:

176.24 (1) notify the chairs of the legislative committees with jurisdiction over health and
176.25 human services finance and policy and allow the legislative committees with jurisdiction
176.26 over health and human services finance and policy to review the terms of the waiver; and

176.27 (2) not implement the waiver until ten legislative days have passed following
176.28 notification of the chairs.

176.29 Subd. 3. **Rulemaking; legislative proposals.** Upon acceptance of the terms of the
176.30 waiver, the commissioner of human services shall:

176.31 (1) adopt rules to implement the waiver; and

176.32 (2) propose any legislative changes necessary to implement the terms of the waiver.

176.33 Subd. 4. **Joint commission on waiver implementation.** (a) After acceptance
176.34 of the terms of the waiver, the governor shall establish a joint commission on waiver
176.35 implementation. The commission shall consist of eight members; four of whom shall

be members of the senate, not more than three from the same political party, to be appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration, and four of whom shall be members of the house of representatives, not more than three from the same political party, to be appointed by the speaker of the house.

(b) The commission shall:

(1) oversee implementation of the waiver;

(2) confer as necessary with state agency commissioners;

(3) make recommendations on services covered under the medical assistance program;

(4) monitor and make recommendations on quality and access to care under the global waiver; and

(5) make recommendations for the efficient and cost-effective administration of the medical assistance program under the terms of the waiver.

Sec. 79. [256B.842] PRINCIPLES AND GOALS FOR MEDICAL ASSISTANCE REFORM.

Subdivision 1. **Goals for reform.** In developing the waiver application and implementing the waiver, the commissioner of human services shall ensure that the reformed medical assistance program is a person-centered, financially sustainable, and cost-effective program.

Subd. 2. **Reformed medical assistance criteria.** The reformed medical assistance program established through the waiver must:

(1) empower consumers to make informed and cost-effective choices about their health and offer consumers rewards for healthy decisions;

(2) ensure adequate access to needed services;

(3) enable consumers to receive individualized health care that is outcome-oriented and focused on prevention, disease management, recovery, and maintaining independence;

(4) promote competition between health care providers to ensure best value purchasing, leverage resources, and to create opportunities for improving service quality and performance;

(5) redesign purchasing and payment methods and encourage and reward high-quality and cost-effective care by incorporating and expanding upon current payment reform and quality of care initiatives, including but not limited to those initiatives authorized under chapter 62U; and

178.1 (6) continually improve technology to take advantage of recent innovations and
178.2 advances that help decision makers, consumers, and providers make informed and
178.3 cost-effective decisions regarding health care.

178.4 Subd. 3. **Annual report.** The commissioner of human services shall annually
178.5 submit a report to the governor and the legislature, beginning December 1, 2012, and each
178.6 December 1 thereafter, describing the status of the administration and implementation
178.7 of the waiver.

178.8 Sec. 80. **[256B.843] WAIVER APPLICATION REQUIREMENTS.**

178.9 Subdivision 1. **Requirements for waiver request.** The commissioner shall seek
178.10 federal approval to:

178.11 (1) enter into a five-year agreement with the United States Department of Health and
178.12 Human Services and Centers for Medicaid and Medicare Services (CMS) under section
178.13 1115a to waive provisions of title XIX of the federal Social Security Act, United States
178.14 Code, title 42, section 1396 et seq., requiring:

178.15 (i) statewideness to allow for the provision of different services in different areas or
178.16 regions of the state;

178.17 (ii) comparability of services to allow for the provision of different services to
178.18 members of the same or different coverage groups;

178.19 (iii) no prohibitions restricting the amount, duration, and scope of services included
178.20 in the medical assistance state plan;

178.21 (iv) no prohibitions limiting freedom of choice of providers; and

178.22 (v) retroactive payment for medical assistance, at the state's discretion;

178.23 (2) waive the applicable provisions of title XIX of the federal Social Security Act,
178.24 United States Code, title 42, section 1396 et seq., in order to:

178.25 (i) expand cost sharing requirements above the five percent of income threshold for
178.26 beneficiaries in certain populations;

178.27 (ii) establish health savings or power accounts that encourage and reward
178.28 beneficiaries who reach certain prevention and wellness targets; and

178.29 (iii) implement a tiered set of parameters to use as the basis for determining
178.30 long-term service care and setting needs;

178.31 (3) modify income and resource rules in a manner consistent with the goals of the
178.32 reformed program;

178.33 (4) provide enrollees with a choice of appropriate private sector health coverage
178.34 options, with full federal financial participation;

(5) treat payments made toward the cost of care as a monthly premium for beneficiaries receiving home and community-based services when applicable;

(6) provide health coverage and services to individuals over the age of 65 that are limited in scope and are available only in the home and community-based setting;

(7) consolidate all home and community-based services currently provided under title XIX of the federal Social Security Act, United States Code, title 42, section 1915(c), into a single program of home and community-based services that include options for consumer direction and shared living;

(8) expand disease management, care coordination, and wellness programs for all medical assistance recipients; and

(9) empower and encourage able-bodied medical assistance recipients to work, whenever possible.

Subd. 2. **Agency coordination.** The commissioner shall establish an intraagency assessment and coordination unit to ensure that decision making and program planning for recipients who may need long-term care, residential placement, and community support services are coordinated. The assessment and coordination unit shall determine level of care, develop service plans and a service budget, make referrals to appropriate settings, provide education and choice counseling to consumers and providers, track utilization, and monitor outcomes.

Sec. 81. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the ~~12-month~~ six-month period of eligibility.

Sec. 82. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for children in families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for children in families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

EFFECTIVE DATE. This section is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 83. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment

of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Sec. 84. Minnesota Statutes 2010, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, ~~or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant,~~ is subject to an annual limit of \$10,000.

182.1 (b) Admissions for inpatient hospital services paid for under section 256L.11,
182.2 subdivision 3, must be certified as medically necessary in accordance with Minnesota
182.3 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

182.4 (1) all admissions must be certified, except those authorized under rules established
182.5 under section 254A.03, subdivision 3, or approved under Medicare; and

182.6 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
182.7 for admissions for which certification is requested more than 30 days after the day of
182.8 admission. The hospital may not seek payment from the enrollee for the amount of the
182.9 payment reduction under this clause.

182.10 **EFFECTIVE DATE.** This section is effective January 1, 2012, or upon federal
182.11 approval, whichever is later, and expires June 30, 2013. The commissioner shall notify
182.12 the revisor of statutes when federal approval is obtained and publish a notice in the State
182.13 Register.

182.14 Sec. 85. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

182.15 Subd. 5. ~~Co-payments and coinsurance~~ **Cost-sharing.** (a) Except as provided in
182.16 paragraphs (b) ~~and~~ (c), ~~and (h),~~ the MinnesotaCare benefit plan shall include the following
182.17 ~~co-payments and coinsurance~~ cost-sharing requirements for all enrollees:

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

182.20 (2) \$3 per prescription for adult enrollees;

182.21 (3) \$25 for eyeglasses for adult enrollees;

182.22 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
182.23 episode of service which is required because of a recipient's symptoms, diagnosis, or
182.24 established illness, and which is delivered in an ambulatory setting by a physician or
182.25 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
182.26 audiologist, optician, or optometrist; ~~and~~

182.27 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
182.28 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

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

182.31 (b) Paragraph (a), clause (1), ~~does~~ and paragraph (e) do not apply to parents and
182.32 relative caretakers of children under the age of 21.

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

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

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

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

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

(h) Effective January 1, 2012, the following co-payments for nonpreventive visits shall apply to enrollees who are adults without children eligible under section 256L.04, subdivision 7:

(1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same type;

(2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county-based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph using a methodology that has been approved by the commissioner.

EFFECTIVE DATE. The amendments to paragraph (e) are effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 86. [256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. Defined contributions to enrollees. (a) Beginning January 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with gross family income equal to or greater than 133 percent

184.1 of the federal poverty guidelines, with a monthly defined contribution to purchase health
184.2 coverage under a health plan as defined in section 62A.011, subdivision 3. Beginning
184.3 January 1, 2012, or upon federal approval, whichever is later, the commissioner shall
184.4 provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 1, with
184.5 gross family income equal to or greater than 133 percent of the federal poverty guidelines,
184.6 with a monthly defined contribution to purchase health coverage under a health plan as
184.7 defined in section 62A.011, subdivision 3, offered by a health plan company as defined
184.8 in section 62Q.01, subdivision 4.

184.9 (b) Enrollees eligible under paragraph (a) shall not be charged premiums under
184.10 section 256L.15 and are exempt from the managed care enrollment requirement of section
184.11 256L.12.

184.12 (c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to
184.13 enrollees eligible under paragraph (a). Covered services, cost-sharing, disenrollment
184.14 for nonpayment of premium, enrollee appeal rights and complaint procedures, and the
184.15 effective date of coverage for enrollees eligible under paragraph (a) shall be as provided
184.16 under the terms of the health plan purchased by the enrollee.

184.17 (d) Unless otherwise provided in this section, all MinnesotaCare requirements
184.18 related to eligibility, income and asset methodology, income reporting, and program
184.19 administration continue to apply to enrollees obtaining coverage under this section.

184.20 Subd. 2. **Use of defined contribution.** An enrollee may use up to the monthly
184.21 defined contribution to pay premiums for coverage under a health plan as defined in
184.22 section 62A.011, subdivision 3.

184.23 Subd. 3. **Determination of defined contribution amount.** (a) The commissioner
184.24 shall determine the defined contribution sliding scale using the base contribution specified
184.25 in paragraph (b) for the specified age ranges. The commissioner shall use a sliding scale
184.26 for defined contributions that provides:

184.27 (1) persons with household incomes equal to 133 percent of the federal poverty
184.28 guidelines with a defined contribution of 150 percent of the base contribution;

184.29 (2) persons with household incomes equal to 175 percent of the federal poverty
184.30 guidelines with a defined contribution of 100 percent of the base contribution;

184.31 (3) persons with household incomes equal to or greater than 250 percent of
184.32 the federal poverty guidelines with a defined contribution of 80 percent of the base
184.33 contribution; and

184.34 (4) persons with household incomes in evenly spaced increments between the
184.35 percentages of the federal poverty guideline specified in clauses (1) to (3) with a base

contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) to (3).

<u>Age</u>	<u>Monthly Per-Person Base Contribution</u>
<u>Under 21</u>	<u>\$122.79</u>
<u>21-29</u>	<u>122.79</u>
<u>30-31</u>	<u>129.19</u>
<u>32-33</u>	<u>132.38</u>
<u>34-35</u>	<u>134.31</u>
<u>36-37</u>	<u>136.06</u>
<u>38-39</u>	<u>141.02</u>
<u>40-41</u>	<u>151.25</u>
<u>42-43</u>	<u>159.89</u>
<u>44-45</u>	<u>175.08</u>
<u>46-47</u>	<u>191.71</u>
<u>48-49</u>	<u>213.13</u>
<u>50-51</u>	<u>239.51</u>
<u>52-53</u>	<u>266.69</u>
<u>54-55</u>	<u>293.88</u>
<u>56-57</u>	<u>323.77</u>
<u>58-59</u>	<u>341.20</u>
<u>60+</u>	<u>357.19</u>

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

(c) Notwithstanding paragraphs (a) and (b), the monthly defined contribution shall not exceed 90 percent of the monthly premium for the health plan purchased by the enrollee. If the enrollee purchases coverage under a health plan that does not include mental health services and chemical dependency treatment services, the monthly defined contribution amount determined under this subdivision shall be reduced by five percent.

Subd. 4. **Administration by commissioner.** The commissioner shall administer the defined contributions. The commissioner shall:

- (1) calculate and process defined contributions for enrollees; and
- (2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning January 1, 2012, MinnesotaCare enrollees who are denied coverage under an individual health plan by a health plan company are eligible for coverage through a health plan offered by the MCHA and may enroll in MCHA according to section 62E.14. Any difference between the revenue and covered losses to the MCHA related to implementation of this section shall be paid to the MCHA from the health care access fund.

Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers and approvals necessary to implement coverage under this section for MinnesotaCare enrollees eligible under section 256L.04, subdivision 1, with gross family incomes equal to or greater than 133 percent of the federal poverty guidelines, while continuing to receive federal matching funds.

Sec. 87. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) ~~Families with~~ Children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size and adults in families with children with family income equal to or less than 200 percent of the federal poverty guidelines for the applicable family size, shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2010, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.

~~(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.~~

(f) [Reserved.]

187.1 **EFFECTIVE DATE.** This section is effective January 1, 2012, or upon federal
187.2 approval, whichever is later, and expires June 30, 2013, except that the amendment
187.3 striking paragraph (e) is effective retroactively from October 1, 2008, does not expire,
187.4 and federal approval is no longer necessary. The commissioner shall notify the revisor of
187.5 statutes when federal approval is obtained and publish a notice in the State Register.

187.6 Sec. 88. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

187.7 Subd. 7. **Single adults and households with no children.** (a) The definition of
187.8 eligible persons includes all individuals and households with no children who have gross
187.9 family incomes that are equal to or less than 200 percent of the federal poverty guidelines.
187.10 ~~(b) Effective July 1, 2009, the definition of eligible persons includes all individuals~~
187.11 ~~and households with no children who have gross family incomes that are equal to or less~~
187.12 ~~than 250 percent of the federal poverty guidelines.~~

187.13 **EFFECTIVE DATE.** This section is effective January 1, 2012, and expires June
187.14 30, 2013.

187.15 Sec. 89. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

187.16 Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall
187.17 use electronic verification as the primary method of income verification. If there is a
187.18 discrepancy between reported income and electronically verified income, an individual
187.19 may be required to submit additional verification. In addition, the commissioner shall
187.20 perform random audits to verify reported income and eligibility. The commissioner
187.21 may execute data sharing arrangements with the Department of Revenue and any other
187.22 governmental agency in order to perform income verification related to eligibility and
187.23 premium payment under the MinnesotaCare program.

187.24 (b) In determining eligibility for MinnesotaCare, the commissioner shall require
187.25 applicants and enrollees seeking renewal of eligibility to verify both earned and unearned
187.26 income. The commissioner shall also require applicants and enrollees to submit the
187.27 names of their employers and a contact name with a phone number for each employer
187.28 for purposes of verifying whether the applicant or enrollee, and any dependents, are
187.29 eligible for employer-subsidized coverage. Data collected is nonpublic data as defined
187.30 in section 13.02, subdivision 9.

187.31 Sec. 90. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, ~~2007~~ 2011, an enrollee's eligibility must be renewed every ~~12~~ six months. ~~The 12-month period begins in the month after the month the application is approved.~~

(b) The first six-month period of eligibility begins the month the application is received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

Sec. 91. Minnesota Statutes 2010, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program ~~whose gross family income is equal to or more than 225 percent of the federal poverty guidelines~~; and (2) single adults and households without children enrolled in the MinnesotaCare program ~~whose gross family income is equal to or more than 165 percent of the federal poverty guidelines~~. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

EFFECTIVE DATE. This section is effective January 1, 2012, and expires June 30, 2013.

189.1 Sec. 92. Minnesota Statutes 2010, section 256L.05, is amended by adding a subdivision
189.2 to read:

189.3 Subd. 6. Referral of veterans. The commissioner shall ensure that all applicants
189.4 for MinnesotaCare with incomes less than 133 percent of the federal poverty guidelines
189.5 who identify themselves as veterans are referred to a county veterans service officer for
189.6 assistance in applying to the United States Department of Veterans Affairs for any veterans
189.7 benefits for which they may be eligible.

189.8 Sec. 93. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

189.9 Subdivision 1. **General requirements.** (a) Children enrolled in the original
189.10 children's health plan as of September 30, 1992, children who enrolled in the
189.11 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
189.12 article 4, section 17, and children who have family gross incomes that are equal to or
189.13 less than 150 percent of the federal poverty guidelines are eligible without meeting
189.14 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
189.15 long as they maintain continuous coverage in the MinnesotaCare program or medical
189.16 assistance. Children who apply for MinnesotaCare on or after the implementation date
189.17 of the employer-subsidized health coverage program as described in Laws 1998, chapter
189.18 407, article 5, section 45, who have family gross incomes that are equal to or less than 150
189.19 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to
189.20 be eligible for MinnesotaCare.

189.21 (b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose
189.22 income increases above 275 percent of the federal poverty guidelines, are no longer
189.23 eligible for the program and shall be disenrolled by the commissioner. ~~Beginning January~~
189.24 ~~1, 2008,~~

189.25 (c) Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7,
189.26 whose income increases above ~~200 percent of the federal poverty guidelines or 250~~
189.27 ~~percent of the federal poverty guidelines on or after July 1, 2009,~~ the limits described
189.28 in section 256L.04, subdivision 7, are no longer eligible for the program and shall be
189.29 disenrolled by the commissioner.

189.30 (d) For persons disenrolled under this subdivision, MinnesotaCare coverage
189.31 terminates the last day of the calendar month following the month in which the
189.32 commissioner determines that the income of a family or individual exceeds program
189.33 income limits.

189.34 ~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in
189.35 MinnesotaCare if ten percent of their gross individual or gross family income as defined

in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month policy with a \$500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(e)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for MinnesotaCare if gross household income exceeds ~~\$57,500 for the 12-month~~ \$25,000 for the six-month period of eligibility.

EFFECTIVE DATE. This section is effective January 1, 2012, and expires June 30, 2013, except the amendments to the new paragraphs (e) and (f) are effective July 1, 2011, and do not expire.

Sec. 94. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275 percent of the federal poverty guidelines~~ the limits described in section 256L.04, subdivision 1, are no longer eligible for the program and shall be disenrolled by the commissioner.

(c) Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner.

(d) For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the

191.1 commissioner determines that the income of a family or individual exceeds program
191.2 income limits.

191.3 ~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in
191.4 MinnesotaCare if ten percent of their gross individual or gross family income as defined in
191.5 section 256L.01, subdivision 4, is less than the annual premium for a policy with a \$500
191.6 deductible available through the Minnesota Comprehensive Health Association. Children
191.7 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month
191.8 notice period from the date that ineligibility is determined before disenrollment. The
191.9 premium for children remaining eligible under this clause shall be the maximum premium
191.10 determined under section 256L.15, subdivision 2, paragraph (b).

191.11 ~~(e)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for
191.12 MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period
191.13 of eligibility.

191.14 **EFFECTIVE DATE.** The amendment in paragraph (b) is effective January 1, 2012,
191.15 or upon federal approval whichever is later, and expires June 30, 2013. The commissioner
191.16 shall notify the revisor of statutes when federal approval is obtained and publish a notice
191.17 in the State Register.

191.18 Sec. 95. Minnesota Statutes 2010, section 256L.09, subdivision 4, is amended to read:

191.19 Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a
191.20 permanent Minnesota resident is a person who has demonstrated, through persuasive and
191.21 objective evidence, that the person is domiciled in the state and intends to live in the
191.22 state permanently.

191.23 (b) To be eligible as a permanent resident, an applicant must demonstrate the
191.24 requisite intent to live in the state permanently by:

191.25 (1) showing that the applicant maintains a residence at a verified address other than a
191.26 place of public accommodation, unless the place of public accommodation is the person's
191.27 primary or only residence, through the use of evidence of residence described in section
191.28 256D.02, subdivision 12a, paragraph (b), clause ~~(2)~~ (1);

191.29 (2) demonstrating that the applicant has been continuously domiciled in the state for
191.30 no less than 180 days immediately before the application; and

191.31 (3) signing an affidavit declaring that (A) the applicant currently resides in the state
191.32 and intends to reside in the state permanently; and (B) the applicant did not come to the
191.33 state for the primary purpose of obtaining medical coverage or treatment.

191.34 (c) A person who is temporarily absent from the state does not lose eligibility for
191.35 MinnesotaCare. "Temporarily absent from the state" means the person is out of the state

192.1 for a temporary purpose and intends to return when the purpose of the absence has been
192.2 accomplished. A person is not temporarily absent from the state if another state has
192.3 determined that the person is a resident for any purpose. If temporarily absent from the
192.4 state, the person must follow the requirements of the health plan in which the person is
192.5 enrolled to receive services.

192.6 Sec. 96. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

192.7 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
192.8 MinnesotaCare enrollees on or after ~~January 1, 2007~~, July 1, 2011, the commissioner shall
192.9 increase payment rates to dentists and dental clinics deemed by the commissioner to be
192.10 critical access providers under section 256B.76, subdivision 4, by ~~50~~ 30 percent above
192.11 the payment rate that would otherwise be paid to the provider. The commissioner shall
192.12 pay the prepaid health plans under contract with the commissioner amounts sufficient to
192.13 reflect this rate increase. The prepaid health plan must pass this rate increase to providers
192.14 who have been identified by the commissioner as critical access dental providers under
192.15 section 256B.76, subdivision 4.

192.16 Sec. 97. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

192.21 (b) For services rendered on or after January 1, 2004, the commissioner shall
192.22 withhold five percent of managed care plan payments and county-based purchasing
192.23 plan payments under this section pending completion of performance targets. Each
192.24 performance target must be quantifiable, objective, measurable, and reasonably attainable,
192.25 except in the case of a performance target based on a federal or state law or rule. Criteria
192.26 for assessment of each performance target must be outlined in writing prior to the
192.27 contract effective date. The managed care plan must demonstrate, to the commissioner's
192.28 satisfaction, that the data submitted regarding attainment of the performance target is
192.29 accurate. The commissioner shall periodically change the administrative measures used
192.30 as performance targets in order to improve plan performance across a broader range of
192.31 administrative services. The performance targets must include measurement of plan
192.32 efforts to contain spending on health care services and administrative activities. The
192.33 commissioner may adopt plan-specific performance targets that take into account factors
192.34 affecting only one plan, such as characteristics of the plan's enrollee population. The

193.1 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
193.2 following calendar year if performance targets in the contract are achieved.

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

193.8 (d) Effective for services rendered on or after January 1, 2011, the commissioner
193.9 shall include as part of the performance targets described in paragraph (b) a reduction in
193.10 the plan's emergency room utilization rate for state health care program enrollees by a
193.11 measurable rate of five percent from the plan's utilization rate for the previous calendar
193.12 year.

193.13 The withheld funds must be returned no sooner than July 1 and no later than July 31
193.14 of the following calendar year if the managed care plan demonstrates to the satisfaction of
193.15 the commissioner that a reduction in the utilization rate was achieved.

193.16 The withhold described in this paragraph shall continue for each consecutive
193.17 contract period until the plan's emergency room utilization rate for state health care
193.18 program enrollees is reduced by 25 percent of the plan's emergency room utilization rate
193.19 for state health care program enrollees for calendar year 2009. Hospitals shall cooperate
193.20 with the health plans in meeting this performance target and shall accept payment
193.21 withholds that may be returned to the hospitals if the performance target is achieved. The
193.22 commissioner shall structure the withhold so that the commissioner returns a portion of
193.23 the withheld funds in amounts commensurate with achieved reductions in utilization less
193.24 than the targeted amount. The withhold described in this paragraph does not apply to
193.25 county-based purchasing plans.

193.26 (e) Effective for services provided on or after January 1, 2012, the commissioner
193.27 shall include as part of the performance targets described in paragraph (b) a reduction in
193.28 the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous
193.29 hospitalization of a patient regardless of the reason for the hospitalization for state health
193.30 care program enrollees by a measurable rate of five percent from the plan's hospitalization
193.31 rate for the previous calendar year.

193.32 The withheld funds must be returned no sooner than July 1 and no later than July 31
193.33 of the following calendar year if the managed care plan or county-based purchasing plan
193.34 demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization
193.35 rate was achieved.

194.1 The withhold described in this paragraph must continue for each consecutive
194.2 contract period until the plan's subsequent hospitalization rate for state health care
194.3 program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate
194.4 for state health care program enrollees for calendar year 2010. Hospitals shall cooperate
194.5 with the plans in meeting this performance target and shall accept payment withholds that
194.6 must be returned to the hospitals if the performance target is achieved. The commissioner
194.7 shall structure the withhold so that the commissioner returns a portion of the withheld
194.8 funds in amounts commensurate with achieved reductions in utilizations less than the
194.9 targeted amount. The withhold described in this paragraph does not apply to county-based
194.10 purchasing plans.

194.11 ~~(e)~~ (f) A managed care plan or a county-based purchasing plan under section
194.12 256B.692 may include as admitted assets under section 62D.044 any amount withheld
194.13 under this section that is reasonably expected to be returned.

194.14 Sec. 98. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

194.15 Subd. 1a. **Payment options.** The commissioner may offer the following payment
194.16 options to an enrollee:

- 194.17 (1) payment by check;
194.18 (2) payment by credit card;
194.19 (3) payment by recurring automatic checking withdrawal;
194.20 (4) payment by onetime electronic transfer of funds;
194.21 (5) payment by wage withholding with the consent of the employer and the
194.22 employee; or
194.23 (6) payment by using state tax refund payments.

194.24 The commissioner shall include information about the payment options on each
194.25 premium notice. At application or reapplication, a MinnesotaCare applicant or enrollee
194.26 may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to
194.27 collect funds from the applicant's or enrollee's refund for the purposes of meeting all or
194.28 part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or
194.29 enrollee may authorize the commissioner to apply for the state working family tax credit
194.30 on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be
194.31 subject to the \$10 fee under section 270A.07, subdivision 1.

194.32 Sec. 99. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to
194.33 read:

194.34 Subd. 5. **Basic Health Care Grants**

195.1	(a) MinnesotaCare Grants		
195.2	Health Care Access	-0-	(770,000)
195.3	Incentive Program and Outreach Grants.		
195.4	Of the appropriation for the Minnesota health		
195.5	care outreach program in Laws 2007, chapter		
195.6	147, article 19, section 3, subdivision 7,		
195.7	paragraph (b):		
195.8	(1) \$400,000 in fiscal year 2009 from the		
195.9	general fund and \$200,000 in fiscal year 2009		
195.10	from the health care access fund are for the		
195.11	incentive program under Minnesota Statutes,		
195.12	section 256.962, subdivision 5. For the		
195.13	biennium beginning July 1, 2009, base level		
195.14	funding for this activity shall be \$360,000		
195.15	from the general fund and \$160,000 from the		
195.16	health care access fund; and		
195.17	(2) \$100,000 in fiscal year 2009 from the		
195.18	general fund and \$50,000 in fiscal year 2009		
195.19	from the health care access fund are for the		
195.20	outreach grants under Minnesota Statutes,		
195.21	section 256.962, subdivision 2. For the		
195.22	biennium beginning July 1, 2009, base level		
195.23	funding for this activity shall be \$90,000		
195.24	from the general fund and \$40,000 from the		
195.25	health care access fund.		
195.26	(b) MA Basic Health Care Grants - Families		
195.27	and Children	-0-	(17,280,000)
195.28	Third-Party Liability. (a) During		
195.29	fiscal year 2009, the commissioner shall		
195.30	employ a contractor paid on a percentage		
195.31	basis to improve third-party collections.		
195.32	Improvement initiatives may include, but not		
195.33	be limited to, efforts to improve postpayment		
195.34	collection from nonresponsive claims and		

196.1 efforts to uncover third-party payers the
196.2 commissioner has been unable to identify.

196.3 (b) In fiscal year 2009, the first \$1,098,000
196.4 of recoveries, after contract payments and
196.5 federal repayments, is appropriated to
196.6 the commissioner for technology-related
196.7 expenses.

196.8 **Administrative Costs.** (a) For contracts
196.9 effective on or after January 1, 2009,
196.10 the commissioner shall limit aggregate
196.11 administrative costs paid to managed care
196.12 plans under Minnesota Statutes, section
196.13 256B.69, and to county-based purchasing
196.14 plans under Minnesota Statutes, section
196.15 256B.692, to an overall average of ~~6.6~~ 6.1
196.16 percent of total contract payments under
196.17 Minnesota Statutes, sections 256B.69 and
196.18 256B.692, for each calendar year. For
196.19 purposes of this paragraph, administrative
196.20 costs do not include premium taxes paid
196.21 under Minnesota Statutes, section 297I.05,
196.22 subdivision 5, and provider surcharges paid
196.23 under Minnesota Statutes, section 256.9657,
196.24 subdivision 3.

196.25 (b) Notwithstanding any law to the contrary,
196.26 the commissioner may reduce or eliminate
196.27 administrative requirements to meet the
196.28 administrative target under paragraph (a).

196.29 (c) Notwithstanding any contrary provision
196.30 of this article, this rider shall not expire.

196.31 **Hospital Payment Delay.** Notwithstanding
196.32 Laws 2005, First Special Session chapter 4,
196.33 article 9, section 2, subdivision 6, payments
196.34 from the Medicaid Management Information
196.35 System that would otherwise have been made

197.1 for inpatient hospital services for medical
197.2 assistance enrollees are delayed as follows:
197.3 (1) for fiscal year 2008, June payments must
197.4 be included in the first payments in fiscal
197.5 year 2009; and (2) for fiscal year 2009,
197.6 June payments must be included in the first
197.7 payment of fiscal year 2010. The provisions
197.8 of Minnesota Statutes, section 16A.124,
197.9 do not apply to these delayed payments.
197.10 Notwithstanding any contrary provision in
197.11 this article, this paragraph expires on June
197.12 30, 2010.

197.13	(c) MA Basic Health Care Grants - Elderly and		
197.14	Disabled	(14,028,000)	(9,368,000)

197.15 **Minnesota Disability Health Options Rate**
197.16 **Setting Methodology.** The commissioner
197.17 shall develop and implement a methodology
197.18 for risk adjusting payments for community
197.19 alternatives for disabled individuals (CADI)
197.20 and traumatic brain injury (TBI) home
197.21 and community-based waiver services
197.22 delivered under the Minnesota disability
197.23 health options program (MnDHO) effective
197.24 January 1, 2009. The commissioner shall
197.25 take into account the weighting system used
197.26 to determine county waiver allocations in
197.27 developing the new payment methodology.
197.28 Growth in the number of enrollees receiving
197.29 CADI or TBI waiver payments through
197.30 MnDHO is limited to an increase of 200
197.31 enrollees in each calendar year from January
197.32 2009 through December 2011. If those limits
197.33 are reached, additional members may be
197.34 enrolled in MnDHO for basic care services
197.35 only as defined under Minnesota Statutes,
197.36 section 256B.69, subdivision 28, and the

198.1 commissioner may establish a waiting list for
198.2 future access of MnDHO members to those
198.3 waiver services.

198.4 **MA Basic Elderly and Disabled**

198.5 **Adjustments.** For the fiscal year ending June
198.6 30, 2009, the commissioner may adjust the
198.7 rates for each service affected by rate changes
198.8 under this section in such a manner across
198.9 the fiscal year to achieve the necessary cost
198.10 savings and minimize disruption to service
198.11 providers, notwithstanding the requirements
198.12 of Laws 2007, chapter 147, article 7, section
198.13 71.

198.14 **(d) General Assistance Medical Care Grants** -0- (6,971,000)

198.15 **(e) Other Health Care Grants** -0- (17,000)

198.16 **MinnesotaCare Outreach Grants Special**

198.17 **Revenue Account.** The balance in the
198.18 MinnesotaCare outreach grants special
198.19 revenue account on July 1, 2009, estimated
198.20 to be \$900,000, must be transferred to the
198.21 general fund.

198.22 **Grants Reduction.** Effective July 1, 2008,
198.23 base level funding for nonforecast, general
198.24 fund health care grants issued under this
198.25 paragraph shall be reduced by 1.8 percent at
198.26 the allotment level.

198.27 Sec. 100. **PLAN TO COORDINATE CARE FOR CHILDREN WITH**
198.28 **HIGH-COST MENTAL HEALTH CONDITIONS.**

198.29 The commissioner of human services shall develop and submit to the legislature
198.30 by December 15, 2011, a plan to provide care coordination to medical assistance and
198.31 MinnesotaCare enrollees who are children with high-cost mental health conditions. For
198.32 purposes of this section, a child has a "high-cost mental health condition" if mental health
198.33 and medical expenses over the past year totalled \$100,000 or more. For purposes of this
198.34 section, "care coordination" means collaboration between an advanced practice nurse and

199.1 primary care physicians and specialists to manage care; development of mental health
199.2 management plans for recurrent mental health issues; oversight and coordination of all
199.3 aspects of care in partnership with families; organization of medical, treatment, and
199.4 therapy information into a summary of critical information; coordination and appropriate
199.5 sequencing of evaluations and multiple appointments; information and assistance with
199.6 accessing resources; and telephone triage for behavior or other problems.

199.7 Sec. 101. **DATA ON CLAIMS AND UTILIZATION.**

199.8 The commissioner of human services, in consultation with the Health and Human
199.9 Services Reform Committee, shall develop and provide to the legislature by December 15,
199.10 2011, a methodology and any draft legislation necessary to allow for the release, upon
199.11 request, of summary data as defined in Minnesota Statutes, section 13.02, subdivision 19,
199.12 on claims and utilization for medical assistance, general assistance medical care, and
199.13 MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the
199.14 Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical
199.15 Systems Improvement, and other research institutions to conduct analyses of health care
199.16 outcomes and treatment effectiveness, provided the research institutions do not release
199.17 private or nonpublic data or data for which dissemination is prohibited by law.

199.18 Sec. 102. **REDUCTION OF STATE-MANDATED ADMINISTRATIVE**
199.19 **REPORTS.**

199.20 (a) The commissioner of management and budget shall convene a report reduction
199.21 working group of persons designated by the commissioners of health, human services, and
199.22 commerce to eliminate redundant, unnecessary, obsolete, and low-priority state-mandated
199.23 administrative reports required of health plans and county-based purchasing plans
199.24 that serve persons enrolled in Minnesota health care programs. The commissioner of
199.25 management and budget and the report reduction working group shall develop a plan to
199.26 oversee the report reduction activities of the individual state agencies and coordinate the
199.27 activities of multiple state agencies to consolidate reports or eliminate redundant reports
199.28 required by more than one state agency on the same or a similar topic.

199.29 (b) The commissioners of health, human services, and commerce shall reduce,
199.30 eliminate, or consolidate state-mandated reports according to the plan developed by the
199.31 commissioner of management and budget through the report reduction working group.
199.32 In addition to other report reduction actions the commissioners or the working group
199.33 may undertake, the commissioners shall:

200.1 (1) collect encounter data, including provider payment data if collected, in a
200.2 consolidated report provided to a single state agency, with the data collected by that state
200.3 agency to be shared with other state agencies who need the data;

200.4 (2) collect only one provider network report annually through a single state agency,
200.5 with the data collected by that state agency to be shared with other state agencies who
200.6 need the data;

200.7 (3) collect only one standard financial report through a single state agency, with
200.8 the data collected by that state agency to be shared with other state agencies who need
200.9 the data. Data collected must be of a nature and in a format to allow comparison of the
200.10 cost-effectiveness of fee-for-service payment systems and prepaid programs administered
200.11 by health plans and county-based purchasing plans;

200.12 (4) consolidate and simplify reports and documentation requirements relating to
200.13 member communications and marketing materials, and establish a single review process
200.14 for all programs, products, and agencies in order to ensure uniform and consistent
200.15 regulation of health plan contracts;

200.16 (5) consolidate state regulation and oversight of health plans and county-based
200.17 purchasing plans so that activities of multiple agencies are administered through an
200.18 efficient and uniform multiagency process of oversight and audits, with consistent
200.19 standards, measures, and definitions for state oversight of quality, utilization management,
200.20 care management, delegation accountability, access to care, appeals and grievances, and
200.21 financial management;

200.22 (6) establish uniform requirements and procedures for denial, termination, or
200.23 reduction of services and member appeals and grievances, and align state requirements
200.24 and procedures with federal requirements and procedures; and

200.25 (7) reform the state's performance improvement projects, requirements, and
200.26 procedures to be more flexible and efficient, and to place greater focus on measuring
200.27 improvement of outcomes and less on mandating detailed or prescriptive requirements for
200.28 specific performance improvement projects or activities.

200.29 (d) New reporting requirements or ad hoc report requests shall be established by a
200.30 state agency only:

200.31 (1) if required by a federal agency;

200.32 (2) if needed for a state regulatory audit or corrective action plan; or

200.33 (3) after the completion of a review and analysis, and the development of
200.34 recommendations by the commissioner of management and budget, in consultation
200.35 with the report reduction working group, regarding the necessity, importance, and
200.36 administrative cost of the new report, and after completing a review to determine

201.1 whether the information sought can be obtained through another available state or federal
201.2 report. The results of the review, analysis, and recommendations of the commissioner of
201.3 management and budget must be provided to health plans and county-based purchasing
201.4 plans for review and comment at least 60 days before a new report or requirement is
201.5 established.

201.6 (e) To the extent possible, all state agencies shall use the procedures, reports,
201.7 and audits of the Centers for Medicare and Medicaid Services instead of requiring an
201.8 additional state-mandated report on the same or a similar topic.

201.9 (f) By January 15, 2012, the commissioner of management and budget shall provide
201.10 a report on the activities and results of the report reduction project to the legislature.

201.11 The report must include:

201.12 (1) a timetable for report reduction actions already taken or planned by the
201.13 commissioners or the report reduction working group;

201.14 (2) the specific reports that have been or will be eliminated or consolidated;

201.15 (3) the amount of money that will be saved through reductions in administrative
201.16 costs of health plans and county-based purchasing plans as a result of the report reduction
201.17 project; and

201.18 (4) proposed legislation for changes to laws or rules that are needed to allow state
201.19 agencies to further reduce, consolidate, or eliminate reports when the changes cannot
201.20 be made administratively.

201.21 **Sec. 103. COMPETITIVE BIDDING PILOT.**

201.22 For managed care contracts effective January 1, 2012, the commissioner of
201.23 human services is required to establish a competitive price bidding pilot for nonelderly,
201.24 nondisabled adults and children in medical assistance and MinnesotaCare in the
201.25 seven-county metropolitan area. The pilot must allow a minimum of two managed care
201.26 organizations to serve the metropolitan area. The pilot shall expire after two full calendar
201.27 years on December 31, 2013. The commissioner of human service shall conduct an
201.28 evaluation of the pilot to determine the cost-effectiveness and impacts to provider access at
201.29 the end of the two-year period. The commissioner must consult with other states that have
201.30 experience implementing competitive bidding in their medical assistance population and
201.31 incorporate best practices from those states in designing this pilot. The commissioner, prior
201.32 to implementation, must also consult with stakeholders on the design and implementation
201.33 of the pilot, including providers, plans, advocacy groups, and other interested parties.

201.34 **Sec. 104. REQUEST FOR PROPOSAL; PROVIDER BILLING PATTERNS.**

202.1 (a) The commissioner of human services shall issue a request for proposal, using
202.2 existing resources, to identify abnormal provider billing patterns in order to prevent and
202.3 identify improper medical assistance payments.

202.4 (b) The request for proposal must include the following requirements for the
202.5 contractor:

202.6 (1) identification and reporting of improper claims, outlier claims, and improper
202.7 payments, both prior to and subsequent to reimbursement;

202.8 (2) utilization of fraud detection methods that maximize contemporary predictive
202.9 analytic tools, including but not limited to identity analytics, link analysis, and matching
202.10 capabilities;

202.11 (3) utilization of data analytics that improve fraud detection through the identification
202.12 of outlier reimbursement;

202.13 (4) reduction in state expenditures by reducing or eliminating payouts of improper
202.14 medical assistance claims; and

202.15 (5) demonstrated success with other states and state agencies using the specified
202.16 proposed solution, deployment, and implementation.

202.17 (c) The commissioner shall enter into a contract for the services in this section by
202.18 October 1, 2011. The contract must incorporate a performance-based vendor financing
202.19 mechanism under which the vendor shares in the risk of the project's success.

202.20 Sec. 105. **HEALTH SERVICES POLICY COMMITTEE STUDIES.**

202.21 (a) The commissioner of human services, through the health services policy
202.22 committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall
202.23 identify and review medical assistance services provided by health care professionals who
202.24 are not trained to provide the services in a high-quality manner. The commissioner shall
202.25 develop a process to limit payment for medical assistance services to providers who are
202.26 not appropriately trained to provide the service, and shall present recommendations and
202.27 draft legislation by January 15, 2012, to the legislature.

202.28 (b) The commissioner of human services, through the health services policy
202.29 committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall
202.30 study the effectiveness of new strategies for wound care treatment for medical assistance
202.31 and MinnesotaCare enrollees with diabetes, including but not limited to the use of new
202.32 wound care technologies, assessment tools, and reporting programs. The commissioner
202.33 shall present recommendations by December 15, 2011, to the legislature on whether these
202.34 new strategies for wound care treatment should be covered under medical assistance
202.35 and MinnesotaCare.

203.1 Sec. 106. **SPECIALIZED MAINTENANCE THERAPY.**

203.2 The commissioner of human services shall evaluate whether providing medical
203.3 assistance coverage for specialized maintenance therapy for enrollees with serious and
203.4 persistent mental illness who are at risk of hospitalization will improve the quality of
203.5 care and lower medical assistance spending by reducing rates of hospitalization. The
203.6 commissioner shall present findings and recommendations to the chairs and ranking
203.7 minority members of the legislative committees with jurisdiction over health and human
203.8 services finance and policy by December 15, 2011.

203.9 Sec. 107. **COVERAGE FOR LOWER-INCOME MINNESOTACARE**
203.10 **ENROLLEES.**

203.11 The commissioner of human services shall develop and present to the legislature,
203.12 by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees
203.13 eligible under Minnesota Statutes, section 256L.04, subdivisions 1 and 7, with incomes
203.14 less than 133 percent of the federal poverty guidelines. The plan must be designed to
203.15 improve continuity and quality of care, reduce unnecessary emergency room visits, and
203.16 reduce average per-enrollee costs. In developing the plan, the commissioner shall consider
203.17 innovative methods of service delivery, including but not limited to increasing the use
203.18 and choice of private sector health plan coverage and encouraging the use of community
203.19 health clinics, as defined in the federal Community Health Care Act of 1964, as health
203.20 care homes.

203.21 Sec. 108. **DIRECTION TO COMMISSIONER; FEDERAL WAIVERS.**

203.22 (a) The commissioner of human services shall apply to the Centers for Medicare
203.23 and Medicaid Services (CMS) for federal waivers to cover:

203.24 (1) families with children eligible under Minnesota Statutes, section 256L.04,
203.25 subdivision 1; and

203.26 (2) adults eligible under Minnesota Statutes, section 256L.04, subdivision 1,
203.27 under the MinnesotaCare healthy Minnesota contribution program established under
203.28 Minnesota Statutes, section 256L.031, by July 1, 2011. The commissioner shall report to
203.29 the legislative committees with jurisdiction over health and human services policy and
203.30 finance whether or not the federal waiver application was accepted within ten working
203.31 days of receipt of the decision.

203.32 (b) The commissioner of human services shall apply to the CMS for a section
203.33 1115(a) demonstration waiver, and any other necessary federal waivers and amendments,
203.34 including, but not limited to, a waiver of the appropriate sections of title XIX, United

States Code, title 42, section 1396a, and a waiver of any applicable federal maintenance of effort provisions that would provide Minnesota with medical assistance program flexibility in exchange for federal budget certainty. The commissioner shall seek federal approval to enter into an agreement with CMS under which Minnesota would:

(1) accept an aggregate annual allotment for the medical assistance program, trended forward at an agreed upon rate, with protections to cover medical inflation and projected caseload growth; and

(2) receive federal waivers of Medicaid requirements related to: statewideness and comparability of services; the amount, duration, and scope of services; freedom of choice; cost-sharing; and other areas of program administration specified by the commissioner.

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

Sec. 109. **TRANSPARENCY AND QUALITY REPORTING FOR PUBLIC HEALTH CARE PROGRAMS.**

When negotiating with external vendors to provide managed care services, the commissioner of human services shall require use of an advanced request for information tool. This tool must provide the department with an evidence-based assessment that focuses on the cost control, quality, and information transparency of the health care vendor. The assessment may include evidence-based performance measures that have been shown to influence better health, better health care, and more cost-effective use of resources including, but not limited to, areas that determine each plan's capabilities and performance with respect to:

(1) consumer engagement, support, and incentives;

(2) processes and outcomes for closing gaps in care according to clinical guideline expectations;

(3) provider management, including outcome and population-based reimbursement, transparent measurement of provider performance, and support of physician practice structures that lead to better care; and

(4) measures of clinical outcomes and waste approved by the National Quality Forum.

Sec. 110. **RISK CORRIDORS.**

(a) Effective for services rendered on or after January 1, 2012, the commissioner shall establish risk corridors for state public programs that are actuarially sound for each managed care plan and each county-based purchasing plan. The risk corridors will be calculated annually based on the calendar year's net underwriting gain or loss. If the

managed care plan or county-based purchasing plan has achieved a net underwriting gain of greater than three percent of revenue, 80 percent of any excess must be repaid to the commissioner by July 31 of the year following calculation of the risk corridor year, and 20 percent must be invested by the plan directly into programs for improving quality of care or access to care for state public health care program enrollees. If the managed care plan or county-based purchasing plan has incurred a net underwriting loss greater than three percent of total revenue, 50 percent of any excess must be repaid to the plan by the commissioner by July 31 of the year following calculation of the risk corridor year. Determination of total revenues and net underwriting gain or loss must be based on the Minnesota Supplement Report #1 which is filed on April 1 of the year following calculation of the risk corridor and adjusted for the actual withhold calculation under sections 256B.69, subdivision 5a, and 256L.12, subdivision 9. The report must be filed with and publicly disclosed by the Department of Health.

(b) For purposes of this section, "state public programs" means those prepaid medical assistance and MinnesotaCare programs for which a managed care plan or county-based purchasing plan contracts with the commissioner to provide coverage under sections 256B.69, 256B.692, and 256L.12. The risk corridors shall not apply to plans for persons who are enrolled in integrated Medicare and medical assistance programs under section 256B.69, subdivisions 23 and 28.

(c) This section expires January 1, 2014.

Sec. 111. CONTINGENT REINSTATEMENT OF GAMC.

Notwithstanding their contingent repeal in Laws 2010, First Special Session chapter 1, article 16, section 47, the following statutes are revived and have the force of law:

(1) Minnesota Statutes 2010, section 256D.03, subdivisions 3, 3a, 5, 6, 7, and 8; and

(2) Laws 2010, chapter 200, article 1, section 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 18, and 19.

EFFECTIVE DATE. This section is effective January 1, 2013, if by that date the federal government has not approved the global medical assistance waiver submitted under Minnesota Statutes, section 256B.841.

Sec. 112. REPEALER.

(a) Minnesota Statutes 2010, section 256.01, subdivision 2b, (**performance payments**) is repealed effective July 1, 2011.

(b) Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, (**Legislative Commission on Health Care Access**) are repealed.

206.1 (c) Laws 2009, chapter 79, article 5, section 64, **(256L.07, subdivision 2)** is repealed
206.2 retroactively from July 1, 2009, and federal approval is no longer necessary.

206.3 (d) Laws 2009, chapter 79, article 5, section 65, **(256L.07, subdivision 3)** is repealed
206.4 retroactively from July 1, 2009, and federal approval is no longer necessary.

206.5 (e) Laws 2009, chapter 79, article 5, section 68, **(256L.15, subdivision 2, exemption**
206.6 **of low-income children from MinnesotaCare premiums and insurance barriers)** is
206.7 repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

206.8 (f) Minnesota Statutes 2010, section 256L.07, subdivision 7, **exempting eligibility**
206.9 **for children formally under medical assistance,** is repealed retroactively from October
206.10 1, 2008, and federal approval is no longer necessary.

206.11 (g) The amendment in Laws 2009, chapter 79, article 5, section 55, as amended by
206.12 Laws 2009, chapter 173, article 1, section 36, **(256L.04, subdivision 1, children deemed**
206.13 **eligible are exempt from eligibility requirements)** is repealed retroactively from January
206.14 1, 2009, and federal approval is no longer necessary.

206.15 (h) Laws 2009, chapter 79, article 5, section 56, **(256L.04, subdivision 1b,**
206.16 **exemption from income limit for children)** is repealed retroactively from July 1, 2009,
206.17 and federal approval is no longer necessary.

206.18 (i) Laws 2009, chapter 79, article 5, section 60, **(256L.05, subdivision 1c, open**
206.19 **enrollment and streamlined application)** is repealed retroactively from July 1, 2009,
206.20 and federal approval is no longer necessary.

206.21 (j) Laws 2009, chapter 79, article 5, section 66, **(256L.07, subdivision 8, automatic**
206.22 **eligibility certain children)** is repealed retroactively from July 1, 2009, and federal
206.23 approval is no longer necessary.

206.24 (k) The amendment in Laws 2009, chapter 79, article 5, section 57, **(256L.04,**
206.25 **subdivision 7a, ineligibility for adults with certain income)** is repealed retroactively
206.26 from July 1, 2009, and federal approval is no longer necessary.

206.27 (l) The amendment in Laws 2009, chapter 79, article 5, section 61, **(256L.05,**
206.28 **subdivision 3, children eligibility following termination from foster care)** is repealed
206.29 retroactively from July 1, 2009, and federal approval is no longer necessary.

206.30 (m) The amendment in Laws 2009, chapter 79, article 5, section 62, **(256L.05,**
206.31 **subdivision 3a, exemption from cancellation for nonrenewal for children)** is repealed
206.32 retroactively from July 1, 2009, and federal approval is no longer necessary.

206.33 (n) The amendment in Laws 2009, chapter 79, article 5, section 63, **(256L.07,**
206.34 **subdivision 1, children whose gross family income is greater than 275 percent FPG**
206.35 **may remain enrolled)** is repealed retroactively from July 1, 2009, and federal approval is
206.36 no longer necessary.

(o) The amendment in Laws 2009, chapter 79, article 5, section 64, **(256L.07, subdivision 2, exempts children from requirement not to have employer-subsidized coverage)** is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(p) The amendment in Laws 2009, chapter 79, article 5, section 65, **(256L.07, subdivision 3, requires children with family gross income over 200 percent of FPG to have had no health coverage for four months prior to application)** is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(q) The amendment in Laws 2009, chapter 79, article 5, section 68, **(256L.15, subdivision 2, children in families with income less than 200 percent FPG pay no premium)** is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(r) The amendment in Laws 2009, chapter 79, article 5, section 69, **(256L.15, subdivision 3, exempts children with family income below 200 percent FPG from sliding fee scale)** is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(s) Laws 2009, chapter 79, article 5, section 79, **(uncoded federal approval)** is repealed the day following final enactment.

(t) Minnesota Statutes 2010, section 256B.057, subdivision 2c, **(extended medical assistance for certain children)** is repealed.

(u) The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9, **(renewal rolling month and premium grace month)** are repealed.

Sec. 113. **CONTINGENT REPEALER; MEDICAL ASSISTANCE EARLY EXPANSION.**

Minnesota Statutes 2010, sections 256B.055, subdivision 15; and 256B.0756, and Laws 2010, First Special Session chapter 1, article 16, sections 6; and 7, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2013, if by that date the federal government has not approved the global medical assistance waiver submitted under Minnesota Statutes, section 256B.841.

ARTICLE 7

CONTINUING CARE

Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 2, is amended to read:

208.1 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

208.2 (1) residential or nonresidential programs that are provided to a person by an

208.3 individual who is related unless the residential program is a child foster care placement

208.4 made by a local social services agency or a licensed child-placing agency, except as

208.5 provided in subdivision 2a;

208.6 (2) nonresidential programs that are provided by an unrelated individual to persons

208.7 from a single related family;

208.8 (3) residential or nonresidential programs that are provided to adults who do

208.9 not abuse chemicals or who do not have a chemical dependency, a mental illness, a

208.10 developmental disability, a functional impairment, or a physical disability;

208.11 (4) sheltered workshops or work activity programs that are certified by the

208.12 commissioner of employment and economic development;

208.13 (5) programs operated by a public school for children 33 months or older;

208.14 (6) nonresidential programs primarily for children that provide care or supervision

208.15 for periods of less than three hours a day while the child's parent or legal guardian is in

208.16 the same building as the nonresidential program or present within another building that is

208.17 directly contiguous to the building in which the nonresidential program is located;

208.18 (7) nursing homes or hospitals licensed by the commissioner of health except as

208.19 specified under section 245A.02;

208.20 (8) board and lodge facilities licensed by the commissioner of health that do not

208.21 provide children's residential services under Minnesota Rules, chapter 2960, mental health

208.22 or chemical dependency treatment;

208.23 (9) homes providing programs for persons placed by a county or a licensed agency

208.24 for legal adoption, unless the adoption is not completed within two years;

208.25 (10) programs licensed by the commissioner of corrections;

208.26 (11) recreation programs for children or adults that are operated or approved by a

208.27 park and recreation board whose primary purpose is to provide social and recreational

208.28 activities;

208.29 (12) programs operated by a school as defined in section 120A.22, subdivision 4;

208.30 YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as

208.31 defined in section 315.51, whose primary purpose is to provide child care or services to

208.32 school-age children;

208.33 (13) Head Start nonresidential programs which operate for less than 45 days in

208.34 each calendar year;

208.35 (14) noncertified boarding care homes unless they provide services for five or more

208.36 persons whose primary diagnosis is mental illness or a developmental disability;

209.1 (15) programs for children such as scouting, boys clubs, girls clubs, and sports and
209.2 art programs, and nonresidential programs for children provided for a cumulative total of
209.3 less than 30 days in any 12-month period;

209.4 (16) residential programs for persons with mental illness, that are located in hospitals;

209.5 (17) the religious instruction of school-age children; Sabbath or Sunday schools; or
209.6 the congregate care of children by a church, congregation, or religious society during the
209.7 period used by the church, congregation, or religious society for its regular worship;

209.8 (18) camps licensed by the commissioner of health under Minnesota Rules, chapter
209.9 4630;

209.10 (19) mental health outpatient services for adults with mental illness or children
209.11 with emotional disturbance;

209.12 (20) residential programs serving school-age children whose sole purpose is cultural
209.13 or educational exchange, until the commissioner adopts appropriate rules;

209.14 (21) unrelated individuals who provide out-of-home respite care services to persons
209.15 with developmental disabilities from a single related family for no more than 90 days in a
209.16 12-month period and the respite care services are for the temporary relief of the person's
209.17 family or legal representative;

209.18 (22) respite care services provided as a home and community-based service to a
209.19 person with a developmental disability, in the person's primary residence;

209.20 (23) community support services programs as defined in section 245.462, subdivision
209.21 6, and family community support services as defined in section 245.4871, subdivision 17;

209.22 (24) the placement of a child by a birth parent or legal guardian in a preadoptive
209.23 home for purposes of adoption as authorized by section 259.47;

209.24 (25) settings registered under chapter 144D which provide home care services
209.25 licensed by the commissioner of health to fewer than seven adults;

209.26 (26) chemical dependency or substance abuse treatment activities of licensed
209.27 professionals in private practice as defined in Minnesota Rules, part 9530.6405, subpart
209.28 15, when the treatment activities are not paid for by the consolidated chemical dependency
209.29 treatment fund;

209.30 (27) consumer-directed community support service funded under the Medicaid
209.31 waiver for persons with developmental disabilities when the individual who provided
209.32 the service is:

209.33 (i) the same individual who is the direct payee of these specific waiver funds or paid
209.34 by a fiscal agent, fiscal intermediary, or employer of record; and

209.35 (ii) not otherwise under the control of a residential or nonresidential program that is
209.36 required to be licensed under this chapter when providing the service; ~~or~~

(28) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided; or

(29) residential facilities that are federally certified as intermediate care facilities that serve people with developmental disabilities.

A program that asserts its exemption from licensure under clause (28), item (ii), shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 2. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

211.1 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
211.2 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
211.3 contribution is \$4 per month;

211.4 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
211.5 poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines,
211.6 the parental contribution shall be determined using a sliding fee scale established by the
211.7 commissioner of human services which begins at one percent of adjusted gross income at
211.8 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted
211.9 gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal
211.10 poverty guidelines;

211.11 (3) if the adjusted gross income is greater than ~~545~~ 525 percent of federal
211.12 poverty guidelines and less than 675 percent of federal poverty guidelines, the parental
211.13 contribution shall be ~~7.5~~ 9.5 percent of adjusted gross income;

211.14 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
211.15 poverty guidelines and less than ~~975~~ 900 percent of federal poverty guidelines, the parental
211.16 contribution shall be determined using a sliding fee scale established by the commissioner
211.17 of human services which begins at ~~7.5~~ 9.5 percent of adjusted gross income at 675 percent
211.18 of federal poverty guidelines and increases to ~~ten~~ 12 percent of adjusted gross income for
211.19 those with adjusted gross income up to ~~975~~ 900 percent of federal poverty guidelines; and

211.20 (5) if the adjusted gross income is equal to or greater than ~~975~~ 900 percent of
211.21 federal poverty guidelines, the parental contribution shall be ~~12.5~~ 13.5 percent of adjusted
211.22 gross income.

211.23 If the child lives with the parent, the annual adjusted gross income is reduced by
211.24 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
211.25 specified in section 256B.35, the parent is responsible for the personal needs allowance
211.26 specified under that section in addition to the parental contribution determined under this
211.27 section. The parental contribution is reduced by any amount required to be paid directly to
211.28 the child pursuant to a court order, but only if actually paid.

211.29 (c) The household size to be used in determining the amount of contribution under
211.30 paragraph (b) includes natural and adoptive parents and their dependents, including the
211.31 child receiving services. Adjustments in the contribution amount due to annual changes
211.32 in the federal poverty guidelines shall be implemented on the first day of July following
211.33 publication of the changes.

211.34 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
211.35 natural or adoptive parents determined according to the previous year's federal tax form,

212.1 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
212.2 have been used to purchase a home shall not be counted as income.

212.3 (e) The contribution shall be explained in writing to the parents at the time eligibility
212.4 for services is being determined. The contribution shall be made on a monthly basis
212.5 effective with the first month in which the child receives services. Annually upon
212.6 redetermination or at termination of eligibility, if the contribution exceeded the cost of
212.7 services provided, the local agency or the state shall reimburse that excess amount to
212.8 the parents, either by direct reimbursement if the parent is no longer required to pay a
212.9 contribution, or by a reduction in or waiver of parental fees until the excess amount is
212.10 exhausted. All reimbursements must include a notice that the amount reimbursed may be
212.11 taxable income if the parent paid for the parent's fees through an employer's health care
212.12 flexible spending account under the Internal Revenue Code, section 125, and that the
212.13 parent is responsible for paying the taxes owed on the amount reimbursed.

212.14 (f) The monthly contribution amount must be reviewed at least every 12 months;
212.15 when there is a change in household size; and when there is a loss of or gain in income
212.16 from one month to another in excess of ten percent. The local agency shall mail a written
212.17 notice 30 days in advance of the effective date of a change in the contribution amount.
212.18 A decrease in the contribution amount is effective in the month that the parent verifies a
212.19 reduction in income or change in household size.

212.20 (g) Parents of a minor child who do not live with each other shall each pay the
212.21 contribution required under paragraph (a). An amount equal to the annual court-ordered
212.22 child support payment actually paid on behalf of the child receiving services shall be
212.23 deducted from the adjusted gross income of the parent making the payment prior to
212.24 calculating the parental contribution under paragraph (b).

212.25 (h) The contribution under paragraph (b) shall be increased by an additional five
212.26 percent if the local agency determines that insurance coverage is available but not
212.27 obtained for the child. For purposes of this section, "available" means the insurance is a
212.28 benefit of employment for a family member at an annual cost of no more than five percent
212.29 of the family's annual income. For purposes of this section, "insurance" means health
212.30 and accident insurance coverage, enrollment in a nonprofit health service plan, health
212.31 maintenance organization, self-insured plan, or preferred provider organization.

212.32 Parents who have more than one child receiving services shall not be required
212.33 to pay more than the amount for the child with the highest expenditures. There shall
212.34 be no resource contribution from the parents. The parent shall not be required to pay
212.35 a contribution in excess of the cost of the services provided to the child, not counting

payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, 2013, the parental contribution shall be computed by applying the following contribution schedule to the adjusted gross income of the natural or adoptive parents:~~

~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;~~

~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;~~

~~(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;~~

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner~~

~~of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and~~
~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.~~

Sec. 3. Minnesota Statutes 2010, section 252.291, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) The commissioner of human services in coordination with the commissioner of health may approve a newly constructed or newly established publicly or privately operated community intermediate care facility for ~~six~~ 16 or fewer persons with developmental disabilities only when:

(1) the facility is developed in accordance with a request for proposal approved by the commissioner of human services;

(2) the facility is necessary to serve the needs of identified persons with developmental disabilities who are seriously behaviorally disordered or who are seriously physically or sensorily impaired. No more than 40 percent of the capacity specified in the proposal submitted to the commissioner must be used for persons being discharged from regional treatment centers; and

(3) the commissioner determines that the need for increased service capacity cannot be met by the use of alternative resources or the modification of existing facilities.

(b) The percentage limitation in paragraph (a), clause (2), does not apply to state-operated, community-based facilities.

Sec. 4. Minnesota Statutes 2010, section 256.01, subdivision 24, is amended to read:

Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability Linkage Line, ~~a to serve as Minnesota's neutral access point for statewide consumer disability information, referral, and assistance system for people with disabilities and chronic illnesses that.~~ The Disability Linkage Line shall:

(1) deliver information and assistance based on national and state standards;

215.1 ~~(1) provides~~ (2) provide information about state and federal eligibility requirements,
215.2 benefits, and service options;
215.3 (3) provide benefits and options counseling;
215.4 ~~(2) makes~~ (4) make referrals to appropriate support entities;
215.5 ~~(3) delivers information and assistance based on national and state standards;~~
215.6 ~~(4) assists~~ (5) educate people ~~to~~ on their options so they can make well-informed
215.7 ~~decisions~~ choices; and
215.8 ~~(5) supports~~ (6) help support the timely resolution of service access and benefit
215.9 issues;
215.10 (7) inform people of their long-term community services and supports;
215.11 (8) provide necessary resources and supports that can lead to employment and
215.12 increased economic stability of people with disabilities; and
215.13 (9) serve as the technical assistance and help center for the Web-based tool,
215.14 Minnesota's Disability Benefits 101.org.

215.15 **EFFECTIVE DATE.** This section is effective July 1, 2011.

215.16 Sec. 5. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:

215.17 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
215.18 determinations of disability by the commissioner's state medical review team under
215.19 sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, ~~paragraph~~
215.20 ~~(f)~~, and 256B.055, subdivision 12, the commissioner shall review all medical evidence
215.21 submitted by county agencies with a referral and seek additional information from
215.22 providers, applicants, and enrollees to support the determination of disability where
215.23 necessary. Disability shall be determined according to the rules of title XVI and title
215.24 XIX of the Social Security Act and pertinent rules and policies of the Social Security
215.25 Administration.

215.26 (b) Prior to a denial or withdrawal of a requested determination of disability due
215.27 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
215.28 necessary and appropriate to a determination of disability, and (2) assist applicants and
215.29 enrollees to obtain the evidence, including, but not limited to, medical examinations
215.30 and electronic medical records.

215.31 (c) The commissioner shall provide the chairs of the legislative committees with
215.32 jurisdiction over health and human services finance and budget the following information
215.33 on the activities of the state medical review team by February 1 of each year:

215.34 (1) the number of applications to the state medical review team that were denied,
215.35 approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief appeals referee.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 6. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

Subd. 4a. **Case management appeals temporary stay of demission.** ~~Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the~~

217.1 ~~county agency has assured that the services identified in the recipient's individual service~~
217.2 ~~plan have been delivered in accordance with the laws and rules governing the provision~~
217.3 ~~of those services. The state human services referee shall recommend an order to the~~
217.4 ~~commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final~~
217.5 ~~order within 60 days of the receipt of the request for a hearing, unless the commissioner~~
217.6 ~~refuses to accept the recommended order, in which event a final order shall issue within 90~~
217.7 ~~days of the receipt of that request. The order may direct the county agency to take those~~
217.8 ~~actions necessary to comply with applicable laws or rules. The commissioner may issue a~~
217.9 ~~temporary order prohibiting the demission of a recipient of case management services~~
217.10 ~~under section 256B.092 from a residential or day habilitation program licensed under~~
217.11 ~~chapter 245A, while a county agency review process or an appeal brought by a recipient~~
217.12 ~~under this subdivision is pending, or for the period of time necessary for the county agency~~
217.13 ~~to implement the commissioner's order. The commissioner shall not issue a final order~~
217.14 ~~staying the demission of a recipient of case management services from a residential or day~~
217.15 ~~habilitation program licensed under chapter 245A.~~

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

217.17 Sec. 7. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

217.18 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
217.19 medical assistance, a person must not individually own more than \$3,000 in assets, or if a
217.20 member of a household with two family members, husband and wife, or parent and child,
217.21 the household must not own more than \$6,000 in assets, plus \$200 for each additional
217.22 legal dependent. In addition to these maximum amounts, an eligible individual or family
217.23 may accrue interest on these amounts, but they must be reduced to the maximum at the
217.24 time of an eligibility redetermination. The accumulation of the clothing and personal
217.25 needs allowance according to section 256B.35 must also be reduced to the maximum at
217.26 the time of the eligibility redetermination. The value of assets that are not considered in
217.27 determining eligibility for medical assistance is the value of those assets excluded under
217.28 the supplemental security income program for aged, blind, and disabled persons, with
217.29 the following exceptions:

217.30 (1) household goods and personal effects are not considered;

217.31 (2) capital and operating assets of a trade or business that the local agency determines
217.32 are necessary to the person's ability to earn an income are not considered;

217.33 (3) motor vehicles are excluded to the same extent excluded by the supplemental
217.34 security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; and

(5) ~~effective upon federal approval~~, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph ~~(e)~~ (d).

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 8. Minnesota Statutes 2010, section 256B.056, is amended by adding a subdivision to read:

Subd. 5d. **Spendedown adjustments.** When income is projected for a six-month budget period, retroactive adjustments to income determined to be available to a person under section 256B.0575 must be made at the end of each six-month budget period based on changes occurring during the budget period. For changes occurring outside the six-month budget period, such retroactive adjustments are limited to the six full calendar months before the month the change is reported or discovered.

Sec. 9. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph ~~(e)~~ (d); and

(4) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than \$65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any

219.1 spousal income or assets shall be disregarded for purposes of eligibility and premium
219.2 determinations.

219.3 ~~(b)~~ (c) After the month of enrollment, a person enrolled in medical assistance under
219.4 this subdivision who:

219.5 (1) is temporarily unable to work and without receipt of earned income due to a
219.6 medical condition, as verified by a physician, ~~may retain eligibility for up to four calendar~~
219.7 ~~months~~; or

219.8 (2) ~~effective January 1, 2004~~, loses employment for reasons not attributable to the
219.9 enrollee, and is without receipt of earned income may retain eligibility for up to four
219.10 consecutive months after the month of job loss. To receive a four-month extension,
219.11 enrollees must verify the medical condition or provide notification of job loss. All other
219.12 eligibility requirements must be met and the enrollee must pay all calculated premium
219.13 costs for continued eligibility.

219.14 ~~(c)~~ (d) For purposes of determining eligibility under this subdivision, a person's
219.15 assets must not exceed \$20,000, excluding:

219.16 (1) all assets excluded under section 256B.056;

219.17 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
219.18 Keogh plans, and pension plans; ~~and~~

219.19 (3) medical expense accounts set up through the person's employer; and

219.20 (4) spousal assets, including spouse's share of jointly held assets.

219.21 ~~(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65~~
219.22 ~~earned income disregard. To be eligible, a person applying for medical assistance under~~
219.23 ~~this subdivision must have earned income above the disregard level.~~

219.24 ~~(2) Effective January 1, 2004, to be considered earned income, Medicare, Social~~
219.25 ~~Security, and applicable state and federal income taxes must be withheld. To be eligible,~~
219.26 ~~a person must document earned income tax withholding.~~

219.27 ~~(c)(1) A person whose earned and unearned income is equal to or greater than 100~~
219.28 ~~percent of federal poverty guidelines for the applicable family size must pay a premium~~
219.29 ~~to be eligible for medical assistance under this subdivision.~~ (e) All enrollees must pay a
219.30 premium to be eligible for medical assistance under this subdivision.

219.31 (1) An enrollee must pay the greater of a \$65 premium or the premium shall be
219.32 calculated based on the person's gross earned and unearned income and the applicable
219.33 family size using a sliding fee scale established by the commissioner, which begins at
219.34 one percent of income at 100 percent of the federal poverty guidelines and increases
219.35 to 7.5 percent of income for those with incomes at or above 300 percent of the federal
219.36 poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

~~(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a \$35 premium or the premium calculated in clause (1).~~

~~(3) Effective November 1, 2003, All enrollees who receive unearned income must pay one-half of one five percent of unearned income in addition to the premium amount.~~

~~(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).~~

~~(5)~~ (4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

221.1 (j) The commissioner shall notify enrollees annually beginning at least 24 months
221.2 before the person's 65th birthday of the medical assistance eligibility rules affecting
221.3 income, assets, and treatment of a spouse's income and assets that will be applied upon
221.4 reaching age 65.

221.5 (k) For enrollees whose income does not exceed 200 percent of the federal poverty
221.6 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
221.7 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
221.8 paragraph (a).

221.9 **EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or
221.10 older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

221.11 Sec. 10. Minnesota Statutes 2010, section 256B.0657, is amended to read:

221.12 **256B.0657 SELF-DIRECTED SUPPORTS OPTION.**

221.13 Subdivision 1. **Definition.** (a) "Lead agency" has the meaning given in section
221.14 256B.0911, subdivision 1a, paragraph (d).

221.15 (b) "Legal representative" means a legal guardian of a child or an adult, or parent of
221.16 a minor child.

221.17 (c) "Managing partner" means an individual who has been authorized, in a written
221.18 statement by the person or the person's legal representative, to speak on the person's
221.19 behalf and help the person understand and make informed choices in matters related
221.20 to identification of needs and choice of services and supports and assist the person to
221.21 implement an approved support plan and has no financial interest in the provision of
221.22 any other services included in the individual's plan unless related by blood, adoption, or
221.23 marriage.

221.24 (d) "Self-directed supports option" means personal assistance, supports, items, and
221.25 related services purchased under an approved budget plan and budget by a recipient.

221.26 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
221.27 who:

221.28 (1) is a recipient of medical assistance as determined under sections 256B.055,
221.29 256B.056, and 256B.057, subdivision 9;

221.30 (2) is eligible for personal care assistance services under section 256B.0659, or
221.31 for a home and community-based services waiver program under section 256B.0915,
221.32 256B.092, or 256B.49, or alternative care under section 256B.0913;

222.1 (3) lives in the person's own apartment or home, which is not owned, operated, or
222.2 controlled by a provider of services not related by blood ~~or~~, adoption, marriage, or foster
222.3 care;

222.4 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
222.5 manage the individuals providing services, and to choose and obtain items, related
222.6 services, and supports as described in the participant's plan. If the recipient is not able to
222.7 carry out these functions but has a legal guardian, managing partner, or parent to carry
222.8 them out, the guardian, managing partner, or parent may fulfill these functions on behalf
222.9 of the recipient; and

222.10 (5) has not been excluded or disenrolled by the commissioner.

222.11 (b) The commissioner may disenroll ~~or~~, exclude, or require other measures such as
222.12 training, increased assistance, reporting, or oversight for recipients, including guardians
222.13 and, parents, and managing partners under the following circumstances:

222.14 (1) recipients who have been restricted by the Primary Care Utilization Review
222.15 Committee may be excluded for a specified time period;

222.16 (2) recipients who exit the self-directed supports option during the recipient's
222.17 service plan year shall not access the self-directed supports option for the remainder of
222.18 that service plan year; and

222.19 (3) when the department determines that the recipient cannot manage recipient
222.20 responsibilities under the program.

222.21 (c) For vendors or other self-directed service providers, the commissioner may
222.22 take any action authorized under surveillance and integrity review in Minnesota Rules,
222.23 parts 9505.2160 to 9505.2245.

222.24 Subd. 3. **Eligibility for other services.** Selection of the self-directed supports
222.25 option by a recipient shall not restrict access to other medically necessary care and
222.26 services furnished under the state plan medical assistance benefit, ~~including home care~~
222.27 ~~targeted case management~~, except that a person ~~receiving~~ choosing lead agency managed
222.28 home and community-based waiver services, agency-provided personal care assistance
222.29 services, a family support grant, or a consumer support grant is not eligible for funding
222.30 under the self-directed supports option.

222.31 Subd. 4. **Assessment requirements.** (a) The self-directed supports option
222.32 assessment must meet the following requirements:

222.33 (1) it shall be conducted ~~by the county public health nurse or a certified public health~~
222.34 ~~nurse under contract with the county~~ consistent with the requirements of personal care
222.35 assistance services under section 256B.0659, subdivision 3a; home and community-based
222.36 waiver services programs under section 256B.0915, 256B.092, or 256B.49; and the

223.1 alternative care program under section 256B.0913, until section 256B.0911, subdivision
223.2 3a, has been implemented;

223.3 (2) it shall be conducted face-to-face in the recipient's home initially, and at least
223.4 annually thereafter; when there is a significant change in the recipient's condition; and
223.5 when there is a change in the person's need for personal care assistance services under the
223.6 programs listed in subdivision 2, paragraph (a), clause (2). A recipient who is residing in a
223.7 facility may be assessed for the self-directed support option for the purpose of returning
223.8 to the community using this option; and

223.9 (3) it shall be completed using the format established by the commissioner.

223.10 (b) The results of the personal care assistance assessment and recommendations
223.11 shall be communicated to the commissioner and the recipient ~~by the county public health~~
223.12 ~~nurse or certified public health nurse under contract with the county~~ as required under
223.13 section 256B.0659, subdivision 3a. The person's annual and self-directed budget amount
223.14 shall be provided within 40 days after the personal care assessment or reassessment, or
223.15 within ten days after a request not related to an assessment.

223.16 (c) The lead agency responsible for administration of home and community-based
223.17 waiver services under section 256B.0915, 256B.092, or 256B.49, and alternative care
223.18 under section 256B.0913, shall provide annual and monthly self-directed services budget
223.19 amounts for all eligible persons within 40 days after an initial assessment or annual review
223.20 and within ten days if requested at a time unrelated to the assessment or annual review.

223.21 Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the
223.22 self-directed supports option must meet the following requirements:

223.23 (1) the plan must be completed using a person-centered process that:

223.24 (i) builds upon the recipient's capacity to engage in activities that promote
223.25 community life;

223.26 (ii) respects the recipient's preferences, choices, and abilities;

223.27 (iii) involves families, friends, and professionals in the planning or delivery of
223.28 services or supports as desired or required by the recipient; and

223.29 (iv) addresses the need for personal care assistance and other services and supports
223.30 identified in the recipient's self-directed supports option assessment;

223.31 (2) the plan shall be developed by the recipient, legal representative, or ~~by the~~
223.32 ~~guardian of an adult recipient or by a parent or guardian of a minor child,~~ managing
223.33 partner, and may be assisted by a provider who meets the requirements established for
223.34 using a person-centered planning process and shall be reviewed at least annually upon
223.35 reassessment or when there is a significant change in the recipient's condition; and

224.1 (3) the plan must include the total budget amount available divided into monthly
224.2 amounts that cover the number of months of personal care assistance services or home
224.3 and community-based waiver or alternative care authorization included in the budget.
224.4 A recipient may reserve funds monthly for the purchase of items that meet the standards
224.5 in subdivision 6, paragraph (a), clause (2), and are reflected in the support plan. The
224.6 amount used each month may vary, but additional funds shall not be provided above the
224.7 annual personal care assistance services authorized amount unless a change in condition
224.8 is documented.

224.9 (b) The commissioner or the commissioner's designee shall:

224.10 (1) establish the format and criteria for the plan as well as the provider enrollment
224.11 requirements for providers who will engage in outreach and training on self-directed
224.12 options, assist with plan development, and offer person-centered plan support services
224.13 including benefits counseling to support employment;

224.14 (2) review the assessment and plan and, within 30 days after receiving the
224.15 assessment and plan, make a decision on approval of the plan;

224.16 (3) notify the recipient, ~~parent, or guardian~~ legal representative, or managing partner
224.17 of approval or denial of the plan and provide notice of the right to appeal under section
224.18 256.045; and

224.19 (4) provide a copy of the plan to the fiscal support entity selected by the recipient
224.20 from among at least three certified entities.

224.21 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
224.22 option include:

224.23 (1) personal care assistance services under section 256B.0659, and services under
224.24 the home and community-based waivers, except those provided in licensed or registered
224.25 residential settings; and

224.26 (2) items, related services, and supports, including assistive technology, that increase
224.27 independence or substitute for human assistance to the extent expenditures would
224.28 otherwise be used for human assistance.

224.29 (b) Items, supports, and related services purchased under this option shall not be
224.30 considered home care services for the purposes of section 144A.43.

224.31 Subd. 7. **Noncovered services.** Services or supports that are not eligible for
224.32 payment under the self-directed supports option include:

224.33 (1) services, goods, or supports that do not benefit the recipient;

224.34 (2) any fees incurred by the recipient, such as Minnesota health care program fees
224.35 and co-pays, legal fees, or costs related to advocate agencies;

225.1 (3) insurance, except for insurance costs related to employee coverage or fiscal
225.2 support entity payments;

225.3 (4) room and board and personal items that are not related to the disability, except
225.4 that medically prescribed specialized diet items may be covered if they reduce the need for
225.5 human assistance;

225.6 (5) home modifications that add square footage, except those modifications that
225.7 configure a bathroom to accommodate a wheelchair;

225.8 (6) home modifications for a residence other than the primary residence of the
225.9 recipient, or in the event of a minor with parents not living together, the primary residences
225.10 of the parents;

225.11 (7) expenses for travel, lodging, or meals related to training the recipient, the
225.12 ~~parent or guardian of an adult recipient, or the parent or guardian of a minor child legal~~
225.13 representative, or paid or unpaid caregivers that exceed \$500 in a 12-month period;

225.14 (8) experimental treatment;

225.15 (9) any service or item to the extent the service or item is covered by other medical
225.16 assistance state plan services, including prescription and over-the-counter medications,
225.17 compounds, and solutions and related fees, including premiums and co-payments;

225.18 (10) membership dues or costs, except when the service is necessary and appropriate
225.19 to treat a physical condition or to improve or maintain the recipient's physical condition.
225.20 The condition must be identified in the recipient's plan of care and monitored by a
225.21 Minnesota health care program enrolled physician;

225.22 (11) vacation expenses other than the cost of direct services;

225.23 (12) vehicle maintenance or modifications not related to the disability;

225.24 (13) tickets and related costs to attend sporting or other recreational events; and

225.25 (14) costs related to Internet access, except when necessary for operation of assistive
225.26 technology, to increase independence, or to substitute for human assistance.

225.27 Subd. 8. **Self-directed budget requirements.** (a) The budget for the provision of
225.28 the self-directed service option shall be established for persons eligible for personal care
225.29 assistance services under section 256B.0659 based on:

225.30 (1) assessed personal care assistance units, not to exceed the maximum number of
225.31 personal care assistance units available, as determined by section 256B.0659; and

225.32 (2) the personal care assistance unit rate:

225.33 (i) with a reduction to the unit rate to pay for a program administrator as defined in
225.34 subdivision 10; and

225.35 (ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for
225.36 the state.

(b) The budget for persons eligible for programs listed in subdivision 2, paragraph (a), clause (2), is based on the approved budget methodologies for each program.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, ~~and~~ (ii) backup and emergency plans, including disaster planning, and (iii) monitoring by the lead agency on quality assurance measures and recipient health, safety, and welfare.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option, including information on the quality assurance efforts and activities of region 10 under sections 256B.095 to 256B.096.

(c) Performance assessments measures, such as of a recipient's functioning, satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group and monitored by the lead agency.

Subd. 10. **Fiscal support entity.** (a) Each recipient or legal representative shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. ~~Recipients~~ The recipient or legal representative shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient, managing partner, or the recipient's legal representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient ~~and the home care targeted case manager~~, legal representative, and managing partner with a monthly written summary of the self-directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate

227.1 and timely submission of employer tax liabilities, and maintain documentation to support
227.2 medical assistance claims;

227.3 (5) must have current and adequate liability insurance and bonding and sufficient
227.4 cash flow and have on staff or under contract a certified public accountant or an individual
227.5 with a baccalaureate degree in accounting; and

227.6 (6) must maintain records to track all self-directed supports option services
227.7 expenditures, including time records of persons paid to provide supports and receipts for
227.8 any goods purchased. The records must be maintained for a minimum of five years from
227.9 the claim date and be available for audit or review upon request. Claims submitted by
227.10 the fiscal support entity must correspond with services, amounts, and time periods as
227.11 authorized in the recipient's self-directed supports option plan.

227.12 (c) The commissioner shall have authority to:

227.13 (1) set or negotiate rates with fiscal support entities;

227.14 (2) limit the number of fiscal support entities;

227.15 (3) identify a process to certify and recertify fiscal support entities and assure fiscal
227.16 support entities are available to recipients throughout the state; and

227.17 (4) establish a uniform format and protocol to be used by eligible fiscal support
227.18 entities.

227.19 Subd. 11. **Stakeholder consultation.** The commissioner shall consult with
227.20 a statewide ~~consumer-directed~~ self-directed services stakeholder group, including
227.21 representatives of all types of ~~consumer-directed~~ self-directed service users, advocacy
227.22 organizations, counties, and ~~consumer-directed~~ self-directed service providers. The
227.23 commissioner shall seek recommendations from this stakeholder group in developing,
227.24 monitoring, evaluating, and modifying:

227.25 (1) the self-directed plan format;

227.26 (2) requirements and guidelines for the person-centered plan assessment and
227.27 planning process;

227.28 (3) implementation of the option and the quality assurance and risk management
227.29 techniques; ~~and~~

227.30 (4) standards and requirements, including rates for the personal support plan
227.31 development provider and the fiscal support entity; policies; training; and implementation;
227.32 and

227.33 (5) the self-directed supports options available through the home and
227.34 community-based waivers under section 256B.0916 and the personal care assistance
227.35 program under section 256B.0659, including ways to increase participation, improve
227.36 flexibility, and include incentives for recipients to participate in a life transition and crisis

228.1 funding pool with others to save and contribute part of their authorized budgets, which
228.2 can be carried over year to year and used according to priority standards under section
228.3 256B.092, subdivision 12, paragraph (a), clauses (1), (3), (4), (5), and (6).

228.4 The stakeholder group shall provide recommendations on the repeal of the personal
228.5 care assistance choice option, transition issues, and whether the consumer support grant
228.6 program under section 256.476 should be modified. The stakeholder group shall meet
228.7 at least three times each year to provide advice on policy, implementation, and other
228.8 aspects of ~~consumer and~~ self-directed services.

228.9 Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports
228.10 option is available to current personal care assistance recipients upon annual personal
228.11 care assistance reassessment, with a maximum enrollment of ~~1,000~~ 2,000 people in the
228.12 first fiscal year of implementation and an additional ~~1,000~~ 3,000 people in the second
228.13 fiscal year. The commissioner shall evaluate the self-directed supports option during the
228.14 first two years of implementation and make any necessary changes ~~prior to the option~~
228.15 ~~becoming available statewide.~~

228.16 **EFFECTIVE DATE.** This section is effective July 1, 2012.

228.17 Sec. 11. Minnesota Statutes 2010, section 256B.0659, subdivision 2, is amended to
228.18 read:

228.19 Subd. 2. **Personal care assistance services; covered services.** (a) The personal
228.20 care assistance services eligible for payment include services and supports furnished
228.21 to an individual, as needed, to assist in:

- 228.22 (1) activities of daily living;
228.23 (2) health-related procedures and tasks;
228.24 (3) observation and redirection of behaviors; and
228.25 (4) instrumental activities of daily living.

228.26 (b) Activities of daily living include the following covered services:

- 228.27 (1) dressing, including assistance with choosing, application, and changing of
228.28 clothing and application of special appliances, wraps, or clothing;
228.29 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
228.30 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
228.31 except for recipients who are diabetic or have poor circulation;
228.32 (3) bathing, including assistance with basic personal hygiene and skin care;
228.33 (4) eating, including assistance with hand washing and application of orthotics
228.34 required for eating, transfers, and feeding;

229.1 (5) transfers, including assistance with transferring the recipient from one seating or
229.2 reclining area to another;

229.3 (6) mobility, including assistance with ambulation, including use of a wheelchair.
229.4 Mobility does not include providing transportation for a recipient;

229.5 (7) positioning, including assistance with positioning or turning a recipient for
229.6 necessary care and comfort; and

229.7 (8) toileting, including assistance with helping recipient with bowel or bladder
229.8 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
229.9 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
229.10 adjusting clothing.

229.11 (c) Health-related procedures and tasks include the following covered services:

229.12 (1) range of motion and passive exercise to maintain a recipient's strength and
229.13 muscle functioning;

229.14 (2) assistance with self-administered medication as defined by this section, including
229.15 reminders to take medication, bringing medication to the recipient, and assistance with
229.16 opening medication under the direction of the recipient or responsible party;

229.17 (3) interventions for seizure disorders, including monitoring and observation; and

229.18 (4) other activities considered within the scope of the personal care service and
229.19 meeting the definition of health-related procedures and tasks under this section, including
229.20 assisting recipients with rehabilitation exercises that are part of a recipient's care plan if
229.21 trained in the procedures and tasks and no additional personal care assistance service time
229.22 is necessary to complete this task.

229.23 (d) A personal care assistant may provide health-related procedures and tasks
229.24 associated with the complex health-related needs of a recipient if the procedures and
229.25 tasks meet the definition of health-related procedures and tasks under this section and the
229.26 personal care assistant is trained by a qualified professional and demonstrates competency
229.27 to safely complete the procedures and tasks. Delegation of health-related procedures and
229.28 tasks and all training must be documented in the personal care assistance care plan and the
229.29 recipient's and personal care assistant's files.

229.30 (e) Effective January 1, 2010, for a personal care assistant to provide the
229.31 health-related procedures and tasks of tracheostomy suctioning and services to recipients
229.32 on ventilator support there must be:

229.33 (1) delegation and training by a registered nurse, certified or licensed respiratory
229.34 therapist, or a physician;

229.35 (2) utilization of clean rather than sterile procedure;

230.1 (3) specialized training about the health-related procedures and tasks and equipment,
230.2 including ventilator operation and maintenance;

230.3 (4) individualized training regarding the needs of the recipient; and

230.4 (5) supervision by a qualified professional who is a registered nurse.

230.5 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
230.6 recipient for episodes where there is a need for redirection due to behaviors. Training of
230.7 the personal care assistant must occur based on the needs of the recipient, the personal
230.8 care assistance care plan, and any other support services provided.

230.9 (g) Instrumental activities of daily living under subdivision 1, paragraph (i).

230.10 Sec. 12. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to
230.11 read:

230.12 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
230.13 must meet the following requirements:

230.14 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
230.15 of age with these additional requirements:

230.16 (i) supervision by a qualified professional every 60 days; and

230.17 (ii) employment by only one personal care assistance provider agency responsible
230.18 for compliance with current labor laws;

230.19 (2) be employed by a personal care assistance provider agency;

230.20 (3) enroll with the department as a personal care assistant after clearing a background
230.21 study. Except as provided in subdivision 11a, before a personal care assistant provides
230.22 services, the personal care assistance provider agency must initiate a background study on
230.23 the personal care assistant under chapter 245C, and the personal care assistance provider
230.24 agency must have received a notice from the commissioner that the personal care assistant
230.25 is:

230.26 (i) not disqualified under section 245C.14; or

230.27 (ii) is disqualified, but the personal care assistant has received a set aside of the
230.28 disqualification under section 245C.22;

230.29 (4) be able to effectively communicate with the recipient and personal care
230.30 assistance provider agency;

230.31 (5) be able to provide covered personal care assistance services according to the
230.32 recipient's personal care assistance care plan, respond appropriately to recipient needs,
230.33 and report changes in the recipient's condition to the supervising qualified professional
230.34 or physician;

230.35 (6) not be a consumer of personal care assistance services;

231.1 (7) maintain daily written records including, but not limited to, time sheets under
231.2 subdivision 12;

231.3 (8) effective January 1, 2010, complete standardized training as determined
231.4 by the commissioner before completing enrollment. The training must be available
231.5 in languages other than English and to those who need accommodations due to
231.6 disabilities. Personal care assistant training must include successful completion of the
231.7 following training components: basic first aid, vulnerable adult, child maltreatment,
231.8 OSHA universal precautions, basic roles and responsibilities of personal care assistants
231.9 including information about assistance with lifting and transfers for recipients, emergency
231.10 preparedness, orientation to positive behavioral practices, fraud issues, and completion of
231.11 time sheets. Upon completion of the training components, the personal care assistant must
231.12 demonstrate the competency to provide assistance to recipients;

231.13 (9) complete training and orientation on the needs of the recipient within the first
231.14 seven days after the services begin; and

231.15 (10) be limited to providing and being paid for up to 275 hours per month, except
231.16 that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,
231.17 2011, of personal care assistance services regardless of the number of recipients being
231.18 served or the number of personal care assistance provider agencies enrolled with. The
231.19 number of hours worked per day shall not be disallowed by the department unless in
231.20 violation of the law.

231.21 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
231.22 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

231.23 (c) Effective January 1, 2010, persons who do not qualify as a personal care assistant
231.24 include parents and stepparents of minors, spouses, paid legal guardians, family foster
231.25 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or
231.26 staff of a residential setting. When the personal care assistant is a relative of the recipient,
231.27 the commissioner shall pay 80 percent of the provider rate. For purposes of this section,
231.28 relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or
231.29 older, an adult child, a grandparent, or a grandchild.

231.30 Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to
231.31 read:

231.32 Subd. 28. **Personal care assistance provider agency; required documentation.**

231.33 (a) Required documentation must be completed and kept in the personal care assistance
231.34 provider agency file or the recipient's home residence. The required documentation
231.35 consists of:

- 232.1 (1) employee files, including:
- 232.2 (i) applications for employment;
- 232.3 (ii) background study requests and results;
- 232.4 (iii) orientation records about the agency policies;
- 232.5 (iv) trainings completed with demonstration of competence;
- 232.6 (v) supervisory visits;
- 232.7 (vi) evaluations of employment; and
- 232.8 (vii) signature on fraud statement;
- 232.9 (2) recipient files, including:
- 232.10 (i) demographics;
- 232.11 (ii) emergency contact information and emergency backup plan;
- 232.12 (iii) personal care assistance service plan;
- 232.13 (iv) personal care assistance care plan;
- 232.14 (v) month-to-month service use plan;
- 232.15 (vi) all communication records;
- 232.16 (vii) start of service information, including the written agreement with recipient; and
- 232.17 (viii) date the home care bill of rights was given to the recipient;
- 232.18 (3) agency policy manual, including:
- 232.19 (i) policies for employment and termination;
- 232.20 (ii) grievance policies with resolution of consumer grievances;
- 232.21 (iii) staff and consumer safety;
- 232.22 (iv) staff misconduct; and
- 232.23 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
- 232.24 resolution of consumer grievances;
- 232.25 (4) time sheets for each personal care assistant along with completed activity sheets
- 232.26 for each recipient served; ~~and~~
- 232.27 (5) agency marketing and advertising materials and documentation of marketing
- 232.28 activities and costs; and
- 232.29 (6) for each personal care assistant, whether or not the personal care assistant is
- 232.30 providing care to a relative as defined in subdivision 11.
- 232.31 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do
- 232.32 not consistently comply with the requirements of this subdivision.

232.33 Sec. 14. **[256B.0661] HOME AND COMMUNITY-BASED ATTENDANT**

232.34 **SERVICES AND SUPPORTS.**

233.1 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms
233.2 have the meanings given.

233.3 (b) "Activities of daily living" means basic personal everyday activities, including
233.4 eating, toileting, grooming, dressing, bathing, transferring, positioning, and mobility.

233.5 (c) "Extended home and community-based attendant services and supports" means
233.6 home and community-based attendant services included in a service plan under one of
233.7 the home and community-based services waivers under sections 256B.0915; 256B.092,
233.8 subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state
233.9 plan home and community-based attendant services for participants who:

233.10 (1) need assistance provided periodically during a week but less than daily and will
233.11 not be able to remain in their homes without assistance, and other replacement services
233.12 are more expensive or are not available when home and community-based attendant
233.13 services are to be reduced; or

233.14 (2) need additional personal care assistant services beyond the amount authorized
233.15 by the state plan personal care assistance assessment in order to ensure that their safety,
233.16 health, and welfare are provided for in their homes.

233.17 (d) "Health-related tasks" means those tasks and procedures listed in section
233.18 256B.0659, subdivision 2, paragraph (c).

233.19 (e) "Home and community-based attendant services and supports" means personal
233.20 assistance, supports, items, and related services that provide assistance with accomplishing
233.21 activities of daily living (ADLs), instrumental activities of daily living (IADLs), and
233.22 health-related tasks including necessary supervision by a qualified professional.

233.23 (f) "Individual's representative" means a parent, family member, advocate, or other
233.24 representative of the individual, authorized in a written statement by the person or
233.25 the person's legal representative, to speak on the person's behalf and help the person
233.26 understand and make informed choices in matters related to identification of needs and
233.27 choice of services and supports and assist the person in the implementation of an approved
233.28 support plan. For minor children and adults who cannot direct their own care, the
233.29 individual representative must meet the requirements of section 256B.0659, subdivisions
233.30 9 and 10, and shall not act as the home and community-based attendant for the individual.

233.31 (g) "Instrumental activities of daily living" means activities related to living
233.32 independently in the community, including meal planning and preparation, managing
233.33 finances, shopping for food, clothing, and other essential items, performing essential
233.34 household chores, communicating by phone or other media, traveling, and participating
233.35 in the community.

233.36 (h) "Legal representative" means the legal guardian or parent of a minor.

234.1 (i) "Qualified professional" means a professional providing supervision of home
234.2 and community-based attendant services and staff as defined in section 256B.0625,
234.3 subdivision 19c.

234.4 Subd. 2. **Eligibility.** (a) The home and community-based attendant services and
234.5 supports option is available to a person who:

234.6 (1) is a recipient of medical assistance as determined under sections 256B.055,
234.7 256B.056, and 256B.057, subdivision 9;

234.8 (2) has an income that meets one of the following thresholds as determined annually:

234.9 (i) is equal to or less than 150 percent of the federal poverty guidelines; or

234.10 (ii) is eligible for nursing facility services under the state plan and for whom it has
234.11 been determined that in the absence of home and community-based attendant services
234.12 and supports, the individual would otherwise require a level of care covered by medical
234.13 assistance and furnished in a hospital, a nursing facility, an intermediate care facility for
234.14 persons with developmental disabilities, or an institution for mental diseases;

234.15 (3) meets the qualification criteria for personal care assistance services under
234.16 section 256B.0625, subdivision 19a, in effect on July 1, 2010, which requires at least one
234.17 dependency in an activity of daily living or Level I behavior; and

234.18 (4) lives in the person's own apartment or home, which is not owned, operated, or
234.19 controlled by a provider of services under this section, not related by blood, adoption,
234.20 family foster care, or marriage. The person does not live in a nursing facility, institution
234.21 for mental diseases, intermediate care facility for persons with developmental disabilities,
234.22 or any setting located in a building that is also an inpatient institution or custodial care
234.23 facility or a building on the grounds or immediately adjacent to a public institution or
234.24 disability-specific housing complex, as defined by the commissioner.

234.25 Subd. 3. **Eligibility for other services.** Selection of the home and community-based
234.26 attendant services and supports option by a recipient does not restrict access to other
234.27 medically necessary care and services furnished under the state plan medical assistance
234.28 benefit or through other funding, except that a person receiving personal care assistance
234.29 services, a family support grant, semi-independent living services, or a consumer support
234.30 grant is not eligible for funding under the home and community-based attendant services
234.31 and supports option.

234.32 Subd. 4. **Assessment requirements.** (a) The home and community-based attendant
234.33 services and supports option assessment must meet the following requirements:

234.34 (1) for persons whose income is below 150 percent of the federal poverty guidelines,
234.35 be consistent with the requirements of the personal care assistance services assessment
234.36 under section 256B.0659, subdivision 3a;

235.1 (2) for persons whose income is above 150 percent of the federal poverty guidelines,
235.2 the person must meet the level of care for a nursing facility, intermediate care facility
235.3 for persons with developmental disabilities, neurobehavioral hospital, or an institution
235.4 for mental diseases;

235.5 (3) be conducted face-to-face in the recipient's home initially and at least annually
235.6 thereafter; when there is a significant change in the recipient's condition; and when there is
235.7 a change in the person's need for services under this option. A recipient who is residing in
235.8 a facility may be assessed for home and community-based attendant services and supports
235.9 for purposes of returning to the community using this option;

235.10 (4) be completed using the format established by the commissioner; and

235.11 (5) for persons whose need for services and supports meets the definition of extended
235.12 home and community-based attendant services, the lead agency is required to assess for
235.13 home and community-based services waiver eligibility.

235.14 (b) The results of the home and community-based attendant services and supports
235.15 option assessment and recommendations shall be communicated to the commissioner and
235.16 the recipient as required under section 256B.0659, subdivision 3a.

235.17 (c) The lead agency responsible for administration and implementation of the
235.18 home and community-based attendant services and supports shall provide the annual and
235.19 monthly self-directed service budget amounts for all eligible persons within 40 days after
235.20 an initial assessment or annual review and within ten days if requested at a time unrelated
235.21 to the assessment or annual review.

235.22 Subd. 5. **Service plan requirements.** (a) The plan for home and community-based
235.23 attendant services and supports option must meet the following requirements:

235.24 (1) the plan must be completed using a person-centered process consistent with the
235.25 requirements in section 256B.0657, subdivision 5;

235.26 (2) reflects the clinical and support needs identified through the assessment;

235.27 (3) includes the person's chosen individual goals and providers;

235.28 (4) includes the services and supports, both paid and unpaid, that will assist the
235.29 individual to achieve identified goals;

235.30 (5) includes an assessment of risk factors and measures to minimize risks and
235.31 a backup plan; and

235.32 (6) must be signed by the individual or legal representative and other persons
235.33 responsible for aspects of the plan.

235.34 Subd. 6. **Covered services.** (a) Services covered under the home and
235.35 community-based attendant services and supports option include:

236.1 (1) assistance with activities of daily living, as described under section 256B.0659,
236.2 subdivision 2;

236.3 (2) assistance with instrumental activities of daily living as defined in section
236.4 256B.0659, subdivision 1, paragraph (i), for both children and adults;

236.5 (3) assistance with health-related procedures and tasks, as defined in section
236.6 256B.0659, subdivision 2;

236.7 (4) backup systems or mechanisms to ensure continuity of services and supports;

236.8 (5) voluntary training for recipients on how to select, manage, and dismiss staff;

236.9 (6) expenditures for transition costs such as rent, utility deposits, first and last
236.10 month's rent, basic kitchen supplies, and other necessities required for an individual to
236.11 transition from a nursing facility, institution for mental diseases, or intermediate care
236.12 facility for persons with developmental disabilities to a community-based home setting
236.13 where the individual resides; and

236.14 (7) expenditures related to a need identified in the individual's person-centered plan
236.15 of services that increase a participant's independence or substitute for human assistance, to
236.16 the extent that expenditures would otherwise be made for human assistance.

236.17 (b) The services and supports that are purchased must be linked to an assessed need
236.18 or goal established in the individual's person-centered service plan.

236.19 (c) All services must be provided to assist the recipient to acquire or enhance skills
236.20 or to maintain functioning so that the individual can accomplish the activities of daily
236.21 living, instrumental activities of daily living, and health-related tasks in order to remain or
236.22 become as independent as possible at home and in the community.

236.23 (d) Shared services under this section must meet the requirements of section
236.24 256B.0659, subdivisions 16 and 17.

236.25 Subd. 7. **Noncovered services.** Services and supports that are not eligible for
236.26 payment under the home and community-based attendant services and supports option
236.27 include:

236.28 (1) services, goods, or supports that do not benefit the recipient;

236.29 (2) special education and related services provided under the Individuals with
236.30 Disabilities Education Act that are related to education only and vocational rehabilitation
236.31 services provided under the Rehabilitation Act of 1973;

236.32 (3) room and board costs for the individual, except for allowable transition services
236.33 listed in subdivision 6;

236.34 (4) assistive devices and assistive technology services other than those identified in
236.35 subdivision 6, or those that are based on a specific need identified in the service plan when
236.36 used in conjunction with other home and community-based attendant services;

237.1 (5) medical supplies and equipment;
237.2 (6) home modifications; and
237.3 (7) items or services listed in section 256B.0659, subdivision 3, except that essential
237.4 household chores and instrumental activities of daily living for children are allowed to the
237.5 extent the need and service is documented in the support plan.

237.6 Subd. 8. **Service budget requirements.** The budget allocation for a person's
237.7 home and community-based attendant services and supports option must be based on
237.8 the budget amount allowed under the assessment for personal care assistant services in
237.9 section 256B.0659.

237.10 Subd. 9. **Staff and qualified professional requirements.** (a) A home and
237.11 community-based attendant must meet the requirements in section 256B.0659,
237.12 subdivisions 11, 11a, and 12.

237.13 (b) Qualified professionals must meet the requirements in section 256B.0659,
237.14 subdivisions 13 and 14.

237.15 Subd. 10. **Requirements for initial enrollment; annual reenrollment; enrollment**
237.16 **after termination.** (a) All home and community-based attendant services and supports
237.17 option provider agencies must meet the enrollment requirements under section 256B.0659,
237.18 subdivision 21.

237.19 (b) All home and community-based attendant services and supports option provider
237.20 agencies shall resubmit, on an annual basis, the information required in a format
237.21 determined by the commissioner as required under section 256B.0659, subdivision 22.

237.22 (c) A home and community-based attendant services and supports provider agency
237.23 that has been disenrolled must meet the requirements of section 256B.0659, subdivision
237.24 23, to reenroll.

237.25 Subd. 11. **General duties of provider agencies.** Home and community-based
237.26 attendant services and supports option provider agencies are required to follow section
237.27 256B.0659, subdivisions 24, 25, 26, 27, and 28.

237.28 Subd. 12. **Stakeholder development and implementation council.** (a)
237.29 The commissioner shall establish and consult with a stakeholder development and
237.30 implementation council comprised primarily of individuals with disabilities, elderly
237.31 individuals and their representatives, and other interested stakeholders, including
237.32 representatives of assessment agencies and provider agencies.

237.33 (b) The commissioner shall consult and collaborate with the council in the
237.34 development and implementation of a state plan amendment to provide home and
237.35 community-based attendant services and supports, on matters of data collection, analysis,
237.36 and outcomes, including the cost of services provided and the cost of alternatives if home

and community-based attendant services and supports were not provided, and other health care and community support and social service costs, as well as other costs involving local, state, and federal funds, and quality assurance issues and measures.

Subd. 13. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for the home and community-based attendant services and supports option that:

(1) recognizes the person-centered services role of the recipient and chosen advocate or other legal representative, and assure the appropriateness of support plans and budgets based upon the person's resources, capabilities, and needs; and

(2) includes background studies, backup emergency plans, and disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource education and materials for recipients and their legal representatives and other involved parties, including appropriate information, counseling, training, and assistance.

(c) Performance assessment measures and other outcome data such as the recipient's functioning in their home and community, satisfaction with services and supports, and ongoing monitoring of health and safety shall be identified in consultation with the stakeholder council.

Subd. 14. **Self-directed home and community-based services and supports.** The home and community-based services and supports option includes the option to self-directed services under section 256B.0657.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations on cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

239.1 (6) federally mandated screening to determine the need for an institutional level of
239.2 care under subdivision 4a;

239.3 (7) determination of home and community-based waiver service eligibility
239.4 including level of care determination for individuals who need an institutional level of
239.5 care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility
239.6 including state plan home care services identified in sections 256B.0625, subdivisions
239.7 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support
239.8 plan development with appropriate referrals, including the option for ~~consumer-directed~~
239.9 ~~community~~ self-directed supports;

239.10 (8) providing recommendations for nursing facility placement when there are no
239.11 cost-effective community services available; ~~and~~

239.12 (9) assistance to transition people back to community settings after facility
239.13 admission; and

239.14 (10) providing notice to the individual and legal representative of the annual and
239.15 monthly amount authorized for traditional agency services and self-directed services under
239.16 section 256B.0657 for which the recipient is found eligible.

239.17 (b) "Long-term care options counseling" means the services provided by the linkage
239.18 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
239.19 telephone assistance and follow up once a long-term care consultation assessment has
239.20 been completed.

239.21 (c) "Minnesota health care programs" means the medical assistance program under
239.22 chapter 256B and the alternative care program under section 256B.0913.

239.23 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
239.24 plans administering long-term care consultation assessment and support planning services.

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

239.26 Sec. 16. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to
239.27 read:

239.28 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
239.29 services planning, or other assistance intended to support community-based living,
239.30 including persons who need assessment in order to determine waiver or alternative
239.31 care program eligibility, must be visited by a long-term care consultation team within
239.32 ~~15 calendar~~ 20 working days after the date on which an assessment was requested or
239.33 recommended. After January 1, 2011, these requirements also apply to personal care
239.34 assistance services, private duty nursing, and home health agency services, on timelines

established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including ~~consumer-directed~~ self-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care. For persons determined eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the community support plan must also include the estimated annual and monthly budget amount for those services.

(f) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to the services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

241.1 (h) The team must give the person receiving assessment or support planning, or
241.2 the person's legal representative, materials, and forms supplied by the commissioner
241.3 containing the following information:

241.4 (1) the need for and purpose of preadmission screening if the person selects nursing
241.5 facility placement;

241.6 (2) the role of the long-term care consultation assessment and support planning in
241.7 waiver and alternative care program eligibility determination;

241.8 (3) information about Minnesota health care programs;

241.9 (4) the person's freedom to accept or reject the recommendations of the team;

241.10 (5) the person's right to confidentiality under the Minnesota Government Data
241.11 Practices Act, chapter 13;

241.12 (6) the long-term care consultant's decision regarding the person's need for
241.13 institutional level of care as determined under criteria established in section 144.0724,
241.14 subdivision 11, or 256B.092; and

241.15 (7) the person's right to appeal the decision regarding the need for nursing facility
241.16 level of care or the county's final decisions regarding public programs eligibility according
241.17 to section 256.045, subdivision 3.

241.18 (i) Face-to-face assessment completed as part of eligibility determination for
241.19 the alternative care, elderly waiver, community alternatives for disabled individuals,
241.20 community alternative care, and traumatic brain injury waiver programs under sections
241.21 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
241.22 than 60 calendar days after the date of assessment. The effective eligibility start date
241.23 for these programs can never be prior to the date of assessment. If an assessment was
241.24 completed more than 60 days before the effective waiver or alternative care program
241.25 eligibility start date, assessment and support plan information must be updated in a
241.26 face-to-face visit and documented in the department's Medicaid Management Information
241.27 System (MMIS). The updated assessment may be completed by face-to-face visit, written
241.28 communication, or telephone. The effective date of program eligibility in this case cannot
241.29 be prior to the date the updated assessment is completed.

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

241.31 Sec. 17. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to
241.32 read:

241.33 Subd. 4a. **Preadmission screening activities related to nursing facility**

241.34 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
241.35 boarding care facilities, must be screened prior to admission regardless of income, assets,

or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

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

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria ~~established~~ developed by the commissioner, and in section 144.0724, subdivision 11, and 256B.092, using forms developed by the commissioner. Effective no sooner than on or after January 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In

243.1 assessing a person's needs, consultation team members shall have a physician available for
243.2 consultation and shall consider the assessment of the individual's attending physician, if
243.3 any. The individual's physician must be included if the physician chooses to participate.
243.4 Other personnel may be included on the team as deemed appropriate by the county.

243.5 Sec. 18. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to
243.6 read:

243.7 Subd. 6. **Payment for long-term care consultation services.** (a) Seventy-five
243.8 percent of the total payment for each county must be paid monthly by certified nursing
243.9 facilities in the county. The monthly amount to be paid by each nursing facility for each
243.10 fiscal year must be determined by dividing the county's annual allocation for long-term
243.11 care consultation services by 12 to determine the monthly payment and allocating the
243.12 monthly payment to each nursing facility based on the number of licensed beds in the
243.13 nursing facility. Payments to counties in which there is no certified nursing facility must be
243.14 made by increasing the payment rate of the two facilities located nearest to the county seat.

243.15 (b) The commissioner shall include the total annual payment determined under
243.16 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
243.17 according to section 256B.431, subdivision 2b, paragraph (g).

243.18 (c) In the event of the layaway, delicensure and decertification, or removal from
243.19 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
243.20 the per diem payment amount in paragraph (b) and may adjust the monthly payment
243.21 amount in paragraph (a). The effective date of an adjustment made under this paragraph
243.22 shall be on or after the first day of the month following the effective date of the layaway,
243.23 delicensure and decertification, or removal from layaway.

243.24 (d) Payments for long-term care consultation services are available to the county
243.25 or counties to cover staff salaries and expenses to provide the services described in
243.26 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
243.27 the limits of available funding, sufficient personnel to provide long-term care consultation
243.28 services while meeting the state's long-term care outcomes and objectives as defined in
243.29 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
243.30 objectives as approved by the commissioner in the biennial home and community-based
243.31 services quality assurance plan on a form provided by the commissioner.

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

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

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. ~~No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.~~ Counties may set a fee schedule for initial assessments and support plan development for individuals who are not financially eligible for medical assistance or MinnesotaCare. The maximum fee must not be greater than the actual cost of the initial assessment and support plan development.

(h) The commissioner shall develop an alternative payment methodology for long-term care consultation services that includes the funding available under this subdivision, and sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of federal funding for this activity.

Sec. 19. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. Eligibility for funding for services for nonmedical assistance recipients.

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4a, paragraph (d), but for the provision of services under the alternative care program. ~~Effective January 1, 2011, this determination must be made according to the criteria established in section 144.0724, subdivision 11;~~

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding \$500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the

monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) only one dependency up to two dependencies in bathing, dressing, grooming, ~~or walking, or (iii) a dependency score of less than three if eating is the only dependency~~ and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed ~~\$600~~ \$593 per month for all new participants enrolled in the program on or after July 1, ~~2009~~ 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

- (i) the appointment of a representative payee;
- (ii) automatic payment from a financial account;
- (iii) the establishment of greater family involvement in the financial management of payments; or
- (iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments.

Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waived services to an individual elderly waiver client except for individuals described in paragraph (b) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in

which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by ~~the greater of any legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment.

(b) The monthly limit for the cost of waived services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with:

- (1) no dependencies in activities of daily living; ~~or~~
- (2) ~~only one dependency up to two dependencies in bathing, dressing, grooming, or walking, or~~ (3) ~~a dependency score of less than three if eating is the only dependency, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911~~

~~shall be the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A \$1,750 per month effective on October July 1, 2008 2011, per month~~ for all new participants enrolled in the program on or after July 1, ~~2009 2011~~. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waived services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a) or (b).

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waived services, a monthly conversion budget limit for the cost of elderly waived services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be the resident class assigned

under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be based on the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the ~~resident~~ elderly waiver applicant currently resides ~~multiplied~~. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365 ~~and~~, divided by 12, ~~less and reduced by~~ the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion rate ~~may budget limit shall~~ be adjusted by the greater of any subsequent legislatively adopted ~~home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates~~ annually as described in subdivision 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the ~~conversion rate limit is equal to the nursing facility rate~~ per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waived services, including ~~extended medical~~ specialized supplies and equipment and environmental ~~modifications and~~ accessibility adaptations; and

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

Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The

lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

~~(e)~~ (f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

250.1 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
250.2 family for additional units of any allowable component service beyond those available
250.3 under the service rate limits described in paragraph (d), nor for additional units of any
250.4 allowable component service beyond those approved in the service plan by the lead agency.

250.5 Sec. 23. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to
250.6 read:

250.7 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
250.8 payment rate for 24-hour customized living services is a monthly rate authorized by the
250.9 lead agency within the parameters established by the commissioner of human services.
250.10 The payment agreement must delineate the amount of each component service included in
250.11 each recipient's customized living service plan. The lead agency shall ensure that there is a
250.12 documented need within the parameters established by the commissioner for all component
250.13 customized living services authorized. The lead agency shall not authorize 24-hour
250.14 customized living services unless there is a documented need for 24-hour supervision.

250.15 (b) For purposes of this section, "24-hour supervision" means that the recipient
250.16 requires assistance due to needs related to one or more of the following:

250.17 (1) intermittent assistance with toileting, positioning, or transferring;

250.18 (2) cognitive or behavioral issues;

250.19 (3) a medical condition that requires clinical monitoring; or

250.20 (4) for all new participants enrolled in the program on or after ~~January~~ July 1, 2011,
250.21 and all other participants at their first reassessment after ~~January~~ July 1, 2011, dependency
250.22 in at least ~~two~~ three of the following activities of daily living as determined by assessment
250.23 under section 256B.0911: bathing; dressing; grooming; walking; or eating when the
250.24 dependency score in eating is three or greater; and needs medication management and at
250.25 least 50 hours of service per month. The lead agency shall ensure that the frequency and
250.26 mode of supervision of the recipient and the qualifications of staff providing supervision
250.27 are described and meet the needs of the recipient.

250.28 (c) The payment rate for 24-hour customized living services must be based on the
250.29 amount of component services to be provided utilizing component rates established by the
250.30 commissioner. Counties and tribes will use tools issued by the commissioner to develop
250.31 and document customized living plans and authorize rates.

250.32 (d) Component service rates must not exceed payment rates for comparable elderly
250.33 waiver or medical assistance services and must reflect economies of scale.

250.34 (e) The individually authorized 24-hour customized living payments, in combination
250.35 with the payment for other elderly waiver services, including case management, must not

251.1 exceed the recipient's community budget cap specified in subdivision 3a. Customized
251.2 living services must not include rent or raw food costs.

251.3 (f) The individually authorized 24-hour customized living payment rates shall not
251.4 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
251.5 living services in effect and in the Medicaid management information systems on March
251.6 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
251.7 to 9549.0059, to which elderly waiver service clients are assigned. When there are
251.8 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
251.9 shall multiply the calculated service payment rate maximum for the A classification by
251.10 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
251.11 9549.0059, to determine the applicable payment rate maximum. Service payment rate
251.12 maximums shall be updated annually based on legislatively adopted changes to all service
251.13 rates for home and community-based service providers.

251.14 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
251.15 may establish alternative payment rate systems for 24-hour customized living services in
251.16 housing with services establishments which are freestanding buildings with a capacity of
251.17 16 or fewer, by applying a single hourly rate for covered component services provided
251.18 in either:

251.19 (1) licensed corporate adult foster homes; or

251.20 (2) specialized dementia care units which meet the requirements of section 144D.065
251.21 and in which:

251.22 (i) each resident is offered the option of having their own apartment; or

251.23 (ii) the units are licensed as board and lodge establishments with maximum capacity
251.24 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
251.25 subparts 1, 2, 3, and 4, item A.

251.26 (h) A provider may not bill or otherwise charge an elderly waiver participant or their
251.27 family for additional units of any allowable component service beyond those available
251.28 under the service rate limits described in paragraph (e), nor for additional units of any
251.29 allowable component service beyond those approved in the service plan by the lead agency.

251.30 Sec. 24. Minnesota Statutes 2010, section 256B.0915, subdivision 5, is amended to
251.31 read:

251.32 **Subd. 5. Assessments and reassessments for waiver clients.** (a) Each client
251.33 shall receive an initial assessment of strengths, informal supports, and need for services
251.34 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
251.35 client served under the elderly waiver must be conducted at least every 12 months and

at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

Sec. 25. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h ~~for the contract period beginning October 1, 2009~~. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

Sec. 26. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to read:

Subd. 6a. **Statewide availability of ~~consumer-directed community self-directed support services~~.** (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver ~~for persons with developmental disabilities under section 256B.092 and by April 1, 2005, for waivers under sections 256B.0915 and 256B.49, to make consumer-directed community self-directed support services available in every county of the state by January 1, 2002.~~

(b) Until the waiver amendment for self-directed community supports under section 54 is effective, if a county declines to meet the requirements for provision of ~~consumer-directed community self-directed~~ supports, the commissioner shall contract

with another county, a group of counties, or a private agency to plan for and administer ~~consumer-directed community~~ self-directed supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with developmental disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative with funds received through the ~~consumer-directed community~~ self-directed support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and services.~~** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~

~~(1) review of eligibility for services;~~
~~(2) screening;~~
~~(3) intake;~~
~~(4) diagnosis;~~
~~(5) the review and authorization of services based upon an individualized service plan; and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~ Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services cannot be provided to a recipient by a private agency that has any financial interest in the provisions of any other services included in the recipient's coordinated service and support plan.

(b) ~~Case management service activities provided to or arranged for a person include~~ services must be provided to each recipient of home and community-based waiver services and available to those eligible for case management under sections 256B.0621 and 256B.0924, subdivision 4, who choose this service. Case management services for an eligible person include:

- 254.1 (1) development of the ~~individual~~ coordinated service and support plan;
- 254.2 (2) informing the individual or the individual's legal guardian or conservator, or
- 254.3 parent if the person is a minor, of service options;
- 254.4 (3) consulting with relevant medical experts or service providers;
- 254.5 (4) assisting the person in the identification of potential providers;
- 254.6 (5) assisting the person to access services;
- 254.7 (6) coordination of services, including coordinating with the person's health care
- 254.8 home or health coordinator, if coordination of long-term care or community supports and
- 254.9 health care is not provided by another service provider;
- 254.10 (7) evaluation and monitoring of the services identified in the plan including at least
- 254.11 one face-to-face visit with each person annually by the case manager; and
- 254.12 (8) ~~annual reviews of service plans and services provided~~ providing the lead agency
- 254.13 with recommendations for service authorization based upon the individual's needs
- 254.14 identified in the support plan within ten working days after receiving the community
- 254.15 support plan from the certified assessor under section 256B.0911.
- 254.16 (c) Case management ~~administration and~~ service activities that are provided to the
- 254.17 person with a developmental disability shall be provided directly by ~~county agencies or~~
- 254.18 ~~under contract~~ a public or private agency that is enrolled as a medical assistance provider
- 254.19 determined by the commissioner to meet all of the requirements in section 256B.0621,
- 254.20 subdivision 5, paragraphs (a) and (b), clauses (1) to (5), and has no financial interest in the
- 254.21 provision of any other services to the person choosing case management service.
- 254.22 (d) ~~Case managers are responsible for the administrative duties and service~~
- 254.23 ~~provisions listed in paragraphs (a) and (b).~~ Case managers shall collaborate with
- 254.24 consumers, families, legal representatives, and relevant medical experts and service
- 254.25 providers in the development and annual review of the individualized service and
- 254.26 habilitation plans.
- 254.27 (e) The Department of Human Services shall offer ongoing education in case
- 254.28 management to case managers. Case managers shall receive no less than ten hours of case
- 254.29 management education and disability-related training each year.
- 254.30 (f) Persons eligible for home and community-based waiver services may choose a
- 254.31 case management service provider from among the public or private vendors enrolled
- 254.32 according to paragraph (d).
- 254.33 (g) For persons eligible for case management under section 256B.0924, and
- 254.34 Minnesota Rules, parts 9525.0004 to 9525.0036, the county or lead agency shall designate
- 254.35 the case management service provider.

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

255.1 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
255.2 read:

255.3 Subd. 1b. ~~Individual~~ Coordinated service and support plan. ~~The individual~~ Each
255.4 recipient of case management services and any legal representative shall be provided a
255.5 written copy of the coordinated service and support plan must, which:

255.6 (1) ~~include~~ is developed within ten working days after the case management service
255.7 receives the community support plan from the certified assessor under section 256B.0911;

255.8 (2) includes the results of the assessment information on the person's need for
255.9 service, including identification of service needs that will be or that are met by the person's
255.10 relatives, friends, and others, as well as community services used by the general public;

255.11 (3) reasonably assures the health, safety, and welfare of the recipient;

255.12 ~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person,
255.13 the person's legal guardian or conservator, or the parent if the person is a minor;

255.14 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
255.15 paragraph (o), of service and support providers;

255.16 ~~(3) identify~~ (6) identifies long- and short-range goals for the person;

255.17 ~~(4) identify~~ (7) identifies specific services and the amount and frequency of the
255.18 services to be provided to the person based on assessed needs, preferences, and available
255.19 resources. The ~~individual~~ coordinated service and support plan shall also specify other
255.20 services the person needs that are not available;

255.21 ~~(5) identify~~ (8) identifies the need for an ~~individual program~~ individual's provider
255.22 plan to be developed by the provider according to the respective state and federal licensing
255.23 and certification standards, and additional assessments to be completed or arranged by the
255.24 provider after service initiation;

255.25 ~~(6) identify~~ (9) identifies provider responsibilities to implement and make
255.26 recommendations for modification to the ~~individual~~ coordinated service and support plan;

255.27 ~~(7) include~~ (10) includes notice of the right to have assessments completed and
255.28 service plans developed within specified time periods, the right to appeal action or
255.29 inaction, and the right to request a conciliation conference or a hearing, an appeal under
255.30 section 256.045;

255.31 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
255.32 or conservator, or the parent if the person is a minor, and the authorized county
255.33 representative; and

255.34 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
255.35 needs that impact the delivery of services.

256.1 ~~Service planning formats developed for interagency planning such as transition,~~
256.2 ~~vocational, and individual family service plans may be substituted for service planning~~
256.3 ~~formats developed by county agencies.~~

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

256.5 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
256.6 read:

256.7 Subd. 1e. **Case management service monitoring, coordination, and evaluation;**
256.8 **and monitoring of services duties.** (a) If the ~~individual~~ coordinated service and support
256.9 plan identifies the need for individual ~~program~~ provider plans for authorized services,
256.10 the case ~~manager~~ management service provider shall assure that ~~individual program~~ the
256.11 individual provider plans are developed by the providers according to clauses (2) to (5).

256.12 The providers shall assure that the individual ~~program~~ provider plans:

256.13 (1) are developed according to the respective state and federal licensing and
256.14 certification requirements;

256.15 (2) are designed to achieve the goals of the individual service plan;

256.16 (3) are consistent with other aspects of the ~~individual~~ coordinated service and
256.17 support plan;

256.18 (4) assure the health and safety of the person; and

256.19 (5) are developed with consistent and coordinated approaches to services among the
256.20 various service providers.

256.21 (b) The case ~~manager~~ management service provider shall monitor the provision of
256.22 services:

256.23 (1) to assure that the individual service plan is being followed according to
256.24 paragraph (a);

256.25 (2) to identify any changes or modifications that might be needed in the individual
256.26 service plan, including changes resulting from recommendations of current service
256.27 providers;

256.28 (3) to determine if the person's legal rights are protected, and if not, notify the
256.29 person's legal guardian or conservator, or the parent if the person is a minor, protection
256.30 services, or licensing agencies as appropriate; and

256.31 (4) to determine if the person, the person's legal guardian or conservator, or the
256.32 parent if the person is a minor, is satisfied with the services provided.

256.33 (c) If the provider fails to develop or carry out the individual program plan according
256.34 to paragraph (a), the case manager shall notify the person's legal guardian or conservator,
256.35 or the parent if the person is a minor, the provider, the respective licensing and certification

257.1 agencies, and the county board where the services are being provided. In addition, the
257.2 case manager shall identify other steps needed to assure the person receives the services
257.3 identified in the ~~individual~~ coordinated service and support plan.

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

257.5 Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to
257.6 read:

257.7 Subd. 1g. **Conditions not requiring development of ~~individual~~ a coordinated**
257.8 **service and support plan.** Unless otherwise required by federal law, the county agency is
257.9 not required to complete ~~an individual~~ a coordinated service and support plan as defined in
257.10 subdivision 1b for:

257.11 (1) persons whose families are requesting respite care for their family member who
257.12 resides with them, or whose families are requesting a family support grant and are not
257.13 requesting purchase or arrangement of habilitative services; and

257.14 (2) persons with developmental disabilities, living independently without authorized
257.15 services or receiving funding for services at a rehabilitation facility as defined in section
257.16 268A.01, subdivision 6, and not in need of or requesting additional services.

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

257.18 Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

257.19 Subd. 3. **Authorization and termination of services.** ~~County agency case~~
257.20 ~~managers~~ Lead agencies, under rules of the commissioner, shall authorize and terminate
257.21 services of community and regional treatment center providers according to ~~individual~~
257.22 coordinated service and support plans. Services provided to persons with developmental
257.23 disabilities may only be authorized and terminated ~~by case managers~~ according to (1)
257.24 rules of the commissioner and (2) the ~~individual~~ coordinated service and support plan as
257.25 defined in subdivision 1b. Medical assistance services not needed shall not be authorized
257.26 by county agencies or funded by the commissioner. When purchasing or arranging for
257.27 unlicensed respite care services for persons with overriding health needs, the county
257.28 agency shall seek the advice of a health care professional in assessing provider staff
257.29 training needs and skills necessary to meet the medical needs of the person.

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

257.31 Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. ~~Screening team~~ Additional certified assessor duties. The ~~screening team~~ certified assessor shall:

- (1) review diagnostic data;
- (2) review health, social, and developmental assessment data using a ~~uniform~~ screening comprehensive assessment tool specified by the commissioner;
- (3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;
- (4) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;
- (5) assess whether a person is in need of long-term residential care;
- (6) make recommendations regarding placement services and payment for: (i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence; (ii) training and habilitation service, vocational rehabilitation, and employment training activities; (iii) community residential placement services; ~~(iv) regional treatment center placement~~; or ~~(v)~~ (iv) a home and community-based service alternative to community residential placement or regional treatment center placement;
- (7) evaluate the availability, location, and quality of the services listed in clause (6), including the impact of ~~placement alternatives~~ services and supports options on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;
- (8) identify the cost implications of recommendations in clause (6) and provide written notice of the annual and monthly amount authorized to be spent for services for the recipient;
- (9) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities; and
- (10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.

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

Sec. 33. **[256B.0961] STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.**

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans

259.1 receiving disability services is enacted. This system is a partnership between the
259.2 Department of Human Services and the State Quality Council established under
259.3 subdivision 3.

259.4 (b) This system is a result of the recommendations from the Department of Human
259.5 Services' licensing and alternative quality assurance study mandated under Laws 2005,
259.6 First Special Session chapter 4, article 7, section 57, and presented to the legislature
259.7 in February 2007.

259.8 (c) The disability services eligible under this section include:

259.9 (1) the home and community-based services waiver programs for persons with
259.10 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
259.11 including traumatic brain injuries and services for those who qualify for nursing facility
259.12 level of care or hospital facility level of care;

259.13 (2) home care services under section 256B.0651;

259.14 (3) family support grants under section 252.32;

259.15 (4) consumer support grants under section 256.476;

259.16 (5) semi-independent living services under section 252.275; and

259.17 (6) services provided through an intermediate care facility for the developmentally
259.18 1.27 disabled.

259.19 (d) For purposes of this section, the following definitions apply:

259.20 (1) "commissioner" means the commissioner of human services;

259.21 (2) "council" means the State Quality Council under subdivision 3;

259.22 (3) "Quality Assurance Commission" means the commission under section
259.23 256B.0951; and

259.24 (4) "system" means the State Quality Assurance, Quality Improvement and 2.7
259.25 Licensing System under this section.

259.26 Subd. 2. **Duties of the commissioner of human services.** (a) The commissioner of
259.27 human services shall establish the State Quality Council under subdivision 3.

259.28 (b) The commissioner shall initially delegate authority to perform licensing
259.29 functions and activities according to section 245A.16 to a host county in Region 10. The
259.30 commissioner must not license or reimburse a participating facility, program, or service
259.31 located in Region 10 if the commissioner has received notification from the host county
259.32 that the facility, program, or service has failed to qualify for licensure.

259.33 (c) The commissioner may conduct random licensing inspections based on outcomes
259.34 adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services
259.35 eligible under this section. The role of the random inspections is to verify that the system

260.1 protects the safety and well-being of persons served and maintains the availability of
260.2 high-quality services for persons with disabilities.

260.3 (d) The commissioner shall ensure that the federal home and community-based
260.4 waiver requirements are met and that incidents that may have jeopardized safety and health
260.5 or violated services-related assurances, civil and human rights, and other protections
260.6 designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and
260.7 acted upon in a timely manner.

260.8 (e) The commissioner shall seek a federal waiver by July 1, 2012 to allow
260.9 intermediate care facilities for persons with developmental disabilities to participate in
260.10 this system.

260.11 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
260.12 Council which must define regional quality councils, and carry out a community-based,
260.13 person-directed quality review component, and a comprehensive system for effective
260.14 incident reporting, investigation, analysis, and follow-up.

260.15 (b) By August 1, 2011, the commissioner of human services shall appoint the
260.16 members of the initial State Quality Council. Members shall include representatives
260.17 from the following groups:

260.18 (1) disability service recipients and their family members;

260.19 (2) during the first two years of the State Quality Council, there must be at least three
260.20 members from the Region 10 stakeholders. As regional quality councils are formed under
260.21 subdivision 4, each regional quality council shall appoint one member;

260.22 (3) disability service providers;

260.23 (4) disability advocacy groups; and

260.24 (5) county human services agencies and staff from the Departments of Human
260.25 Services and Health, and Ombudsman for Mental Health and Developmental Disabilities;

260.26 (c) Members of the council who do not receive a salary or wages from an employer
260.27 for time spent on council duties may receive a per diem payment when performing council
260.28 duties and functions.

260.29 (d) The State Quality Council shall:

260.30 (1) assist the Departments of Human Services and Health in fulfilling federally
260.31 mandated obligations by monitoring disability service quality and quality assurance and
260.32 improvement practices in Minnesota; and

260.33 (2) establish state quality improvement priorities with methods for achieving results
260.34 and provide an annual report to the legislative committees with jurisdiction over policy
260.35 and funding of disability services on the outcomes, improvement priorities, and activities
260.36 undertaken by the commission during the previous state fiscal year.

261.1 (e) The State Quality Council, in partnership with the commissioner, shall:

261.2 (1) approve and direct implementation of the community-based, person-directed
261.3 system established in this section;

261.4 (2) recommend an appropriate method of funding this system, and determine the
261.5 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

261.6 (3) approve measurable outcomes in the areas of health and safety, consumer
261.7 evaluation, education and training, providers, and systems;

261.8 (4) establish variable licensure periods not to exceed three years based on outcomes
261.9 achieved; and

261.10 (5) in cooperation with the Quality Assurance Commission, design a transition plan
261.11 for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

261.12 (f) The State Quality Council shall notify the commissioner of human services that a
261.13 facility, program, or service has been reviewed by quality assurance team members under
261.14 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

261.15 (g) The State Quality Council, in partnership with the commissioner, shall establish
261.16 an ongoing review process for the system. The review shall take into account the
261.17 comprehensive nature of the system which is designed to evaluate the broad spectrum of
261.18 licensed and unlicensed entities that provide services to persons with disabilities. The
261.19 review shall address efficiencies and effectiveness of the system.

261.20 (h) The State Quality Council may recommend to the commissioner certain
261.21 variances from the standards governing licensure of programs for persons with disabilities
261.22 in order to improve the quality of services so long as the recommended variances do
261.23 not adversely affect the health or safety of persons being served or compromise the
261.24 qualifications of staff to provide services.

261.25 (i) The safety standards, rights, or procedural protections referenced under
261.26 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
261.27 recommendations to the commissioner or to the legislature in the report required under
261.28 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
261.29 procedural protections referenced under subdivision 2, paragraph (c).

261.30 (j) The State Quality Council may hire staff to perform the duties assigned in this
261.31 4.14 subdivision.

261.32 **Subd. 4. Regional quality councils.** (a) The commissioner shall establish, as
261.33 selected by the State Quality Council, regional quality councils of key stakeholders,
261.34 including regional representatives of:

261.35 (1) disability service recipients and their family members;

261.36 (2) disability service providers;

262.1 (3) disability advocacy groups; and
262.2 (4) county human services agencies and staff from the Departments of Human
262.3 Services, and Health, and Ombudsman for Mental Health and Developmental Disabilities.
262.4 (b) Each regional quality council shall:
262.5 (1) direct and monitor the community-based, person-directed quality assurance
262.6 system in this section;
262.7 (2) approve a training program for quality assurance team members under clause
262.8 (13);
262.9 (3) review summary reports from quality assurance team reviews and make
262.10 recommendations to the State Quality Council regarding program licensure;
262.11 (4) make recommendations to the State Quality Council regarding the system;
262.12 (5) resolve complaints between the quality assurance teams, counties, providers,
262.13 persons receiving services, their families, and legal representatives;
262.14 (6) analyze and review quality outcomes and critical incident data reporting
262.15 incidents of life safety concerns immediately to the Department of Human Services
262.16 licensing division;
262.17 (7) provide information and training programs for persons with disabilities and their
262.18 families and legal representatives on service options and quality expectations;
262.19 (8) disseminate information and resources developed to other regional quality
262.20 councils;
262.21 (9) respond to state-level priorities;
262.22 (10) establish regional priorities for quality improvement;
262.23 (11) submit an annual report to the State Quality Council on the status, outcomes,
262.24 improvement priorities, and activities in the region;
262.25 (12) choose a representative to participate on the State Quality Council and assume
262.26 other responsibilities consistent with the priorities of the State Quality Council; and
262.27 (13) recruit, train, and assign duties to members of quality assurance teams, taking
262.28 into account the size of the service provider, the number of services to be reviewed,
262.29 the skills necessary for the team members to complete the process, and ensure that no
262.30 team member has a financial, personal, or family relationship with the facility, program,
262.31 or service being reviewed or with anyone served at the facility, program, or service.
262.32 Quality assurance teams must be comprised of county staff, persons receiving services
262.33 or the person's families, legal representatives, members of advocacy organizations,
262.34 providers, and other involved community members. Team members must complete
262.35 the training program approved by the regional quality council and must demonstrate

performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality counsels under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are effective July 1, 2011.

(b) The jurisdictions of the regional quality councils in subdivision 4 must be defined, with implementation dates, by July 1, 2012. During the biennium beginning July 6.20 1, 2011, the Quality Assurance Commission shall continue to implement the

264.1 alternative licensing system under this section. An additional two regional quality
264.2 counsels must begin implementation on July 1, 2012, and the final three regional quality
264.3 counsels must begin implementation on July 1, 2013.

264.4 Sec. 34. Minnesota Statutes 2010, section 256B.19, is amended by adding a
264.5 subdivision to read:

264.6 Subd. 2d. **Obligation of local agency to process medical assistance applications**
264.7 **within established timelines.** (a) Except as provided in paragraph (b), when an individual
264.8 submits an application for medical assistance and the applicant's eligibility is based on
264.9 disability or on being age 65 or older, the county must determine the applicant's eligibility
264.10 and mail a notice of its decision to the applicant within:

264.11 (1) 60 days from the date of the application for an individual whose eligibility
264.12 is based on disability; or

264.13 (2) 45 days from the date of the application for an individual whose eligibility is
264.14 based on being age 65 or older.

264.15 (b) The county must determine eligibility and mail a notice of its decision within the
264.16 time frames stated in paragraph (a), except in the following circumstances:

264.17 (1) the county cannot make a determination because, despite reasonable efforts by
264.18 the county to communicate what is required, the applicant or an examining physician
264.19 delays or fails to take a required action; or

264.20 (2) there is an administrative or other emergency beyond the county's control. For
264.21 purposes of this clause, a staffing shortage does not constitute an emergency beyond
264.22 the county's control.

264.23 For the events in either clause (1) or (2), the county must document in the applicant's
264.24 case record the reason for delaying beyond the established time frames.

264.25 (c) The county must not use the time frames established in paragraph (a) as a waiting
264.26 period before determining eligibility or as a reason for denying eligibility because it has
264.27 not determined eligibility within the established time frames.

264.28 (d) Effective July 1, 2011, unless one of the exceptions listed under paragraph (b)
264.29 applies, if a county fails to comply with paragraph (a) and the applicant ultimately is
264.30 determined to be eligible for medical assistance, the county is responsible for the entire
264.31 cost of medical assistance services provided to the applicant by a nursing facility and not
264.32 paid for by federal funds, from and including the first date of eligibility through the date
264.33 on which the county mails written notice of its decision on the application. The applicable
264.34 facility will bill and receive payment directly from the commissioner in customary

265.1 fashion, and the commissioner shall deduct any obligation incurred under this paragraph
265.2 from the amount due to the local agency under subdivision 1.

265.3 (e) This subdivision supersedes subdivision 1, clause (2), if both apply to an
265.4 applicant.

265.5 Sec. 35. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to
265.6 read:

265.7 Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the
265.8 commissioner shall limit payment for leave days in a nursing facility to 79 percent of that
265.9 nursing facility's total payment rate for the involved resident.

265.10 (b) For services rendered on or after July 1, 2003, for facilities reimbursed under this
265.11 section or section 256B.434, the commissioner shall limit payment for leave days in a
265.12 nursing facility to 60 percent of that nursing facility's total payment rate for the involved
265.13 resident.

265.14 (c) For services rendered on or after July 1, 2011, for facilities reimbursed under
265.15 this chapter, the commissioner shall limit payment for leave days in a nursing facility
265.16 to 30 percent of that nursing facility's total payment rate for the involved resident, and
265.17 shall allow this payment only when the occupancy of the nursing facility, inclusive of
265.18 bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules,
265.19 part 9505.0415.

265.20 Sec. 36. Minnesota Statutes 2010, section 256B.431, is amended by adding a
265.21 subdivision to read:

265.22 Subd. 44. **Property rate increase for a facility in Bloomington effective**
265.23 **November 1, 2010.** Notwithstanding any other law to the contrary, money available for
265.24 moratorium projects under section 144A.073, subdivision 11, shall be used, effective
265.25 November 1, 2010, to fund an approved moratorium exception project for a nursing
265.26 facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total
265.27 property rate adjustment of \$19.33.

265.28 Sec. 37. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

265.29 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
265.30 have their payment rates determined under this section rather than section 256B.431, the
265.31 commissioner shall establish a rate under this subdivision. The nursing facility must enter
265.32 into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, October 1, 2011, and October 1, 2012, this paragraph shall apply only to the property-related payment rate, ~~except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided.~~ For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

267.1 (1) successful diversion or discharge of residents to the residents' prior home or other
267.2 community-based alternatives;

267.3 (2) adoption of new technology to improve quality or efficiency;

267.4 (3) improved quality as measured in the Nursing Home Report Card;

267.5 (4) reduced acute care costs; and

267.6 (5) any additional outcomes proposed by a nursing facility that the commissioner
267.7 finds desirable.

267.8 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
267.9 take action to come into compliance with existing or pending requirements of the life
267.10 safety code provisions or federal regulations governing sprinkler systems must receive
267.11 reimbursement for the costs associated with compliance if all of the following conditions
267.12 are met:

267.13 (1) the expenses associated with compliance occurred on or after January 1, 2005,
267.14 and before December 31, 2008;

267.15 (2) the costs were not otherwise reimbursed under subdivision 4f or section
267.16 144A.071 or 144A.073; and

267.17 (3) the total allowable costs reported under this paragraph are less than the minimum
267.18 threshold established under section 256B.431, subdivision 15, paragraph (e), and
267.19 subdivision 16.

267.20 The commissioner shall use money appropriated for this purpose to provide to qualifying
267.21 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
267.22 2008. Nursing facilities that have spent money or anticipate the need to spend money
267.23 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
267.24 system or (2) replacing all or portions of an existing sprinkler system may submit to the
267.25 commissioner by June 30, 2007, on a form provided by the commissioner the actual
267.26 costs of a completed project or the estimated costs, based on a project bid, of a planned
267.27 project. The commissioner shall calculate a rate adjustment equal to the allowable
267.28 costs of the project divided by the resident days reported for the report year ending
267.29 September 30, 2006. If the costs from all projects exceed the appropriation for this
267.30 purpose, the commissioner shall allocate the money appropriated on a pro rata basis
267.31 to the qualifying facilities by reducing the rate adjustment determined for each facility
267.32 by an equal percentage. Facilities that used estimated costs when requesting the rate
267.33 adjustment shall report to the commissioner by January 31, 2009, on the use of this
267.34 money on a form provided by the commissioner. If the nursing facility fails to provide
267.35 the report, the commissioner shall recoup the money paid to the facility for this purpose.
267.36 If the facility reports expenditures allowable under this subdivision that are less than

268.1 the amount received in the facility's annualized rate adjustment, the commissioner shall
268.2 recoup the difference.

268.3 Sec. 38. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

268.4 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
268.5 services shall calculate the amount of the planned closure rate adjustment available under
268.6 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

268.7 (1) the amount available is the net reduction of nursing facility beds multiplied
268.8 by \$2,080;

268.9 (2) the total number of beds in the nursing facility or facilities receiving the planned
268.10 closure rate adjustment must be identified;

268.11 (3) capacity days are determined by multiplying the number determined under
268.12 clause (2) by 365; and

268.13 (4) the planned closure rate adjustment is the amount available in clause (1), divided
268.14 by capacity days determined under clause (3).

268.15 (b) A planned closure rate adjustment under this section is effective on the first day
268.16 of the month following completion of closure of the facility designated for closure in the
268.17 application and becomes part of the nursing facility's total operating payment rate.

268.18 (c) Applicants may use the planned closure rate adjustment to allow for a property
268.19 payment for a new nursing facility or an addition to an existing nursing facility or as an
268.20 operating payment rate adjustment. Applications approved under this subdivision are
268.21 exempt from other requirements for moratorium exceptions under section 144A.073,
268.22 subdivisions 2 and 3.

268.23 (d) Upon the request of a closing facility, the commissioner must allow the facility a
268.24 closure rate adjustment as provided under section 144A.161, subdivision 10.

268.25 (e) A facility that has received a planned closure rate adjustment may reassign it
268.26 to another facility that is under the same ownership at any time within three years of its
268.27 effective date. The amount of the adjustment shall be computed according to paragraph (a).

268.28 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
268.29 the commissioner shall recalculate planned closure rate adjustments for facilities that
268.30 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
268.31 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
268.32 from the date the per bed dollar amount is increased.

268.33 (g) For planned closures approved after June 30, 2009, the commissioner of human
268.34 services shall calculate the amount of the planned closure rate adjustment available under
268.35 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

269.1 (h) Beginning July 16, 2011, the commissioner shall no longer approve planned
269.2 closure rate adjustments under this subdivision.

269.3 Sec. 39. Minnesota Statutes 2010, section 256B.441, is amended by adding a
269.4 subdivision to read:

269.5 Subd. 60. **Rate increase for low-rate facilities.** (a) Effective October 1, 2011,
269.6 the commissioner shall adjust the operating payment rates of a nursing facility whose
269.7 operating payment rate on September 30, 2011, is greater than the 95th percentile of all
269.8 nursing facilities operating payment rates. The commissioner shall:

269.9 (1) array all operating payment rates in effect on September 30, 2011, at a case-mix
269.10 weight equal to 1.00 (DDF) from lowest to highest;

269.11 (2) remove from the array any nursing facility determined by the commissioner to
269.12 be providing specialized care, determined in accordance with criteria in subdivision 51a,
269.13 paragraph (b), and any facilities receiving a rate increase under paragraph (c), clause (1);

269.14 (3) determine the 95th percentile of the array in clause (1);

269.15 (4) compute a reduction amount not to exceed three percent, if a facility's amount
269.16 in clause (1) is greater than the amount computed in clause (3) by subtracting a facility's
269.17 DDF rate in clause (1) from the amount computed in clause (3);

269.18 (5) compute the portion of each facility's DDF operating payment rate that is the
269.19 direct care per diem based on the rates in effect on September 30, 2011; and

269.20 (6) determine the change for all other case-mix levels, by multiplying the amount in
269.21 clause (4) by the percentage in clause (5) and by the corresponding case-mix weight for
269.22 each care level. Add to this product the non-direct care per diem portion of the amount
269.23 in clause (4).

269.24 (b) The total amount to be saved by the rate reductions will be computed. The
269.25 commissioner shall:

269.26 (1) for each facility receiving a rate change in paragraph (a), multiply each case-mix
269.27 level's rate change in paragraph (a), clause (6), by the corresponding case-mix resident
269.28 days from the most recent cost report that has been desk audited; and

269.29 (2) sum all the products computed in clause (1).

269.30 (c) The amount of total payment reductions computed in paragraph (b) shall be
269.31 distributed to the facilities with the lowest DDF operating payment rates determined in
269.32 paragraph (a), clause (1). The commissioner shall:

269.33 (1) for nursing facilities located no more than one-quarter mile from a peer group
269.34 with higher limits under either subdivision 50 or 51, give an operating rate adjustment.
269.35 The operating payment rates of a lower-limit peer group facility must be adjusted to be

equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route;

(2) start with the facility or facilities with the lowest DDF operating payment rate and compute the amount of a rate adjustment needed to make the DDF rate equal to the DDF of the facility directly below it in the array;

(3) compute the rate increases for the other case-mix levels using the amount computed in clause (2), and the process stated in paragraph (a), clauses (5) and (6);

(4) compute the total amount the lowest facilities will receive using the process described in paragraph (b);

(5) compute the running total to be spent at all facilities receiving an increase under this paragraph by summing each facility's amount computed in clause (4); and

(6) repeat the process in clauses (2) to (5) as long as the amount in clause (5) does not exceed the amount in paragraph (b), clause (2). In no case shall the DDF operating payment rate increase determined in clauses (2) to (6) exceed two percent.

Sec. 40. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 61. **Rate reduction for low-need residents.** Beginning July 1, 2011, the operating payment paid to nursing facilities by Medicaid or private pay and reimbursed under this chapter for all residents classified as PA1 shall be reduced by the lesser of: (1) 25 percent of the PA1 rate in effect on June 30, 2011, for the specific facility; or (2) the PA1 rate in effect on June 30, 2011, for the specific facility less the PA1 rate in effect on June 30, 2011, for the facility at the tenth percentile of all facilities ranked from the highest to the lowest PA1 rate in effect on June 30, 2011. No operating payment rate increases may result from this provision.

Sec. 41. Minnesota Statutes 2010, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances:

(1) the nursing facility may;

~~(1)~~ (i) charge private paying residents a higher rate for a private room; and

271.1 ~~(2)~~ (ii) charge for special services which are not included in the daily rate if medical
271.2 assistance residents are charged separately at the same rate for the same services in
271.3 addition to the daily rate paid by the commissioner;

271.4 (2) effective July 1, 2011, through September 30, 2012, nursing facilities may charge
271.5 private paying residents rates up to two percent higher than the allowable payment rate
271.6 determined by the commissioner for the RUGS group currently assigned to the resident;

271.7 (3) effective October 1, 2012, through September 30, 2013, nursing facilities
271.8 may charge private paying residents rates up to four percent higher than the allowable
271.9 payment rate determined by the commissioner for the RUGS group currently assigned
271.10 to the resident;

271.11 (4) effective October 1, 2013, through September 30, 2014, nursing facilities may
271.12 charge private paying residents rates up to six percent higher than the allowable payment
271.13 rate determined by the commissioner for the RUGS group currently assigned to the
271.14 resident;

271.15 (5) effective October 1, 2014, nursing facilities may charge private paying
271.16 residents up to eight percent higher than the allowable payment rate determined by the
271.17 commissioner for the RUGS group currently assigned to the resident; and

271.18 (6) the higher private pay charges allowed in this paragraph shall be limited to actual
271.19 costs per resident day, as determined by the commissioner, based on data provided in the
271.20 statistical and cost report in section 256B.441.

271.21 Nothing in this section precludes a nursing facility from charging a rate allowable
271.22 under the facility's single room election option under Minnesota Rules, part 9549.0060,
271.23 subpart 11. Services covered by the payment rate must be the same regardless of payment
271.24 source. Special services, if offered, must be available to all residents in all areas of the
271.25 nursing facility and charged separately at the same rate. Residents are free to select
271.26 or decline special services. Special services must not include services which must be
271.27 provided by the nursing facility in order to comply with licensure or certification standards
271.28 and that if not provided would result in a deficiency or violation by the nursing facility.
271.29 Services beyond those required to comply with licensure or certification standards must
271.30 not be charged separately as a special service if they were included in the payment rate for
271.31 the previous reporting year. A nursing facility that charges a private paying resident a rate
271.32 in violation of this clause is subject to an action by the state of Minnesota or any of its
271.33 subdivisions or agencies for civil damages. A private paying resident or the resident's legal
271.34 representative has a cause of action for civil damages against a nursing facility that charges
271.35 the resident rates in violation of this clause. The damages awarded shall include three
271.36 times the payments that result from the violation, together with costs and disbursements,

including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

(b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan. For residents on medical assistance, medical assistance payment according to the state plan must be accepted as payment in full for continued stay, except where otherwise provided for under statute;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota Board of Pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

(d) Providing differential treatment on the basis of status with regard to public assistance.

273.1 (e) Discriminating in admissions, services offered, or room assignment on the
273.2 basis of status with regard to public assistance ~~or refusal to purchase special services.~~
273.3 Discrimination in admissions discrimination, services offered, or room assignment shall
273.4 include, but is not limited to:

273.5 (1) basing admissions decisions upon ~~assurance by the applicant to the nursing~~
273.6 ~~facility, or the applicant's guardian or conservator, that the applicant is neither eligible for~~
273.7 ~~nor will seek~~ information or assurances regarding current or future eligibility for public
273.8 assistance for payment of nursing facility care ~~costs~~; and

273.9 (2) engaging in preferential selection from waiting lists based on an applicant's
273.10 ability to pay privately or an applicant's refusal to pay for a special service.

273.11 The collection and use by a nursing facility of financial information of any applicant
273.12 pursuant to a preadmission screening program established by law shall not raise an
273.13 inference that the nursing facility is utilizing that information for any purpose prohibited
273.14 by this paragraph.

273.15 (f) Requiring any vendor of medical care as defined by section 256B.02, subdivision
273.16 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any
273.17 amount based on utilization or service levels or any portion of the vendor's fee to the
273.18 nursing facility except as payment for renting or leasing space or equipment or purchasing
273.19 support services from the nursing facility as limited by section 256B.433. All agreements
273.20 must be disclosed to the commissioner upon request of the commissioner. Nursing
273.21 facilities and vendors of ancillary services that are found to be in violation of this provision
273.22 shall each be subject to an action by the state of Minnesota or any of its subdivisions or
273.23 agencies for treble civil damages on the portion of the fee in excess of that allowed by
273.24 this provision and section 256B.433. Damages awarded must include three times the
273.25 excess payments together with costs and disbursements including reasonable attorney's
273.26 fees or their equivalent.

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

273.30 (h) For a period not to exceed 180 days, the commissioner may continue to make
273.31 medical assistance payments to a nursing facility or boarding care home which is in
273.32 violation of this section if extreme hardship to the residents would result. In these cases
273.33 the commissioner shall issue an order requiring the nursing facility to correct the violation.
273.34 The nursing facility shall have 20 days from its receipt of the order to correct the violation.
273.35 If the violation is not corrected within the 20-day period the commissioner may reduce
273.36 the payment rate to the nursing facility by up to 20 percent. The amount of the payment

rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

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

Sec. 42. Minnesota Statutes 2010, section 256B.49, is amended by adding a subdivision to read:

Subd. 10a. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Comprehensive transitional service plan" means a plan detailing specific measurable functional skills and timelines and additional systems of support for achieving the fundamental service outcome.

(c) "Functional milestone" means a functional skill attained through service outcomes that take the place of a provider funded service.

(d) "Fundamental service outcome" means the specific end objective for the service being provided.

(e) "Natural community supports" means relationships developed with friends, family, work places, neighborhoods, and organizations that are not reimbursed to provide supportive relationships that enhance the quality and security of individuals in their communities.

(f) "Short-term service outcome" means the measurable functional skill outcomes necessary to achieve the fundamental service outcome.

(g) "Transitional service planning team" means the individual receiving services; the case manager; service providers; the guardian, if applicable; and other identified individuals such as advocates, family members, and other natural supports who are able to commit to a plan of support, housing, and treatment that maximizes the individual's opportunity for success in transitioning to community living or the next level of care.

Sec. 43. Minnesota Statutes 2010, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under ~~sections 144.0724, subdivision 11, and section 256B.0911;~~ or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 44. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** ~~(a) Each recipient of a home and community-based waiver under this section shall be provided case management services according to section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:~~

~~(1) assessing the needs of the individual within 20 working days of a recipient's request;~~

~~(2) developing the written individual service plan within ten working days after the assessment is completed;~~

~~(3) informing the recipient or the recipient's legal guardian or conservator of service options;~~

~~(4) assisting the recipient in the identification of potential service providers;~~

~~(5) assisting the recipient to access services;~~

~~(6) coordinating, evaluating, and monitoring of the services identified in the service plan;~~

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

~~(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.~~

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

Sec. 45. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify individuals whose level of functioning is reasonably expected to improve and reassess these individuals every six months. Individuals who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c). Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

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

Sec. 46. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waived services shall be provided a copy of the written coordinated service and support plan which ~~that~~ complies with the requirements of section 256B.092, subdivision 1b.

~~(1) is developed and signed by the recipient within ten working days of the completion of the assessment;~~
~~(2) meets the assessed needs of the recipient;~~
~~(3) reasonably ensures the health and safety of the recipient;~~
~~(4) promotes independence;~~
~~(5) allows for services to be provided in the most integrated settings; and~~
~~(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.~~

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the individual to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the individual to seek the resources necessary to secure

the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the individual's current level of functioning. Individuals who move from a transitional to a maintenance service plan must be reassessed to determine if the individual would benefit from a transitional service plan on at least an annual basis. This assessment should consider any changes to technological or natural community supports.

~~(b)~~ (e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

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

Sec. 47. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/MR rate increase.** Effective July 1, 2011, the commissioner shall increase the daily rate to \$138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 48. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 10. **ICF/MR rate adjustment.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to ...

279.1 percent of the operating payment rates in effect on June 30, 2011. For each facility, the
279.2 commissioner shall apply the rate reduction, based on occupied beds, using the percentage
279.3 specified in this subdivision multiplied by the total payment rate, including the variable rate
279.4 but excluding the property-related payment rate, in effect on the preceding date. The total
279.5 rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

279.6 Sec. 49. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

279.7 Subd. 6. **Excluded time.** "Excluded time" means:

279.8 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
279.9 other than an emergency shelter, halfway house, foster home, semi-independent living
279.10 domicile or services program, residential facility offering care, board and lodging facility
279.11 or other institution for the hospitalization or care of human beings, as defined in section
279.12 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
279.13 or correctional facility; or any facility based on an emergency hold under sections
279.14 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

279.15 (b) any period an applicant spends on a placement basis in a training and habilitation
279.16 program, including a rehabilitation facility or work or employment program as defined
279.17 in section 268A.01; ~~or receiving personal care assistance services pursuant to section~~
279.18 ~~256B.0659~~; semi-independent living services provided under section 252.275, and
279.19 Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs
279.20 and assisted living services; and

279.21 (c) any placement for a person with an indeterminate commitment, including
279.22 independent living.

279.23 **EFFECTIVE DATE.** This section is effective July 1, 2011.

279.24 Sec. 50. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by
279.25 Laws 2010, First Special Session chapter 1, article 24, section 12, is amended to read:

279.26 **EFFECTIVE DATE.** ~~The~~ This section is effective July 1, 2011 on or after January
279.27 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals
279.28 under age 21.

279.29 Sec. 51. Laws 2009, chapter 79, article 8, section 51, the effective date, as amended by
279.30 Laws 2010, First Special Session chapter 1, article 17, section 14, is amended to read:

279.31 **EFFECTIVE DATE.** ~~This section is effective July 1, 2011~~ January 1, 2014.

280.1 Sec. 52. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
280.2 Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special
280.3 Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

280.4 Subd. 8. **Continuing Care Grants**

280.5 The amounts that may be spent from the
280.6 appropriation for each purpose are as follows:

280.7 (a) Aging and Adult Services Grants	13,499,000	15,805,000

280.8 **Base Adjustment.** The general fund base is
280.9 increased by \$5,751,000 in fiscal year 2012
280.10 and \$6,705,000 in fiscal year 2013.

280.11 **Information and Assistance**

280.12 **Reimbursement.** Federal administrative
280.13 reimbursement obtained from information
280.14 and assistance services provided by the
280.15 Senior LinkAge or Disability Linkage lines
280.16 to people who are identified as eligible for
280.17 medical assistance shall be appropriated to
280.18 the commissioner for this activity.

280.19 **Community Service Development Grant**

280.20 **Reduction.** Funding for community service
280.21 development grants must be reduced by
280.22 \$260,000 for fiscal year 2010; \$284,000 in
280.23 fiscal year 2011; \$43,000 in fiscal year 2012;
280.24 and \$43,000 in fiscal year 2013. Base level
280.25 funding shall be restored in fiscal year 2014.

280.26 **Community Service Development Grant**

280.27 **Community Initiative.** Funding for
280.28 community service development grants shall
280.29 be used to offset the cost of aging support
280.30 grants. Base level funding shall be restored
280.31 in fiscal year 2014.

280.32 **Senior Nutrition Use of Federal Funds.**

280.33 For fiscal year 2010, general fund grants
280.34 for home-delivered meals and congregate

281.1 dining shall be reduced by \$500,000. The
 281.2 commissioner must replace these general
 281.3 fund reductions with equal amounts from
 281.4 federal funding for senior nutrition from the
 281.5 American Recovery and Reinvestment Act
 281.6 of 2009.

281.7 (b) Alternative Care Grants	50,234,000	48,576,000

281.8 **Base Adjustment.** The general fund base is
 281.9 decreased by \$3,598,000 in fiscal year 2012
 281.10 and \$3,470,000 in fiscal year 2013.

281.11 **Alternative Care Transfer.** Any money
 281.12 allocated to the alternative care program that
 281.13 is not spent for the purposes indicated does
 281.14 not cancel but must be transferred to the
 281.15 medical assistance account.

281.16 (c) Medical Assistance Grants; Long-Term 281.17 Care Facilities.	367,444,000	419,749,000

281.18 (d) Medical Assistance Long-Term Care 281.19 Waivers and Home Care Grants	853,567,000	1,039,517,000

281.20 **Manage Growth in TBI and CADI**
 281.21 **Waivers.** During the fiscal years beginning
 281.22 on July 1, 2009, and July 1, 2010, the
 281.23 commissioner shall allocate money for home
 281.24 and community-based waiver programs
 281.25 under Minnesota Statutes, section 256B.49,
 281.26 to ensure a reduction in state spending that is
 281.27 equivalent to limiting the caseload growth of
 281.28 the TBI waiver to 12.5 allocations per month
 281.29 each year of the biennium and the CADI
 281.30 waiver to 95 allocations per month each year
 281.31 of the biennium. Limits do not apply: (1)
 281.32 when there is an approved plan for nursing
 281.33 facility bed closures for individuals under
 281.34 age 65 who require relocation due to the
 281.35 bed closure; (2) to fiscal year 2009 waiver

282.1 allocations delayed due to unallotment; or (3)
282.2 to transfers authorized by the commissioner
282.3 from the personal care assistance program
282.4 of individuals having a home care rating
282.5 of "CS," "MT," or "HL." Priorities for the
282.6 allocation of funds must be for individuals
282.7 anticipated to be discharged from institutional
282.8 settings or who are at imminent risk of a
282.9 placement in an institutional setting.

282.10 **Manage Growth in DD Waiver.** The
282.11 commissioner shall manage the growth in
282.12 the DD waiver by limiting the allocations
282.13 included in the February 2009 forecast to 15
282.14 additional diversion allocations each month
282.15 for the calendar years that begin on January
282.16 1, 2010, and January 1, 2011. Additional
282.17 allocations must be made available for
282.18 transfers authorized by the commissioner
282.19 from the personal care program of individuals
282.20 having a home care rating of "CS," "MT,"
282.21 or "HL."

282.22 **Adjustment to Lead Agency Waiver**
282.23 **Allocations.** Prior to the availability of the
282.24 alternative license defined in Minnesota
282.25 Statutes, section 245A.11, subdivision 8,
282.26 the commissioner shall reduce lead agency
282.27 waiver allocations for the purposes of
282.28 implementing a moratorium on corporate
282.29 foster care.

282.30 ~~**Alternatives to Personal Care Assistance**~~
282.31 ~~**Services.** Base level funding of \$3,237,000~~
282.32 ~~in fiscal year 2012 and \$4,856,000 in~~
282.33 ~~fiscal year 2013 is to implement alternative~~
282.34 ~~services to personal care assistance services~~
282.35 ~~for persons with mental health and other~~

283.1 ~~behavioral challenges who can benefit~~
283.2 ~~from other services that more appropriately~~
283.3 ~~meet their needs and assist them in living~~
283.4 ~~independently in the community. These~~
283.5 ~~services may include, but not be limited to, a~~
283.6 ~~1915(i) state plan option.~~

283.7 **(e) Mental Health Grants**

283.8	Appropriations by Fund		
283.9	General	77,739,000	77,739,000
283.10	Health Care Access	750,000	750,000
283.11	Lottery Prize	1,508,000	1,508,000

283.12 **Funding Usage.** Up to 75 percent of a fiscal
283.13 year's appropriation for adult mental health
283.14 grants may be used to fund allocations in that
283.15 portion of the fiscal year ending December
283.16 31.

283.17	(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000

283.18	(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

283.19 **Payments for Substance Abuse Treatment.**

283.20 For placements beginning during fiscal years
283.21 2010 and 2011, county-negotiated rates and
283.22 provider claims to the consolidated chemical
283.23 dependency fund must not exceed the lesser
283.24 of:

- 283.25 (1) rates charged for these services on
283.26 January 1, 2009; or
- 283.27 (2) 160 percent of the average rate on January
283.28 1, 2009, for each group of vendors with
283.29 similar attributes.

283.30 Rates for fiscal years 2010 and 2011 must
283.31 not exceed 160 percent of the average rate on
283.32 January 1, 2009, for each group of vendors
283.33 with similar attributes.

284.1 Effective July 1, 2010, rates that were above
284.2 the average rate on January 1, 2009, are
284.3 reduced by five percent from the rates in
284.4 effect on June 1, 2010. Rates below the
284.5 average rate on January 1, 2009, are reduced
284.6 by 1.8 percent from the rates in effect on
284.7 June 1, 2010. Services provided under
284.8 this section by state-operated services are
284.9 exempt from the rate reduction. For services
284.10 provided in fiscal years 2012 and 2013, the
284.11 statewide aggregate payment under the new
284.12 rate methodology to be developed under
284.13 Minnesota Statutes, section 254B.12, must
284.14 not exceed the projected aggregate payment
284.15 under the rates in effect for fiscal year 2011
284.16 excluding the rate reduction for rates that
284.17 were below the average on January 1, 2009,
284.18 plus a state share increase of \$3,787,000 for
284.19 fiscal year 2012 and \$5,023,000 for fiscal
284.20 year 2013. Notwithstanding any provision
284.21 to the contrary in this article, this provision
284.22 expires on June 30, 2013.

284.23 **Chemical Dependency Special Revenue**
284.24 **Account.** For fiscal year 2010, \$750,000
284.25 must be transferred from the consolidated
284.26 chemical dependency treatment fund
284.27 administrative account and deposited into the
284.28 general fund.

284.29 **County CD Share of MA Costs for**
284.30 **ARRA Compliance.** Notwithstanding the
284.31 provisions of Minnesota Statutes, chapter
284.32 254B, for chemical dependency services
284.33 provided during the period October 1, 2008,
284.34 to December 31, 2010, and reimbursed by
284.35 medical assistance at the enhanced federal
284.36 matching rate provided under the American

285.1 Recovery and Reinvestment Act of 2009, the
285.2 county share is 30 percent of the nonfederal
285.3 share. This provision is effective the day
285.4 following final enactment.

285.5	(h) Chemical Dependency Nonentitlement		
285.6	Grants	1,729,000	1,729,000
285.7	(i) Other Continuing Care Grants	19,201,000	17,528,000

285.8 **Base Adjustment.** The general fund base is
285.9 increased by \$2,639,000 in fiscal year 2012
285.10 and increased by \$3,854,000 in fiscal year
285.11 2013.

285.12 **Technology Grants.** \$650,000 in fiscal
285.13 year 2010 and \$1,000,000 in fiscal year
285.14 2011 are for technology grants, case
285.15 consultation, evaluation, and consumer
285.16 information grants related to developing and
285.17 supporting alternatives to shift-staff foster
285.18 care residential service models.

285.19 **Other Continuing Care Grants; HIV**
285.20 **Grants.** Money appropriated for the HIV
285.21 drug and insurance grant program in fiscal
285.22 year 2010 may be used in either year of the
285.23 biennium.

285.24 **Quality Assurance Commission.** Effective
285.25 July 1, 2009, state funding for the quality
285.26 assurance commission under Minnesota
285.27 Statutes, section 256B.0951, is canceled.

285.28 Sec. 53. **DIRECTIONS TO COMMISSIONER.**

285.29 Subdivision 1. **Community first choice option.** (a) The commissioner shall

285.30 provide information on all state-funded grants and medical assistance-funded services and

285.31 programs which could be included in the community first choice option, including those in

285.32 the continuing care and mental health and children's mental health divisions that provide

285.33 assistance in a home or in the community for individuals in the eligibility categories

285.34 described in paragraph (b). Recommendations on the grants and programs and the number

of persons who use those grants and programs and would be eligible for home and community-based attendant services and supports and any changes to Minnesota Statutes or Minnesota Rules shall be provided to the legislative committees with jurisdiction over health and human services finance and policy by January 15, 2012.

(b) For individuals whose income is less than 150 percent of the federal poverty guidelines and who qualify for semi-independent living services under Minnesota Statutes, section 252.275, and epilepsy demonstration project funding, the commissioner shall assure an assessment under Minnesota Statutes, section 256B.0659, subdivision 3a, is completed by November 30, 2011, for home and community-based attendant services and supports.

Subd. 2. **Co-payments for home and community-based services.** Upon federal approval, the commissioner of human services shall develop and implement a co-payment schedule for individuals receiving home and community-based services under Minnesota Statutes, chapter 256B.

Subd. 3. **Federal waiver amendment.** The commissioner shall seek an amendment to the 1915c home and community-based waivers under Minnesota Statutes, sections 256B.092 and 256B.49, to allow properly licensed residential programs under Minnesota Statutes, section 245A.02, subdivision 14, to provide residential services to up to eight individuals with physical or developmental disabilities, chronic illnesses, or traumatic brain injuries.

Subd. 4. **Recommendations for personal care assistance service changes.** The commissioner shall consult with stakeholder groups, including counties, advocates, persons receiving personal care assistance services, and personal care assistance providers, and make recommendations to the legislature by February 1, 2012, on changes that could be made to the program to improve oversight, program efficiency, and cost-effectiveness.

Subd. 5. **Nursing facility pay-for-performance reimbursement system.** The commissioner of human services shall report to the legislative committees with jurisdiction over nursing facility policy and finance with recommendations for developing and implementing a pay-for-performance reimbursement system with a quality add-on by January 15, 2012.

Subd. 6. **ICF/MR transition plan.** The commissioner of human services shall work with stakeholders to develop and implement a plan by June 30, 2013, to transition individuals currently residing in intermediate care facilities for persons with developmental disabilities into the least restrictive community settings possible. The plan must include a requirement for a cooperative planning process between the counties and providers for the downsizing or closure of intermediate care facilities for persons with developmental

287.1 disabilities, with funding from the bed closures converting to home and community-based
287.2 waiver funding to fund services for those leaving the intermediate care facilities for
287.3 persons with developmental disabilities based on a plan approved by the commissioner. In
287.4 order to facilitate this process, the commissioner shall provide information to facilities and
287.5 counties about the number of people in facilities who have requested to move to home and
287.6 community-based services. Individuals residing in intermediate care facilities for persons
287.7 with developmental disabilities who choose to remain there or whose health or safety
287.8 would be put at risk in a less restrictive setting may continue to reside in intermediate care
287.9 facilities for persons with developmental disabilities.

287.10 Sec. 54. **STATE PLAN AMENDMENT TO IMPLEMENT SELF-DIRECTED**
287.11 **PERSONAL SUPPORTS.**

287.12 By July 15, 2011, the commissioner shall submit a state plan amendment to
287.13 implement Minnesota Statutes, section 256B.0657, as soon as possible upon federal
287.14 approval.

287.15 Sec. 55. **AMENDMENT FOR SELF-DIRECTED COMMUNITY SUPPORTS.**

287.16 By September 1, 2011, the commissioner shall submit an amendment to the home
287.17 and community-based waiver programs consistent with implementing the self-directed
287.18 option under Minnesota Statutes, section 256B.0657, through statewide enrolled providers
287.19 contracted to provide outreach information, training, and fiscal support entity services to
287.20 all eligible recipients choosing this option and with shared care in some types of services.
287.21 The waiver amendment shall be consistent with changes in case management services
287.22 under Minnesota Statutes, section 256B.092.

287.23 Sec. 56. **ESTABLISHMENT OF RATES FOR SHARED HOME AND**
287.24 **COMMUNITY-BASED WAIVER SERVICES.**

287.25 By January 1, 2012, the commissioner shall establish rates to be paid for in-home
287.26 services and personal supports under all of the home and community-based waiver
287.27 services programs consistent with the standards in Minnesota Statutes, section 256B.4912,
287.28 subdivision 2.

287.29 Sec. 57. **ESTABLISHMENT OF RATE FOR CASE MANAGEMENT**
287.30 **SERVICES.**

288.1 By January 1, 2012, the commissioner shall establish the rate to be paid for
288.2 case management services under Minnesota Statutes, sections 256B.092 and 256B.49,
288.3 consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

288.4 Sec. 58. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**
288.5 **REDESIGN.**

288.6 By February 1, 2012, the commissioner of human services shall develop a legislative
288.7 report with specific recommendations and language for proposed legislation to be effective
288.8 July 1, 2012, for the following:

288.9 (1) definitions of service and consolidation of standards and rates to the extent
288.10 appropriate for all types of medical assistance case management services, including
288.11 targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625,
288.12 subdivision 20; and 256B.0924; mental health case management services for children
288.13 and adults, all types of home and community-based waiver case management, and case
288.14 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be
288.15 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

288.16 (2) recommendations on county of financial responsibility requirements and quality
288.17 assurance measures for case management;

288.18 (3) identification of county administrative functions that may remain entwined in
288.19 case management service delivery models; and

288.20 (4) implementation of a methodology to fully fund county case management
288.21 administrative functions.

288.22 Sec. 59. **MY LIFE, MY CHOICES TASK FORCE.**

288.23 Subdivision 1. **Establishment.** The My Life, My Choices Task Force is established
288.24 to create a system of supports and services for people with disabilities governed by the
288.25 following principles:

288.26 (1) freedom to act as a consumer of services in the marketplace;

288.27 (2) freedom to choose to take as much risk as any other citizen;

288.28 (3) more choices in levels of service that may vary throughout life;

288.29 (4) opportunity to work with a trusted partner and fiscal support entity to manage a
288.30 personal budget and to be accountable for reporting spending and personal outcomes;

288.31 (5) opportunity to live with minimal constraints instead of minimal freedoms; and

288.32 (6) ability to consolidate funding streams into an individualized budget.

288.33 Subd. 2. **Membership.** The My Life, My Choices Task Force shall consist of the
288.34 lieutenant governor; the commissioner of human services, or designee; a representative of

289.1 the Minnesota Chamber of Commerce; and the following to be appointed by the governor:
289.2 one administrative law judge, one labor representative, two family members of people
289.3 with disabilities, and one individual with disabilities. In addition, the following shall be
289.4 appointed jointly by the speaker of the house and the senate Subcommittee on Committees
289.5 of the Committee on Rules and Administration, a representative of a disability advocacy
289.6 organization; a representative of a disability legal services advocacy organization;
289.7 representatives of two nonprofit organizations, one of which serves all 87 counties; and
289.8 a representative of a philanthropic organization. Appointed nongovernmental members
289.9 of the task force shall serve as staff for the task force and take on the responsibilities of
289.10 coordinating meetings, reporting on committee recommendations, and providing other
289.11 staff support as needed to meet the responsibilities of the task force as described in
289.12 subdivision 3. Legislative appointment of nongovernmental members of the task force
289.13 shall be conditioned upon agreement from the appointees to provide staff assistance to
289.14 execute the work of the task force. The chairs and ranking minority members of the
289.15 legislative committees with jurisdiction over health and human services policy and finance
289.16 shall serve as ex officio members.

289.17 Subd. 3. **Duties.** The task force shall make recommendations, including proposed
289.18 legislation, and report to the legislative committees with jurisdiction over health and
289.19 human services policy and finance by November 15, 2011, on creating a system of
289.20 supports and services for people with disabilities by July 1, 2012, as governed by the
289.21 principles under subdivision 1. In making recommendations and proposed legislation, the
289.22 council shall work in conjunction with the Consumer-Directed Community Supports Task
289.23 Force and shall include self-directed planning, individual budgeting, choice of trusted
289.24 partner, self-directed purchasing of services and supports, reporting of outcomes, ability
289.25 to share in any savings, and any additional rules or laws that may need to be waived.
289.26 Recommendations from the task force shall be fully implemented by July 1, 2013.

289.27 Subd. 4. **Expense reimbursement.** The members of the task force shall not be
289.28 reimbursed for expenses related to the duties of the task force. The task force shall be
289.29 independently staffed and coordinated by nongovernmental appointees who serve on the
289.30 task force, and no state funding shall be appropriated for expenses related to the task
289.31 force under this section.

289.32 Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

ARTICLE 8

REDESIGNING SERVICE DELIVERY

Section 1. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

Subd. 4b. **Electronic verification.** County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for the child care assistance under this chapter. The information is sufficient to determine eligibility.

Sec. 2. Minnesota Statutes 2010, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 18 years of age who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

291.1 (3) have a substantial number of children for whom determinations of maltreatment
291.2 have occurred;

291.3 (4) have capacity to respond to reports of abuse and neglect under section 626.556;
291.4 (5) provide a wide range of services to families in need of child welfare services; and
291.5 (6) have a tribal-state title IV-E agreement in effect.

291.6 (d) Grants awarded under this section may be used for the nonfederal costs of
291.7 providing child welfare services to American Indian children on the tribe's reservation,
291.8 including costs associated with:

291.9 (1) assessment and prevention of child abuse and neglect;
291.10 (2) family preservation;
291.11 (3) facilitative, supportive, and reunification services;
291.12 (4) out-of-home placement for children removed from the home for child protective
291.13 purposes; and
291.14 (5) other activities and services approved by the commissioner that further the goals
291.15 of providing safety, permanency, and well-being of American Indian children.

291.16 (e) When a tribe has initiated a project and has been approved by the commissioner
291.17 to assume child welfare responsibilities for American Indian children of that tribe under
291.18 this section, the affected county social service agency is relieved of responsibility for
291.19 responding to reports of abuse and neglect under section 626.556 for those children
291.20 during the time within which the tribal project is in effect and funded. The commissioner
291.21 shall work with tribes and affected counties to develop procedures for data collection,
291.22 evaluation, and clarification of ongoing role and financial responsibilities of the county
291.23 and tribe for child welfare services prior to initiation of the project. Children who have not
291.24 been identified by the tribe as participating in the project shall remain the responsibility
291.25 of the county. Nothing in this section shall alter responsibilities of the county for law
291.26 enforcement or court services.

291.27 (f) Participating tribes may conduct children's mental health screenings under section
291.28 245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the
291.29 initiative and living on the reservation and who meet one of the following criteria:

291.30 (1) the child must be receiving child protective services;
291.31 (2) the child must be in foster care; or
291.32 (3) the child's parents must have had parental rights suspended or terminated.

291.33 Tribes may access reimbursement from available state funds for conducting the screenings.
291.34 Nothing in this section shall alter responsibilities of the county for providing services
291.35 under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) The commissioner may authorize a project to test the provision of child welfare services by the White Earth Band of Ojibwe Indians to White Earth member children who reside in Hennepin County. This project will be subject to all provisions of this subdivision. Hennepin County shall transfer to the tribe the proportion of property taxes collected and used to fund child welfare services received by White Earth member children when the tribe assumes responsibility for providing child welfare services.

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

Subd. 14c. American Indian child welfare, social, and human services project; White Earth Band of Ojibwe. (a) The commissioner of human services shall enter into a contractual agreement as authorized under subdivision 2, paragraph (a), clause (7), with the White Earth Band of Ojibwe Indians for the tribe to provide all human services and public assistance programs that are under the supervision of the commissioner to tribal members who reside on the reservation. Grants may be issued to the White Earth Band of Ojibwe Indians to support the project. The commissioner may waive existing rules to support this project. The commissioner shall seek any federal approvals necessary to carry out the project as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for purposes of the project.

293.1 (b) The commissioner shall redirect all funds provided to Mahnomen County for
293.2 these services, including administrative expenses, to the White Earth Band of Ojibwe
293.3 Indians.

293.4 (c) The commissioner, in consultation with the tribe, is authorized to determine: (1)
293.5 which programs not currently provided by the White Earth Band of Ojibwe Indians will be
293.6 transferred to the tribe; and (2) the process by which the new programs will be transferred.
293.7 In the case of a dispute, a two-thirds vote of the tribal council to transfer a program to
293.8 the tribe must overrule the decision of the commissioner.

293.9 (d) When the commissioner approves transfer of programs and the tribe assumes
293.10 responsibility under this section, Mahnomen County is relieved of responsibility for
293.11 providing program services to tribal members who live on the reservation while the tribal
293.12 project is in effect and funded. Mahnomen County shall transfer to the tribe the proportion
293.13 of property taxes allocated for funding of the county social services that are assumed by
293.14 the tribe.

293.15 (e) The tribe shall comply with all reporting and record keeping requirements under
293.16 state and federal laws and rules.

293.17 Sec. 4. **[256.0145] COMPUTER SYSTEM SIMPLIFICATION.**

293.18 Subdivision 1. **Reprogram MAXIS.** The commissioner of human services, as part
293.19 of the enterprise architecture project, shall reprogram the MAXIS computer system to
293.20 automatically apply child support payments entered into the PRISM computer system to
293.21 a MAXIS case file.

293.22 Subd. 2. **Program the social service information system.** The commissioner of
293.23 human services shall require all prepaid health plans to accept a billing format identical to
293.24 the MMIS billing format for payment to county agencies for mental health targeted case
293.25 management claims, elderly waiver claims, and other claim categories as added to the
293.26 benefit set. The commissioner shall make any necessary changes to the SSIS system to
293.27 bill prepaid health plans for those claims.

293.28 Sec. 5. **[256.0147] COUNTY ELECTRONIC VERIFICATION TO DETERMINE**
293.29 **ELIGIBILITY.**

293.30 County agencies are authorized to use all automated databases containing
293.31 information regarding recipients' or applicants' income in order to determine eligibility
293.32 for child support enforcement, general assistance, Minnesota supplemental aid, and
293.33 programs, services, and supports under chapter 256J. The information is sufficient to
293.34 determine eligibility. State and county caseworkers shall not be cited in error, as part of

294.1 any audit and quality review, for an incorrect eligibility determination based on current but
294.2 inaccurate information received through a state-approved electronic data source. If there
294.3 is a potential error, the reviewer must forward a corrective action notice to the caseworker
294.4 for proper and immediate correction. If the state or county caseworker has data available
294.5 through client reporting, or other means, that are more accurate than state-approved
294.6 electronic data, the caseworker should use the more accurate information in making the
294.7 eligibility determination.

294.8 Sec. 6. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

294.9 Subd. 4a. **Case management appeals.** (a) Any recipient of case management
294.10 services pursuant to section 256B.0625 or 256B.092, or personal care assistance services
294.11 under section 256B.0625, who contests the county agency's action, reduction, suspension,
294.12 denial, or termination of services, or failure to act in the provision of those services,
294.13 other than a failure to act with reasonable promptness or a suspension, reduction, denial,
294.14 or termination of services, must submit a written request for a ~~conciliation~~ an informal
294.15 conference with the recipient's case worker and the county social service director or
294.16 designee to the county agency. The county agency shall inform the commissioner of the
294.17 receipt of a request when it is submitted and shall schedule a ~~conciliation~~ conference
294.18 within ten days of receipt of the recipient's written request. The county agency shall notify
294.19 the recipient, the commissioner, and all interested persons of the time, date, and location
294.20 of the ~~conciliation~~ conference. The commissioner may assist the county by providing
294.21 mediation services or by identifying other resources that may assist in the mediation
294.22 between the parties. Within ~~30~~ 15 days of the conference, the county agency shall conduct
294.23 the ~~conciliation~~ conference and inform the recipient in writing of the action the county
294.24 agency is going to take and when that action will be taken and notify the recipient of the
294.25 right to a hearing under this subdivision. The ~~conciliation~~ conference shall be conducted
294.26 in a manner consistent with the commissioner's instructions.

294.27 (b) If the county fails to conduct the ~~conciliation~~ conference and issue its report
294.28 within ~~30~~ 15 days, or, at any time up to 90 days after the ~~conciliation~~ conference is held,
294.29 a recipient may submit to the commissioner a written request for a hearing before a
294.30 state human services referee to determine whether case management services have been
294.31 provided in accordance with applicable laws and rules or whether the county agency has
294.32 assured that the services identified in the recipient's individual service plan have been
294.33 delivered in accordance with the laws and rules governing the provision of those services.
294.34 The state human services referee shall recommend an order to the commissioner, who
294.35 shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days

of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules. The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

(c) Any recipient of case management services under section 256B.0625 or 256B.092, or personal care assistance services under section 256B.0625, must be informed in writing at the time of application and at the time of any change in services of the recipient's right to submit a written request to the county agency for an informal conference with the case manager and the county social services director.

Sec. 7. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) provision in an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a

296.1 confirmation letter to the enrollee from the prepaid health plan that explains that the
296.2 enrollee may change the request at any time;

296.3 (2) the materials are sent to a secured mailbox and are made available at a
296.4 password-protected secured Web site or on a data storage device if the materials contain
296.5 enrollee data that is individually identifiable;

296.6 (3) the enrollee is provided a customer service number on the enrollee's membership
296.7 card that may be called to request a paper version of the materials provided in an
296.8 alternative format; and

296.9 (4) the materials provided in an alternative format meet all other requirements of
296.10 the commissioner regarding content, size of typeface, and any required time frames for
296.11 distribution. "Required time frames for distribution" must permit sufficient time for
296.12 prepaid health plans to distribute materials in alternative formats upon receipt of enrollees'
296.13 requests for the materials.

296.14 (c) A prepaid health plan may provide in an alternative format its primary care
296.15 network list to the commissioner and to local agencies within its service area. The
296.16 commissioner or local agency, as applicable, shall inform a potential enrollee of the
296.17 availability of a prepaid health plan's primary care network list in an alternative format. If
296.18 the potential enrollee requests an alternative format of the prepaid health plan's primary
296.19 care network list, a record of that request shall be retained by the commissioner or local
296.20 agency. The potential enrollee is permitted to withdraw the request at any time.

296.21 The prepaid health plan shall submit sufficient paper versions of the primary
296.22 care network list to the commissioner and to local agencies within its service area to
296.23 accommodate potential enrollee requests for paper versions of the primary care network
296.24 list.

296.25 (d) A prepaid health plan may provide in an alternative format materials otherwise
296.26 required to be available in writing under Code of Federal Regulations, title 42, section
296.27 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions
296.28 of paragraphs (b), (c), and (e), are met for persons who are:

296.29 (1) enrolled in integrated Medicare and Medicaid programs under subdivisions
296.30 23 and 28;

296.31 (2) enrolled in managed care long-term care programs under subdivision 6b;

296.32 (3) dually eligible for Medicare and medical assistance; or

296.33 (4) in the waiting period for Medicare.

296.34 (e) The commissioner shall seek any federal Medicaid waivers within 90 days after
296.35 the effective date of this subdivision that are necessary to provide alternative formats of
296.36 required material to enrollees of prepaid health plans as authorized under this subdivision.

297.1 (f) The commissioner shall consult with managed care plans, county-based
297.2 purchasing plans, counties, and other interested parties to determine how materials
297.3 required to be made available to enrollees under Code of Federal Regulations, title 42,
297.4 section 438.10, or under the commissioner's contract with a prepaid health plan may
297.5 be provided in an alternative format on the basis that the enrollee has not opted in to
297.6 receive the alternative format. The commissioner shall consult with managed care
297.7 plans, county-based purchasing plans, counties, and other interested parties to develop
297.8 recommendations relating to the conditions that must be met for an opt-out process
297.9 to be granted.

297.10 Sec. 8. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:

297.11 Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or
297.12 family general assistance is paid to a recipient in excess of the payment due, it shall be
297.13 recoverable by the county agency. The agency shall give written notice to the recipient of
297.14 its intention to recover the overpayment.

297.15 (b) Except as provided for interim assistance in section 256D.06, subdivision
297.16 5, when an overpayment occurs, the county agency shall recover the overpayment
297.17 from a current recipient by reducing the amount of aid payable to the assistance unit of
297.18 which the recipient is a member, for one or more monthly assistance payments, until
297.19 the overpayment is repaid. All county agencies in the state shall reduce the assistance
297.20 payment by three percent of the assistance unit's standard of need in nonfraud cases and
297.21 ten percent where fraud has occurred, or the amount of the monthly payment, whichever is
297.22 less, for all overpayments.

297.23 (c) In cases when there is both an overpayment and underpayment, the county
297.24 agency shall offset one against the other in correcting the payment.

297.25 (d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
297.26 in addition to the aid reductions provided in this subdivision, to include further voluntary
297.27 reductions in the grant level agreed to in writing by the individual, until the total amount
297.28 of the overpayment is repaid.

297.29 (e) The county agency shall make reasonable efforts to recover overpayments to
297.30 persons no longer on assistance under standards adopted in rule by the commissioner
297.31 of human services. The county agency need not attempt to recover overpayments of
297.32 less than \$35 paid to an individual no longer on assistance if the individual does not
297.33 receive assistance again within three years, unless the individual has been convicted of
297.34 violating section 256.98.

298.1 (f) Establishment of an overpayment is limited to 12 months prior to the month of
298.2 discovery due to agency error and six years prior to the month of discovery due to client
298.3 error or an intentional program violation determined under section 256.046.

298.4 Sec. 9. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

298.5 Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When
298.6 the county agency determines that an overpayment of the recipient's monthly payment
298.7 of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment
298.8 to the recipient. If the person is no longer receiving Minnesota supplemental aid, the
298.9 county agency may request voluntary repayment or pursue civil recovery. If the person is
298.10 receiving Minnesota supplemental aid, the county agency shall recover the overpayment
298.11 by withholding an amount equal to three percent of the standard of assistance for the
298.12 recipient or the total amount of the monthly grant, whichever is less.

298.13 (b) Establishment of an overpayment is limited to 12 months from the date of
298.14 discovery due to agency error and six years prior to the month of discovery due to client
298.15 error or an intentional program violation determined under section 256.046.

298.16 (c) For recipients receiving benefits via electronic benefit transfer, if the overpayment
298.17 is a result of an automated teller machine (ATM) dispensing funds in error to the recipient,
298.18 the agency may recover the ATM error by immediately withdrawing funds from the
298.19 recipient's electronic benefit transfer account, up to the amount of the error.

298.20 (d) Residents of ~~nursing homes, regional treatment centers, and~~ licensed residential
298.21 facilities with negotiated rates shall not have overpayments recovered from their personal
298.22 needs allowance.

298.23 Sec. 10. Minnesota Statutes 2010, section 256J.38, subdivision 1, is amended to read:

298.24 Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant
298.25 receives an overpayment due to agency, client, or ATM error, or due to assistance received
298.26 while an appeal is pending and the participant or former participant is determined
298.27 ineligible for assistance or for less assistance than was received, the county agency must
298.28 recoup or recover the overpayment using the following methods:

298.29 (1) reconstruct each affected budget month and corresponding payment month;

298.30 (2) use the policies and procedures that were in effect for the payment month; and

298.31 (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the
298.32 calculation of the overpayment when the unit has not reported within two calendar months
298.33 following the end of the month in which the income was received.

299.1 (b) Establishment of an overpayment is limited to 12 months prior to the month of
299.2 discovery due to agency error and six years prior to the month of discovery due to client
299.3 error or an intentional program violation determined under section 256.046.

299.4 Sec. 11. Minnesota Statutes 2010, section 393.07, subdivision 10, is amended to read:

299.5 Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local
299.6 social services agency shall establish and administer the food stamp program according
299.7 to rules of the commissioner of human services, the supervision of the commissioner as
299.8 specified in section 256.01, and all federal laws and regulations. The commissioner of
299.9 human services shall monitor food stamp program delivery on an ongoing basis to ensure
299.10 that each county complies with federal laws and regulations. Program requirements to be
299.11 monitored include, but are not limited to, number of applications, number of approvals,
299.12 number of cases pending, length of time required to process each application and deliver
299.13 benefits, number of applicants eligible for expedited issuance, length of time required
299.14 to process and deliver expedited issuance, number of terminations and reasons for
299.15 terminations, client profiles by age, household composition and income level and sources,
299.16 and the use of phone certification and home visits. The commissioner shall determine the
299.17 county-by-county and statewide participation rate.

299.18 (b) On July 1 of each year, the commissioner of human services shall determine a
299.19 statewide and county-by-county food stamp program participation rate. The commissioner
299.20 may designate a different agency to administer the food stamp program in a county if the
299.21 agency administering the program fails to increase the food stamp program participation
299.22 rate among families or eligible individuals, or comply with all federal laws and regulations
299.23 governing the food stamp program. The commissioner shall review agency performance
299.24 annually to determine compliance with this paragraph.

299.25 (c) A person who commits any of the following acts has violated section 256.98 or
299.26 609.821, or both, and is subject to both the criminal and civil penalties provided under
299.27 those sections:

299.28 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
299.29 willful statement or misrepresentation, or intentional concealment of a material fact, food
299.30 stamps or vouchers issued according to sections 145.891 to 145.897 to which the person
299.31 is not entitled or in an amount greater than that to which that person is entitled or which
299.32 specify nutritional supplements to which that person is not entitled; or

299.33 (2) presents or causes to be presented, coupons or vouchers issued according to
299.34 sections 145.891 to 145.897 for payment or redemption knowing them to have been
299.35 received, transferred or used in a manner contrary to existing state or federal law; or

(3) willfully uses, possesses, or transfers food stamp coupons, authorization to purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner contrary to existing state or federal law, rules, or regulations; or

(4) buys or sells food stamp coupons, authorization to purchase cards, other assistance transaction devices, vouchers issued according to sections 145.891 to 145.897, or any food obtained through the redemption of vouchers issued according to sections 145.891 to 145.897 for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps, authorization to purchase cards, or other assistance transaction devices found in the possession of any person who is neither a recipient of the food stamp program nor otherwise authorized to possess and use such materials. Confiscated property shall be disposed of as the commissioner may direct and consistent with state and federal food stamp law. The confiscated property must be retained for a period of not less than 30 days to allow any affected person to appeal the confiscation under section 256.045.

~~(e) Food stamp overpayment claims which are due in whole or in part to client error shall be established by the county agency for a period of six years from the date of any resultant overpayment~~ Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(f) With regard to the federal tax revenue offset program only, recovery incentives authorized by the federal food and consumer service shall be retained at the rate of 50 percent by the state agency and 50 percent by the certifying county agency.

(g) A peace officer, welfare fraud investigator, federal law enforcement official, or the commissioner of health may confiscate vouchers found in the possession of any person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise authorized to possess and use such vouchers. Confiscated property shall be disposed of as the commissioner of health may direct and consistent with state and federal law. The confiscated property must be retained for a period of not less than 30 days.

(h) The commissioner of human services may seek a waiver from the United States Department of Agriculture to allow the state to specify foods that may and may not be purchased in Minnesota with benefits funded by the federal Food Stamp Program. The commissioner shall consult with the members of the house of representatives and senate policy committees having jurisdiction over food support issues in developing the waiver. The commissioner, in consultation with the commissioners of health and education, shall develop a broad public health policy related to improved nutrition and health status. The commissioner must seek legislative approval prior to implementing the waiver.

Sec. 12. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

Subd. 4. **Essential human services or essential services.** "Essential human services" or "essential services" means assistance and services to recipients or potential recipients of public welfare and other services delivered by counties or tribes that are mandated in federal and state law that are to be available in all counties of the state.

Sec. 13. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

Subd. 5. **Service delivery authority.** "Service delivery authority" means a single county, or ~~group~~ consortium of counties operating by execution of a joint powers agreement under section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of the county board of commissioners to participate in the redesign under this chapter or has been assigned by the commissioner pursuant to section 402A.18. A service delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen by resolution of tribal government to participate in redesign under this chapter.

Sec. 14. Minnesota Statutes 2010, section 402A.15, is amended to read:

402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME REFORMS.

Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome Reforms shall develop a uniform process to establish and review performance and outcome standards for all essential human services based on the current level of resources available, and ~~to shall~~ develop appropriate reporting measures and a uniform accountability process for responding to a county's or ~~human~~ service delivery authority's failure to make adequate progress on achieving performance measures. The accountability process shall focus on the performance measures rather than inflexible implementation requirements.

(b) The steering committee shall:

(1) by November 1, 2009, establish an agreed-upon list of essential services;

(2) by February 15, 2010, develop and recommend to the legislature a uniform, graduated process, in addition to the remedies identified in section 402A.18, for responding to a county's failure to make adequate progress on achieving performance measures; and

(3) by December 15, 2012, for each essential service, make recommendations to the legislature regarding ~~(1)~~ (i) performance measures and goals based on those measures for each essential service, ~~(2)~~ and (ii) a system for reporting on the performance measures and goals, ~~and (3) appropriate resources, including funding, needed to achieve those performance measures and goals. The resource recommendations shall take into consideration program demand and the unique differences of local areas in geography and~~

~~the populations served. Priority shall be given to services with the greatest variation in availability and greatest administrative demands.~~ By January 15 of each year starting January 15, 2011, the steering committee shall report its recommendations to the governor and legislative committees with jurisdiction over health and human services. As part of its report, the steering committee shall, as appropriate, recommend statutory provisions, rules and requirements, and reports that should be repealed or eliminated.

(c) As far as possible, the performance measures, reporting system, and funding shall be consistent across program areas. The development of performance measures shall consider the manner in which data will be collected and performance will be reported. The steering committee shall consider state and local administrative costs related to collecting data and reporting outcomes when developing performance measures. ~~The steering committee shall correlate the performance measures and goals to available levels of resources, including state and local funding.~~ The steering committee shall also identify and incorporate federal performance measures in its recommendations for those program areas where federal funding is contingent on meeting federal performance standards. The steering committee shall take into consideration that the goal of implementing changes to program monitoring and reporting the progress toward achieving outcomes is to significantly minimize the cost of administrative requirements and to allow funds freed by reduced administrative expenditures to be used to provide additional services, allow flexibility in service design and management, and focus energies on achieving program and client outcomes.

(d) In making its recommendations, the steering committee shall consider input from the council established in section 402A.20. ~~The steering committee shall review the measurable goals established in a memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied as statewide performance outcomes.~~

(e) The steering committee shall form work groups that include persons who provide or receive essential services and representatives of organizations who advocate on behalf of those persons.

(f) By December 15, 2009, the steering committee shall establish a three-year schedule for completion of its work. The schedule shall be published on the Department of Human Services Web site and reported to the legislative committees with jurisdiction over health and human services. In addition, the commissioner shall post quarterly updates on the progress of the steering committee on the Department of Human Services Web site.

Subd. 2. Composition. (a) The steering committee shall include:

(1) the commissioner of human services, or designee, and two additional representatives of the department;

(2) two county commissioners, representative of rural and urban counties, selected by the Association of Minnesota Counties;

(3) two county directors of human services, representative of rural and urban counties, selected by the Minnesota Association of County Social Service Administrators; and

(4) three clients or client advocates representing different populations receiving services from the Department of Human Services, who are appointed by the commissioner.

(b) The commissioner, or designee, and a county commissioner shall serve as cochair of the committee. The committee shall be convened within 60 days of May 15, 2009.

(c) State agency staff shall serve as informational resources and staff to the steering committee. Statewide county associations may assemble county program data as required.

~~(d) To promote information sharing and coordination between the steering committee and council, one of the county representatives from paragraph (a), clause (2), and one of the county representatives from paragraph (a), clause (3), must also serve as a representative on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).~~

Sec. 15. Minnesota Statutes 2010, section 402A.18, is amended to read:

402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET PERFORMANCE OUTCOMES.

Subdivision 1. **Underperforming county; specific service.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for a specific essential service, the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential service to the commissioner.

Subd. 2. **Underperforming county; more than one-half of ~~service~~ services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for more than one-half of the defined essential ~~service~~ services, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of ~~the specific~~ essential ~~service~~ services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of ~~the specific~~ essential ~~service~~ services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of ~~the specific~~ essential ~~service~~ services to the commissioner.

Subd. 2a. Financial responsibility of underperforming county. A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the essential service or essential services the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:

(1) the county or service delivery authority determined by the commissioner to be deficient in achieving minimum performance outcomes has the opportunity, in coordination with the council, to develop a program outcome improvement plan. The program outcome improvement plan must be developed no later than six months from the date of the deficiency determination; and

(2) the council has conducted an assessment of the program outcome improvement plan to determine if the county or service delivery authority has made satisfactory progress toward performance outcomes and has made a recommendation about remedies to the commissioner. The ~~review~~ assessment and recommendation must be made to the commissioner within 12 months from the date of the deficiency determination.

Sec. 16. Minnesota Statutes 2010, section 402A.20, is amended to read:

402A.20 COUNCIL.

Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service Delivery Redesign Council is established. Appointed council members must be appointed by their respective agencies, associations, or governmental units by November 1, 2009. The council shall be cochaired by the commissioner of human services, or designee, and a county representative from paragraph (b), clause (4) or (5), appointed by the Association of Minnesota Counties. Recommendations of the council must be approved by a majority of the voting council members. The provisions of section 15.059 do not apply to this council, and this council does not expire.

(b) The council must consist of the following members:

(1) two legislators appointed by the speaker of the house, one from the minority and one from the majority;

(2) two legislators appointed by the Senate Rules Committee, one from the majority and one from the minority;

(3) the commissioner of human services, or designee, and three employees from the department;

(4) two county commissioners appointed by the Association of Minnesota Counties;

(5) two county representatives appointed by the Minnesota Association of County Social Service Administrators;

(6) one representative appointed by AFSCME as a nonvoting member; and

(7) one representative appointed by the Teamsters as a nonvoting member.

(c) Administrative support to the council may be provided by the Association of Minnesota Counties and affiliates.

(d) Member agencies and associations are responsible for initial and subsequent appointments to the council.

Subd. 2. **Council duties.** The council shall:

(1) provide review of the service delivery redesign process, including proposed memoranda of understanding to establish a service delivery authority to conduct and administer experimental projects to test new methods and procedures of delivering services;

~~(2) certify, in accordance with section 402A.30, subdivision 4, the formation of a service delivery authority, including the memorandum of understanding in section 402A.30, subdivision 2, paragraph (b);~~

~~(3) ensure the consistency of the memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), with the performance standards recommended by the steering committee and enacted by the legislature;~~

~~(4)~~ (2) ensure the consistency of the memorandum of understanding, to the extent appropriate, ~~or with~~ other memorandum of understanding entered into by other service delivery authorities;

(3) review and make recommendations on applications from a service delivery authority for waivers of statutory or rule program requirements that are needed for flexibility to determine the most cost-effective means of achieving specified measurable goals in a redesign of human services delivery;

~~(5)~~ (4) establish a process to take public input on the service delivery framework specified in the memorandum of understanding in section 402A.30, subdivision 2, paragraph (b) scope of essential services over which a service delivery authority has jurisdiction;

~~(6)~~ (5) form work groups as necessary to carry out the duties of the council under the redesign;

~~(7)~~ (6) serve as a forum for resolving conflicts among participating counties and tribes or between participating counties or tribes and the commissioner of human services, provided nothing in this section is intended to create a formal binding legal process;

~~(8)~~ (7) engage in the program improvement process established in section 402A.18, subdivision 3; and

~~(9)~~ (8) identify and recommend incentives for counties and tribes to participate in ~~human services~~ service delivery authorities.

Subd. 3. **Program evaluation.** By December 15, 2014, the council shall request consideration by the legislative auditor for a reevaluation under section 3.971, subdivision 7, of those aspects of the program evaluation of human services administration reported in January 2007 affected by this chapter.

Sec. 17. **[402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

Subdivision 1. **Requirements for establishing a service delivery authority.**

(a) A county, tribe, or consortium of counties is eligible to establish a service delivery authority if:

(1) the county, tribe, or consortium of counties is:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more;

(iii) a consortium of four or more counties in reasonable geographic proximity without regard to population; or

(iv) one or more tribes with a total combined population of 25,000 or more.

The council may recommend that the commissioner of human services exempt a single county, tribe, or consortium of counties from the minimum population standard if the county, tribe, or consortium of counties can demonstrate that it can otherwise meet the requirements of this chapter.

(b) A service delivery authority shall:

(1) comply with current state and federal law, including any existing federal or state performance measures and performance measures under section 402A.15 when they are enacted into law, except where waivers are approved by the commissioner. Nothing in this subdivision requires the establishment of performance measures under section 402A.15 prior to a service delivery authority participating in the service delivery redesign under this chapter;

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of those services included in a proposal for a redesigned service or services and identify a single administrative agent for purposes of contact and communication with the department;

(4) identify the waivers from statutory or rule program requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals that the participating service delivery authority is expected to achieve;

(5) set forth a reasonable level of targeted reductions in overhead and administrative costs for each service delivery authority participating in the service delivery redesign; and

(6) set forth the terms under which a county, tribe, or consortium of counties may withdraw from participation.

(c) Once a county, tribe, or consortium of counties establishes a service delivery authority, no county, tribe, or consortium of counties that is a member of the service delivery authority may participate as a member of any other service delivery authority. The service delivery authority may allow an additional county, a tribe, or a consortium of counties to join the service delivery authority subject to the approval of the council and the commissioner.

(d) Nothing in this chapter precludes local governments from using sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Nothing in this chapter limits the authority of a county board or tribal

council to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Subd. 2. **Relief from statutory requirements.** (a) Unless otherwise identified in the memorandum of understanding, any county, tribe, or consortium of counties forming a service delivery authority is exempt from the provisions of sections 245.465; 245.4835; 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph (b); and 256M.30.

(b) This subdivision does not preclude any county, tribe, or consortium of counties forming a service delivery authority from requesting additional waivers from statutory and rule requirements to ensure greater local control and flexibility.

Subd. 3. **Duties.** The service delivery authority shall:

(1) within the scope of essential services set forth in the memorandum of understanding establishing the authority, carry out the responsibilities required of local agencies under chapter 393 and human services boards under chapter 402;

(2) manage the public resources devoted to human services and other public services delivered or purchased by the counties or tribes that are subsidized or regulated by the Department of Human Services under chapters 245 to 261;

(3) employ staff to assist in carrying out its duties;

(4) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human services functions in the event of any business interruption according to local, state, and federal emergency planning requirements;

(5) receive and expend funds received for the redesign process under the memorandum of understanding;

(6) plan and deliver services directly or through contract with other governmental, tribal, or nongovernmental providers;

(7) rent, purchase, sell, and otherwise dispose of real and personal property as necessary to carry out the redesign; and

(8) carry out any other service designated as a responsibility of a county.

Subd. 4. **Process for establishing a service delivery authority.** (a) The county, tribe, or consortium of counties meeting the requirements of section 402A.30 and proposing to establish a service delivery authority shall present to the council:

(1) in conjunction with the commissioner, a proposed memorandum of understanding meeting the requirements of subdivision 1, paragraph (b), and outlining:

(i) the details of the proposal;

(ii) the state, tribal, and local resources, which may include, but are not limited to, funding, administrative and technology support, and other requirements necessary for the service delivery authority; and

(iii) the relief available to the service delivery authority if the resource commitments identified in item (ii) are not met; and

(2) a board resolution from the board of commissioners of each participating county stating the county's intent to participate, or in the case of a tribe, a resolution from tribal government, stating the tribe's intent to participate.

(b) After the council has considered and recommended approval of a proposed memorandum of understanding, the commissioner may finalize and execute the memorandum of understanding.

Subd. 5. Commissioner authority to seek waivers. The commissioner may use the authority under section 256.01, subdivision 2, paragraph (l), to grant waivers identified as part of a proposed service delivery authority under subdivision 1, paragraph (b), clause (4), except that waivers granted under this section must be approved by the council under section 402A.20 rather than the Legislative Advisory Committee.

Sec. 18. ALIGNMENT OF VERIFICATION AND REDETERMINATION POLICIES.

The commissioner of human services shall develop recommendations to align eligibility verification procedures for all health care, economic assistance, food support, child support enforcement, and child care programs. The commissioner shall report back to the chairs of the legislative committees with jurisdiction over these issues by January 15, 2012, with recommendations and draft legislation to implement the alignment of eligibility verifications.

Sec. 19. ALTERNATIVE STRATEGIES FOR CERTAIN REDETERMINATIONS.

The commissioner of human services shall develop and implement by January 15, 2012, a simplified process to redetermine eligibility for recipient populations in the medical assistance, Minnesota supplemental aid, food support, and group residential housing programs who are eligible based upon disability, age, or chronic medical conditions, and who are expected to experience minimal change in income or assets from month to month. The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 20. REQUEST FOR PROPOSALS; COMBINED ONLINE APPLICATION.

310.1 (a) The commissioner of human services shall issue a request for proposals for a
310.2 contract to implement a phased-in integrated online eligibility and application portal for
310.3 health care programs, if federal matching funds are available. The health care portal must
310.4 be developed in phases with the capacity to integrate food support, cash assistance, and
310.5 child care programs as funds are available. The request for proposals must require that the
310.6 system recommended and implemented by the contractor:

310.7 (1) streamline eligibility determination and case processing in the state to support
310.8 statewide eligibility processing;

310.9 (2) enable interested persons to determine eligibility for each program, and to apply
310.10 for programs online in a manner that the applicant will be asked only those questions that
310.11 relate to the programs the person is applying for;

310.12 (3) leverage technology that has been operational in production in other similar
310.13 state environments; and

310.14 (4) include Web-based application and worker application processing support and
310.15 opportunity for expansion.

310.16 (b) If responses to the request for proposals meet the requirements set forth, the
310.17 commissioner shall enter into a contract for the services specified in paragraph (a) by
310.18 January 31, 2012. The contract may incorporate a performance-based vendor financing
310.19 option whereby the vendor shares the risk of the project's success. If the commissioner
310.20 determines there is no adequate response to the request for proposals, the commissioner
310.21 shall report this to the chairs and ranking minority members of the legislative committees
310.22 with jurisdiction over health and human services prior to January 31, 2012.

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

310.24 **Sec. 21. REPEALER.**

310.25 (a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.

310.26 (b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

ARTICLE 9

CHEMICAL AND MENTAL HEALTH

310.29 Section 1. Minnesota Statutes 2010, section 246B.10, is amended to read:

310.30 **246B.10 LIABILITY OF COUNTY: REIMBURSEMENT.**

310.31 The civilly committed sex offender's county shall pay to the state a portion of the
310.32 cost of care provided in the Minnesota sex offender program to a civilly committed sex
310.33 offender who has legally settled in that county. A county's payment must be made from

311.1 the county's own sources of revenue and payments must equal ~~ten~~ 30 percent of the cost of
311.2 care, as determined by the commissioner, for each day or portion of a day, that the civilly
311.3 committed sex offender spends at the facility. If payments received by the state under this
311.4 chapter exceed ~~90~~ 70 percent of the cost of care, the county is responsible for paying the
311.5 state the remaining amount. The county is not entitled to reimbursement from the civilly
311.6 committed sex offender, the civilly committed sex offender's estate, or from the civilly
311.7 committed sex offender's relatives, except as provided in section 246B.07.

311.8 **EFFECTIVE DATE.** This section is effective for all individuals who are civilly
311.9 committed to the Minnesota sex offender program on or after August 1, 2011.

311.10 Sec. 2. Minnesota Statutes 2010, section 252.025, subdivision 7, is amended to read:

311.11 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
311.12 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who
311.13 have developmental disabilities and exhibit severe behaviors which present a risk to
311.14 public safety. This program is statewide and must provide specialized residential services
311.15 in Cambridge and an array of community-based services with sufficient levels of care
311.16 and a sufficient number of specialists to ensure that individuals referred to the program
311.17 receive the appropriate care. The individuals working in the community-based services
311.18 under this section are state employees supervised by the commissioner of human services.
311.19 No midcontract layoffs shall occur as a result of restructuring under this section, but
311.20 layoffs may occur as a normal consequence of a low census or closure of the facility
311.21 due to decreased census.

311.22 Sec. 3. Minnesota Statutes 2010, section 253B.212, is amended to read:

311.23 **253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS;**
311.24 **WHITE EARTH BAND OF OJIBWE.**

311.25 Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake**
311.26 **Band of Chippewa Indians.** The commissioner of human services may contract with
311.27 and receive payment from the Indian Health Service of the United States Department of
311.28 Health and Human Services for the care and treatment of those members of the Red
311.29 Lake Band of Chippewa Indians who have been committed by tribal court order to the
311.30 Indian Health Service for care and treatment of mental illness, developmental disability, or
311.31 chemical dependency. The contract shall provide that the Indian Health Service may not
311.32 transfer any person for admission to a regional center unless the commitment procedure

312.1 utilized by the tribal court provided due process protections similar to those afforded
312.2 by sections 253B.05 to 253B.10.

312.3 Subd. 1a. **Cost of care; commitment by tribal court order; White Earth Band of**
312.4 **Ojibwe Indians.** The commissioner of human services may contract with and receive
312.5 payment from the Indian Health Service of the United States Department of Health and
312.6 Human Services for the care and treatment of those members of the White Earth Band
312.7 of Ojibwe Indians who have been committed by tribal court order to the Indian Health
312.8 Service for care and treatment of mental illness, developmental disability, or chemical
312.9 dependency. The tribe may also contract directly with the commissioner for treatment
312.10 of those members of the White Earth Band who have been committed by tribal court
312.11 order to the White Earth Department of Health for care and treatment of mental illness,
312.12 developmental disability, or chemical dependency. The contract shall provide that the
312.13 Indian Health Service and the White Earth Band shall not transfer any person for admission
312.14 to a regional center unless the commitment procedure utilized by the tribal court provided
312.15 due process protections similar to those afforded by sections 253B.05 to 253B.10.

312.16 Subd. 2. **Effect given to tribal commitment order.** When, under an agreement
312.17 entered into pursuant to ~~subdivision 1~~ subdivisions 1 or 1a, the Indian Health Service
312.18 applies to a regional center for admission of a person committed to the jurisdiction of the
312.19 health service by the tribal court as a person who is mentally ill, developmentally disabled,
312.20 or chemically dependent, the commissioner may treat the patient with the consent of
312.21 the Indian Health Service.

312.22 A person admitted to a regional center pursuant to this section has all the rights
312.23 accorded by section 253B.03. In addition, treatment reports, prepared in accordance with
312.24 the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health
312.25 Service within 60 days of commencement of the patient's stay at the facility. A subsequent
312.26 treatment report shall be filed with the Indian Health Service within six months of the
312.27 patient's admission to the facility or prior to discharge, whichever comes first. Provisional
312.28 discharge or transfer of the patient may be authorized by the head of the treatment facility
312.29 only with the consent of the Indian Health Service. Discharge from the facility to the
312.30 Indian Health Service may be authorized by the head of the treatment facility after notice
312.31 to and consultation with the Indian Health Service.

312.32 Sec. 4. Minnesota Statutes 2010, section 254B.03, subdivision 1, is amended to read:

312.33 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
312.34 dependency services to persons residing within its jurisdiction who meet criteria
312.35 established by the commissioner for placement in a chemical dependency residential

or nonresidential treatment service subject to the limitations on residential chemical dependency treatment in section 254B.04, subdivision 1. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~16.14~~ 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~16.14~~ 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

EFFECTIVE DATE. This section is effective for claims processed beginning July 1, 2011.

Sec. 6. Minnesota Statutes 2010, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical

314.1 dependency fund services subject to the following limitations: (1) no more than three
314.2 residential chemical dependency treatment episodes for the same person in a four-year
314.3 period of time unless the person meets the criteria established by the commissioner of
314.4 human services; and (2) no more than four residential chemical dependency treatment
314.5 episodes in a lifetime unless the person meets the criteria established by the commissioner
314.6 of human services. State money appropriated for this paragraph must be placed in a
314.7 separate account established for this purpose.

314.8 Persons with dependent children who are determined to be in need of chemical
314.9 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
314.10 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
314.11 local agency to access needed treatment services. Treatment services must be appropriate
314.12 for the individual or family, which may include long-term care treatment or treatment in a
314.13 facility that allows the dependent children to stay in the treatment facility. The county
314.14 shall pay for out-of-home placement costs, if applicable.

314.15 (b) A person not entitled to services under paragraph (a), but with family income
314.16 that is less than 215 percent of the federal poverty guidelines for the applicable family
314.17 size, shall be eligible to receive chemical dependency fund services within the limit
314.18 of funds appropriated for this group for the fiscal year. If notified by the state agency
314.19 of limited funds, a county must give preferential treatment to persons with dependent
314.20 children who are in need of chemical dependency treatment pursuant to an assessment
314.21 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
314.22 6, or 260C.212. A county may spend money from its own sources to serve persons under
314.23 this paragraph. State money appropriated for this paragraph must be placed in a separate
314.24 account established for this purpose.

314.25 (c) Persons whose income is between 215 percent and 412 percent of the federal
314.26 poverty guidelines for the applicable family size shall be eligible for chemical dependency
314.27 services on a sliding fee basis, within the limit of funds appropriated for this group for the
314.28 fiscal year. Persons eligible under this paragraph must contribute to the cost of services
314.29 according to the sliding fee scale established under subdivision 3. A county may spend
314.30 money from its own sources to provide services to persons under this paragraph. State
314.31 money appropriated for this paragraph must be placed in a separate account established
314.32 for this purpose.

314.33 **EFFECTIVE DATE.** This section is effective for all chemical dependency
314.34 residential treatment beginning on or after July 1, 2011.

315.1 Sec. 7. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision
315.2 to read:

315.3 Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding
315.4 provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's
315.5 discretion in making placements to residential treatment settings, a person eligible for
315.6 services under this section must score at level 4 on assessment dimensions related to
315.7 relapse, continued use, and recovery environment in order to be assigned to services with
315.8 a room and board component reimbursed under this section.

315.9 Sec. 8. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

315.10 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal
315.11 financial participation collections to a special revenue account. The commissioner shall
315.12 allocate ~~83.86~~ 77.05 percent of patient payments and third-party payments to the special
315.13 revenue account and ~~16.14~~ 22.95 percent to the county financially responsible for the
315.14 patient.

315.15 **EFFECTIVE DATE.** This section is effective for claims processed beginning
315.16 July 1, 2011.

315.17 Sec. 9. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to
315.18 read:

315.19 Subd. 41. **Residential services for children with severe emotional disturbance.**
315.20 Medical assistance covers rehabilitative services in accordance with section 256B.0945
315.21 that are provided by a county or an American Indian tribe through a residential facility,
315.22 for children who have been diagnosed with severe emotional disturbance and have been
315.23 determined to require the level of care provided in a residential facility.

315.24 **EFFECTIVE DATE.** This section is effective October 1, 2011.

315.25 Sec. 10. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to
315.26 read:

315.27 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
315.28 payments to counties for residential services provided by a residential facility shall only
315.29 be made of federal earnings for services provided under this section, and the nonfederal
315.30 share of costs for services provided under this section shall be paid by the county from
315.31 sources other than federal funds or funds used to match other federal funds. Payment to
315.32 counties for services provided according to this section shall be a proportion of the per

day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective October 1, 2011.

Sec. 11. **COMMUNITY MENTAL HEALTH SERVICES; USE OF BEHAVIORAL HEALTH HOSPITALS.**

The commissioner shall issue a written report to the chairs and ranking minority members of the house and senate committees with jurisdiction of health and human services by December 31, 2011, on how the community behavioral health hospital facilities will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The commissioner must consult with the regional planning work groups for adult mental health and must include the recommendations of the work groups in the legislative report. The report must address future use of community behavioral health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65 percent licensed bed occupancy rate, and using the facilities for another purpose that will meet the mental health needs of residents of the region. The regional planning work groups shall work with the commissioner to prioritize the needs of their regions. These priorities, by region, must be included in the commissioner's report to the legislature.

Sec. 12. **INTEGRATED DUAL DIAGNOSIS TREATMENT.**

317.1 (a) The commissioner shall require individuals who perform chemical dependency
317.2 assessments or mental health assessments to use approved screening tools in order to
317.3 identify whether an individual who is the subject of the assessment has a co-occurring
317.4 mental health or chemical dependency disorder. Screening for co-occurring disorders must
317.5 begin no later than December 31, 2011.

317.6 (b) No later than October 1, 2011, the commissioner shall develop and implement a
317.7 certification process for integrated dual diagnosis treatment providers.

317.8 (c) No later than December 31, 2011, the commissioner shall develop and implement
317.9 a referral system so that individuals who, at screening, are identified with co-occurring
317.10 disorders are referred to certified integrated dual diagnosis treatment providers.

317.11 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
317.12 extent allowed by law, federal financial participation for the provision of integrated dual
317.13 diagnosis treatment to persons with co-occurring disorders.

317.14 Sec. 13. **CLOSURE OF STATE-OPERATED SERVICES FACILITIES.**

317.15 (a) The commissioner shall close the Willmar Community Behavioral Health
317.16 Hospital no later than October 1, 2011.

317.17 (b) The commissioner shall close the inpatient child and adolescent behavioral
317.18 health services program in Willmar, the subacute mental health facility in Wadena, and
317.19 the Community Behavioral Health Hospitals in Alexandria, Annandale, Baxter, Bemidji,
317.20 Fergus Falls, and Rochester no later than October 1, 2012.

317.21 (c) The commissioner shall present a plan to the legislative committees with
317.22 jurisdiction over health and human services finance no later than January 15, 2012, on
317.23 how the department will:

317.24 (1) accommodate the mental health needs of clients impacted by the closure of
317.25 these state-operated services facilities; and

317.26 (2) accommodate the state employees adversely affected by the closure of these
317.27 facilities.

317.28 Sec. 14. **REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.**

317.29 (a) No layoffs shall occur as a result of restructuring services at the Anoka-Metro
317.30 Regional Treatment Center.

317.31 (b) The commissioner shall issue a report to the legislative committees with
317.32 jurisdiction over health and human services finance no later than December 31, 2011,
317.33 which provides the number of employees in management positions at the Anoka-Metro

Regional Treatment Center and the Minnesota Security Hospital at St. Peter and the ratio of management to direct-care staff for each facility.

Sec. 15. **COMMISSIONER'S CRITERIA FOR RESIDENTIAL TREATMENT.**

The commissioner shall develop specific criteria to approve treatment for individuals who require residential chemical dependency treatment in excess of the maximum allowed in section 254B.04, subdivision 1, due to co-occurring disorders, including disorders related to cognition, traumatic brain injury, or documented disability. Criteria shall be developed for use no later than October 1, 2011.

Sec. 16. **REPEALER.**

Laws 2009, chapter 79, article 3, section 18, as amended by Laws 2010, First Special Session chapter 1, article 19, section 19, is repealed.

ARTICLE 10

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	<u>2012</u>	<u>2013</u>	<u>Total</u>
<u>General</u>	<u>\$ 5,551,038,000</u>	<u>\$ 5,192,190,000</u>	<u>\$ 10,743,228,000</u>
<u>State Government Special Revenue</u>	<u>63,198,000</u>	<u>63,154,000</u>	<u>126,352,000</u>
<u>Health Care Access</u>	<u>398,372,000</u>	<u>400,962,000</u>	<u>799,334,000</u>
<u>Federal TANF</u>	<u>274,091,000</u>	<u>282,814,000</u>	<u>556,905,000</u>
<u>Lottery Prize Fund</u>	<u>1,584,000</u>	<u>1,587,000</u>	<u>3,171,000</u>
<u>Total</u>	<u>\$ 6,288,283,000</u>	<u>\$ 5,940,707,000</u>	<u>\$ 12,228,990,000</u>

Sec. 2. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal year 2013. "The biennium" is fiscal years 2012 and 2013.

		<u>APPROPRIATIONS</u>	
		<u>Available for the Year</u>	
		<u>Ending June 30</u>	
		<u>2012</u>	<u>2013</u>
319.1			
319.2			
319.3			
319.4			
319.5	<u>Sec. 3. COMMISSIONER OF HUMAN</u>		
319.6	<u>SERVICES</u>		
319.7	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 6,117,437,000</u>	<u>\$ 5,779,413,000</u>
319.8	<u>Appropriations by Fund</u>		
319.9		<u>2012</u>	<u>2013</u>
319.10	<u>General</u>	<u>5,468,249,000</u>	<u>5,114,297,000</u>
319.11	<u>State Government</u>		
319.12	<u>Special Revenue</u>	<u>565,000</u>	<u>565,000</u>
319.13	<u>Health Care Access</u>	<u>384,661,000</u>	<u>391,863,000</u>
319.14	<u>Federal TANF</u>	<u>262,378,000</u>	<u>271,101,000</u>
319.15	<u>Lottery Prize Fund</u>	<u>1,584,000</u>	<u>1,587,000</u>
319.16	<u>Receipts for Systems Projects.</u>		
319.17	<u>Appropriations and federal receipts for</u>		
319.18	<u>information systems projects for MAXIS,</u>		
319.19	<u>PRISM, MMIS, and SSIS must be deposited</u>		
319.20	<u>in the state systems account authorized in</u>		
319.21	<u>Minnesota Statutes, section 256.014. Money</u>		
319.22	<u>appropriated for computer projects approved</u>		
319.23	<u>by the Minnesota Office of Enterprise</u>		
319.24	<u>Technology, funded by the legislature,</u>		
319.25	<u>and approved by the commissioner of</u>		
319.26	<u>Minnesota Management and Budget, may</u>		
319.27	<u>be transferred from one project to another</u>		
319.28	<u>and from development to operations as the</u>		
319.29	<u>commissioner of human services considers</u>		
319.30	<u>necessary. Any unexpended balance in</u>		
319.31	<u>the appropriation for these projects does</u>		
319.32	<u>not cancel but is available for ongoing</u>		
319.33	<u>development and operations.</u>		
319.34	<u>Nonfederal Share Transfers. The</u>		
319.35	<u>nonfederal share of activities for which</u>		
319.36	<u>federal administrative reimbursement is</u>		

320.1 appropriated to the commissioner may be
320.2 transferred to the special revenue fund.

320.3 **TANF Maintenance of Effort.**

320.4 (a) In order to meet the basic maintenance
320.5 of effort (MOE) requirements of the TANF
320.6 block grant specified under Code of Federal
320.7 Regulations, title 45, section 263.1, the
320.8 commissioner may only report nonfederal
320.9 money expended for allowable activities
320.10 listed in the following clauses as TANF/MOE
320.11 expenditures:

320.12 (1) MFIP cash, diversionary work program,
320.13 and food assistance benefits under Minnesota
320.14 Statutes, chapter 256J;

320.15 (2) the child care assistance programs
320.16 under Minnesota Statutes, sections 119B.03
320.17 and 119B.05, and county child care
320.18 administrative costs under Minnesota
320.19 Statutes, section 119B.15;

320.20 (3) state and county MFIP administrative
320.21 costs under Minnesota Statutes, chapters
320.22 256J and 256K;

320.23 (4) state, county, and tribal MFIP
320.24 employment services under Minnesota
320.25 Statutes, chapters 256J and 256K;

320.26 (5) expenditures made on behalf of
320.27 noncitizen MFIP recipients who qualify
320.28 for the medical assistance without federal
320.29 financial participation program under
320.30 Minnesota Statutes, section 256B.06,
320.31 subdivision 4, paragraphs (d), (e), and (j);

320.32 (6) qualifying working family credit
320.33 expenditures under Minnesota Statutes,
320.34 section 290.0671; and

321.1 (7) qualifying Minnesota education credit
321.2 expenditures under Minnesota Statutes,
321.3 section 290.0674.

321.4 (b) The commissioner shall ensure that
321.5 sufficient qualified nonfederal expenditures
321.6 are made each year to meet the state's
321.7 TANF/MOE requirements. For the activities
321.8 listed in paragraph (a), clauses (2) to
321.9 (7), the commissioner may only report
321.10 expenditures that are excluded from the
321.11 definition of assistance under Code of
321.12 Federal Regulations, title 45, section 260.31.

321.13 (c) For fiscal years beginning with state fiscal
321.14 year 2003, the commissioner shall assure
321.15 that the maintenance of effort used by the
321.16 commissioner of management and budget
321.17 for the February and November forecasts
321.18 required under Minnesota Statutes, section
321.19 16A.103, contains expenditures under
321.20 paragraph (a), clause (1), equal to at least 16
321.21 percent of the total required under Code of
321.22 Federal Regulations, title 45, section 263.1.

321.23 (d) Minnesota Statutes, section 256.011,
321.24 subdivision 3, which requires that federal
321.25 grants or aids secured or obtained under that
321.26 subdivision be used to reduce any direct
321.27 appropriations provided by law, do not apply
321.28 if the grants or aids are federal TANF funds.

321.29 (e) Notwithstanding any contrary provision
321.30 in this article, paragraph (a), clauses (1) to
321.31 (7), and paragraphs (b) to (d), expire June
321.32 30, 2015.

321.33 **Working Family Credit Expenditures**
321.34 **as TANF/MOE. The commissioner may**
321.35 **claim as TANF maintenance of effort up to**

322.1 \$6,707,000 per year of working family credit
322.2 expenditures for fiscal years 2012 and 2013.

322.3 **Working Family Credit Expenditures**
322.4 **to be Claimed for TANF/MOE.** The
322.5 commissioner may count the following
322.6 amounts of working family credit
322.7 expenditures as TANF/MOE:

322.8 (1) fiscal year 2012, \$12,037,000;
322.9 (2) fiscal year 2013, \$29,942,000;
322.10 (3) fiscal year 2014, \$23,235,000; and
322.11 (4) fiscal year 2015, \$23,198,000.

322.12 Notwithstanding any contrary provision in
322.13 this article, this rider expires June 30, 2015.

322.14 **TANF Transfer to Federal Child Care**
322.15 **and Development Fund.** (a) The following
322.16 TANF fund amounts are appropriated
322.17 to the commissioner for purposes of
322.18 MFIP/Transition Year Child Care Assistance
322.19 under Minnesota Statutes, section 119B.05:

322.20 (1) fiscal year 2012, \$11,020,000;
322.21 (2) fiscal year 2013, \$35,020,000;
322.22 (3) fiscal year 2014, \$14,020,000; and
322.23 (4) fiscal year 2015, \$14,020,000.

322.24 (b) The commissioner shall authorize the
322.25 transfer of sufficient TANF funds to the
322.26 federal child care and development fund to
322.27 meet this appropriation and shall ensure that
322.28 all transferred funds are expended according
322.29 to federal child care and development fund
322.30 regulations.

322.31 **Food Stamps Employment and Training**
322.32 **Funds.** (a) Notwithstanding Minnesota
322.33 Statutes, sections 256D.051, subdivisions 1a,

323.1 6b, and 6c, and 256J.626, federal food stamps
323.2 employment and training funds received
323.3 as reimbursement for child care assistance
323.4 program expenditures must be deposited in
323.5 the general fund. The amount of funds must
323.6 be limited to \$500,000 per year in fiscal
323.7 years 2012 through 2015, contingent upon
323.8 approval by the federal Food and Nutrition
323.9 Service.

323.10 (b) Consistent with the receipt of these
323.11 federal funds, the commissioner may
323.12 adjust the level of working family credit
323.13 expenditures claimed as TANF maintenance
323.14 of effort. Notwithstanding any contrary
323.15 provision in this article, this rider expires
323.16 June 30, 2015.

323.17 **ARRA Food Support Benefit Increases.**
323.18 The funds provided for food support benefit
323.19 increases under the Supplemental Nutrition
323.20 Assistance Program provisions of the
323.21 American Recovery and Reinvestment Act
323.22 (ARRA) of 2009 must be used for benefit
323.23 increases beginning July 1, 2009.

323.24 **Supplemental Security Interim Assistance**
323.25 **Reimbursement Funds.** \$2,800,000 of
323.26 uncommitted revenue available to the
323.27 commissioner of human services for SSI
323.28 advocacy and outreach services must be
323.29 transferred to and deposited into the general
323.30 fund by June 30, 2012.

323.31 **Subd. 2. Central Office Operations**

323.32 The amounts that may be spent from this
323.33 appropriation for each purpose are as follows:

323.34 **(a) Operations**

324.1	<u>Appropriations by Fund</u>		
324.2	<u>General</u>	<u>81,119,000</u>	<u>80,932,000</u>
324.3	<u>Health Care Access</u>	<u>11,742,000</u>	<u>11,508,000</u>
324.4	<u>State Government</u>		
324.5	<u>Special Revenue</u>	<u>440,000</u>	<u>440,000</u>
324.6	<u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>

324.7 **DHS Receipt Center Accounting.** The
324.8 commissioner is authorized to transfer
324.9 appropriations to, and account for DHS
324.10 receipt center operations in, the special
324.11 revenue fund.

324.12 **Base Adjustment.** The general fund base
324.13 for fiscal year 2014 shall be increased by
324.14 \$79,000. This adjustment is onetime.

324.15 **(b) Children and Families**

324.16	<u>Appropriations by Fund</u>		
324.17	<u>General</u>	<u>9,302,000</u>	<u>9,227,000</u>
324.18	<u>Federal TANF</u>	<u>2,160,000</u>	<u>2,160,000</u>

324.19 **Financial Institution Data Match and**
324.20 **Payment of Fees.** The commissioner is
324.21 authorized to allocate up to \$310,000 each
324.22 year in fiscal years 2012 and 2013 from the
324.23 PRISM special revenue account to make
324.24 payments to financial institutions in exchange
324.25 for performing data matches between account
324.26 information held by financial institutions
324.27 and the public authority's database of child
324.28 support obligors as authorized by Minnesota
324.29 Statutes, section 13B.06, subdivision 7.

324.30 **(c) Health Care**

324.31	<u>Appropriations by Fund</u>		
324.32	<u>General</u>	<u>15,989,000</u>	<u>15,801,000</u>
324.33	<u>Health Care Access</u>	<u>22,574,000</u>	<u>22,439,000</u>

324.34 **Minnesota Senior Health Options**

324.35 **Reimbursement.** Federal administrative

325.1 reimbursement resulting from the Minnesota
325.2 senior health options project is appropriated
325.3 to the commissioner for this activity.

325.4 **Utilization Review.** Federal administrative
325.5 reimbursement resulting from prior
325.6 authorization and inpatient admission
325.7 certification by a professional review
325.8 organization shall be dedicated to the
325.9 commissioner for these purposes. A portion
325.10 of these funds must be used for activities to
325.11 decrease unnecessary pharmaceutical costs
325.12 in medical assistance.

325.13 **Base Adjustment.** The general fund base
325.14 shall be decreased by \$2,000 in fiscal year
325.15 2014 and \$114,000 in 2015.

325.16 The health care access fund base is decreased
325.17 by \$16,000 in fiscal year 2014 and \$142,000
325.18 in 2015.

325.19 **(d) Continuing Care**

325.20	<u>Appropriations by Fund</u>		
325.21	<u>General</u>	<u>16,706,000</u>	<u>16,661,000</u>
325.22	<u>State Government</u>		
325.23	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

325.24 **Base Adjustment.** The general fund base is
325.25 decreased by \$259,000 in each of fiscal years
325.26 2014 and 2015.

325.27 **(e) Chemical and Mental Health**

325.28	<u>Appropriations by Fund</u>		
325.29	<u>General</u>	<u>4,194,000</u>	<u>4,194,000</u>
325.30	<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>

325.31 **Subd. 3. Forecasted Programs**

325.32 The amounts that may be spent from this
325.33 appropriation for each purpose are as follows:

325.34 **(a) MFIP/DWP Grants**

326.1	<u>Appropriations by Fund</u>		
326.2	<u>General</u>	<u>84,276,000</u>	<u>91,331,000</u>
326.3	<u>Federal TANF</u>	<u>84,425,000</u>	<u>75,417,000</u>
326.4	<u>(b) MFIP Child Care Assistance Grants</u>	<u>55,258,000</u>	<u>24,789,000</u>
326.5	<u>(c) General Assistance Grants</u>	<u>49,664,000</u>	<u>49,775,000</u>
326.6	<u>General Assistance Standard. The</u>		
326.7	<u>commissioner shall set the monthly standard</u>		
326.8	<u>of assistance for general assistance units</u>		
326.9	<u>consisting of an adult recipient who is</u>		
326.10	<u>childless and unmarried or living apart</u>		
326.11	<u>from parents or a legal guardian at \$203.</u>		
326.12	<u>The commissioner may reduce this amount</u>		
326.13	<u>according to Laws 1997, chapter 85, article</u>		
326.14	<u>3, section 54.</u>		
326.15	<u>Emergency General Assistance. The</u>		
326.16	<u>amount appropriated for emergency general</u>		
326.17	<u>assistance funds is limited to no more</u>		
326.18	<u>than \$7,889,812 in fiscal year 2012 and</u>		
326.19	<u>\$7,889,812 in fiscal year 2013. Funds</u>		
326.20	<u>to counties shall be allocated by the</u>		
326.21	<u>commissioner using the allocation method</u>		
326.22	<u>specified in Minnesota Statutes, section</u>		
326.23	<u>256D.06.</u>		
326.24	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>38,095,000</u>	<u>39,120,000</u>
326.25	<u>Emergency Minnesota Supplemental</u>		
326.26	<u>Aid Funds. The amount appropriated for</u>		
326.27	<u>emergency Minnesota supplemental aid</u>		
326.28	<u>funds is limited to no more than \$1,100,000</u>		
326.29	<u>in fiscal year 2012 and \$1,100,000 in fiscal</u>		
326.30	<u>year 2013. Funds to counties shall be</u>		
326.31	<u>allocated by the commissioner using the</u>		
326.32	<u>allocation method specified in Minnesota</u>		
326.33	<u>Statutes, section 256D.46.</u>		
326.34	<u>(e) Group Residential Housing Grants</u>	<u>121,092,000</u>	<u>129,250,000</u>

327.1	<u>(f) MinnesotaCare Grants</u>	<u>349,445,000</u>	<u>357,016,000</u>
327.2	<u>This appropriation is from the health care</u>		
327.3	<u>access fund.</u>		
327.4	<u>(g) GAMC Grants</u>		
327.5	<u>Payments for Cost Settlements.</u> The		
327.6	<u>commissioner is authorized to use amounts</u>		
327.7	<u>repaid to the general assistance medical care</u>		
327.8	<u>program under Minnesota Statutes 2009</u>		
327.9	<u>Supplement, section 256D.03, subdivision</u>		
327.10	<u>3, to pay cost settlements for claims for</u>		
327.11	<u>services provided prior to June 1, 2010.</u>		
327.12	<u>Notwithstanding any contrary provision in</u>		
327.13	<u>this article, this provision does not expire.</u>		
327.14	<u>(h) Medical Assistance Grants</u>	<u>4,287,303,000</u>	<u>3,983,684,000</u>
327.15	<u>Managed Care Incentive Payments.</u> The		
327.16	<u>commissioner shall not make managed care</u>		
327.17	<u>incentive payments for expanding preventive</u>		
327.18	<u>services during fiscal years beginning July 1,</u>		
327.19	<u>2011 and July 1, 2012.</u>		
327.20	<u>Region 10.</u> \$450,000 for the biennium		
327.21	<u>beginning July 1, 2011, is to administer</u>		
327.22	<u>the State Quality Assurance, Quality</u>		
327.23	<u>Improvement, and Licensing System under</u>		
327.24	<u>Minnesota Statutes, section 256B.0961.</u>		
327.25	<u>Of this appropriation, \$200,000 is for the</u>		
327.26	<u>State Quality Council and \$250,000 is</u>		
327.27	<u>for the continuation of Region 10 Quality</u>		
327.28	<u>Assurance.</u>		
327.29	<u>Limit Growth in the Developmental</u>		
327.30	<u>Disability Waiver.</u> The commissioner shall		
327.31	<u>limit growth in the developmental disability</u>		
327.32	<u>waiver to 15 diversion allocations per month</u>		
327.33	<u>beginning July 1, 2011, through June 30,</u>		
327.34	<u>2013. Waiver allocations shall be available</u>		

328.1 to individuals who meet the priorities for
328.2 accessing waiver services identified in
328.3 Minnesota Statutes, 256B.092, subdivision
328.4 12. The limits do not include conversions
328.5 from intermediate care facilities for persons
328.6 with developmental disabilities.

328.7 **Limit Growth in the Community**

328.8 **Alternatives for Disabled Individuals**

328.9 **Waiver.** The commissioner shall limit
328.10 growth in the community alternatives for
328.11 disabled individuals waiver to 85 allocations
328.12 per month beginning July 1, 2011, through
328.13 June 30, 2013. Waiver allocations must
328.14 be available to individuals who meet the
328.15 priorities for accessing waiver services
328.16 identified in Minnesota Statutes, section
328.17 256B.49, subdivision 11a. The limits include
328.18 conversions and diversions, unless the
328.19 commissioner has approved a plan to convert
328.20 funding due to the closure or downsizing
328.21 of a residential facility or nursing facility
328.22 to serve directly affected individuals on
328.23 the community alternatives for disabled
328.24 individuals waiver.

328.25 **Reduction of Rates for Congregate**

328.26 **Living for Individuals with Lower Needs.**

328.27 Beginning October 1, 2011, lead agencies
328.28 must reduce rates in effect on January 1,
328.29 2011, by ten percent for individuals with
328.30 lower needs living in foster care settings
328.31 where the license holder does not share the
328.32 residence with recipients on the CADI, DD,
328.33 and TBI waivers and customized living
328.34 settings for CADI and TBI. Lead agencies
328.35 must adjust contracts within 60 days of the
328.36 effective date.

329.1 **Reduction of Lead Agency Waiver**
329.2 **Allocations to Implement Rate Reductions**
329.3 **for Congregate Living for Individuals**
329.4 **with Lower Needs.** Beginning October 1,
329.5 2011, the commissioner shall reduce lead
329.6 agency waiver allocations to implement the
329.7 reduction of rates for individuals with lower
329.8 needs living in foster care settings where the
329.9 license holder does not share the residence
329.10 with recipients on the CADI, DD, and TBI
329.11 waivers and customized living settings for
329.12 CADI and TBI.

329.13 **Home and Community-Based Waiver**
329.14 **Appropriations Limits.** (a) Total state and
329.15 federal funding for the biennium beginning
329.16 on July 1, 2011, for the medicaid home and
329.17 community-based waivers for the elderly and
329.18 persons with disabilities including elderly
329.19 waiver under Minnesota Statutes, section
329.20 256B.0915; DD waiver under Minnesota
329.21 Statutes, section 256B.092; and the CAC,
329.22 CADI, and TBI waivers under Minnesota
329.23 Statutes, section 256B.49, are limited to
329.24 the following amounts: the DD waiver is
329.25 limited to \$1,964,344,000; elderly waiver
329.26 fee-for-service is limited to \$69,114,000;
329.27 elderly waiver managed care is limited
329.28 to \$530,566,000; the CADI waiver is
329.29 limited to \$820,176,000; the CAC waiver
329.30 is limited to \$41,444,000; and the TBI
329.31 waiver is limited to \$194,092,000. Of
329.32 these amounts, the commissioner shall set
329.33 aside five percent of each waiver amount
329.34 to manage emergency situations around the
329.35 state. The commissioner must ensure that at
329.36 least the same number of people are served

330.1 on the home and community-based waiver
330.2 programs as were served on March 22,
330.3 2010. Notwithstanding any law or rule to the
330.4 contrary, in order to meet the funding limits
330.5 in this provision, the commissioner may
330.6 reduce or adjust benefits and services, reduce
330.7 or adjust case-mix capitation rates, limit or
330.8 freeze waiver enrollment, establish needed
330.9 thresholds for service eligibility, adjust
330.10 eligibility criteria to the extent allowable
330.11 under federal regulations, establish prior
330.12 authorization criteria, and adjust county home
330.13 and community-based waiver allocations
330.14 as needed. Priorities for the use of waiver
330.15 slots must be for individuals anticipated to
330.16 be discharged from an institutional setting or
330.17 who are at imminent risk of an institutional
330.18 placement. The limits include conversions
330.19 and diversions, unless the commissioner has
330.20 approved a plan to convert funding due to
330.21 the restructuring, closure, or downsizing of
330.22 a residential facility or nursing facility to
330.23 serve directly affected individuals on the
330.24 home and community-based waivers. The
330.25 commissioner and counties are prohibited
330.26 from reducing provider rates under this
330.27 provision. The commissioner shall maintain
330.28 the waiting list and access to the waiver.
330.29 (b) If the commissioner determines that
330.30 application of the methods specified in
330.31 paragraph (a) will not allow spending to
330.32 remain within the limits specified in that
330.33 paragraph, the commissioner, effective July
330.34 1, 2011, must reduce by ten percent the
330.35 salaries of all central office staff who, as of

331.1 June 1, 2011, received a salary of greater
331.2 than \$90,000.

331.3 (c) If the commissioner determines that
331.4 the application of the methods specified
331.5 in paragraphs (a) and (b) will not allow
331.6 spending to remain within the limits specified
331.7 in paragraph (a), the commissioner may
331.8 reduce provider payment rates by the
331.9 amount necessary to remain within the limits
331.10 specified in paragraph (a).

331.11 **Management of Fee-for-Service Spending.**

331.12 Total state and federal funding for the
331.13 biennium beginning on July 1, 2011, for
331.14 fee-for-service medical assistance basic care
331.15 for the elderly and persons with disabilities
331.16 is limited to \$2,536,949,000. Total state and
331.17 federal funding for the biennium beginning
331.18 July 1, 2011, for fee-for-service medical
331.19 assistance basic care for adults without
331.20 children is limited to \$526,251,000.

331.21 **Freeze in Fee-for-Service Spending.** The
331.22 commissioner shall manage spending within
331.23 these limits by:

331.24 (1) managing and coordinating the care
331.25 provided by high-cost providers;

331.26 (2) expanding the use of health care homes to
331.27 manage the care provided to enrollees with
331.28 chronic conditions;

331.29 (3) implementing payment reform to
331.30 encourage efficient and cost-effective service
331.31 provision; and

331.32 (4) modifying or restricting medical
331.33 assistance program eligibility, and seeking

332.1 any necessary approvals or waivers related to
332.2 federal maintenance of effort requirements.

332.3 **Contingent Rate Reductions.** If
332.4 the commissioner determines that
332.5 implementation of the global waiver under
332.6 Minnesota Statutes, sections 256B.841,
332.7 256B.842, and 256B.843, will not achieve a
332.8 state general fund savings of \$300,000,000
332.9 for the biennium beginning July 1, 2011, the
332.10 commissioner shall calculate an estimate of
332.11 the shortfall in savings, and, for the fiscal
332.12 year beginning July 1, 2012, shall reduce
332.13 medical assistance provider payment rates,
332.14 including but not limited to rates to individual
332.15 health care providers and provider agencies,
332.16 hospitals, nursing facilities, other residential
332.17 settings, and capitation rates provided to
332.18 managed care and county-based purchasing
332.19 plans, by the amount necessary to recoup the
332.20 shortfall in savings over that fiscal year.

332.21	<u>(i) Alternative Care Grants</u>	<u>44,978,000</u>	<u>45,106,000</u>

332.22 **Alternative Care Transfer.** Any money
332.23 allocated to the alternative care program that
332.24 is not spent for the purposes indicated does
332.25 not cancel but shall be transferred to the
332.26 medical assistance account.

332.27	<u>(j) Chemical Dependency Entitlement Grants</u>	<u>94,675,000</u>	<u>93,298,000</u>

332.28 **Subd. 4. Grant Programs**

332.29 The amounts that may be spent from this
332.30 appropriation for each purpose are as follows:

332.31 **(a) Support Services Grants**

332.32	<u>Appropriations by Fund</u>		
332.33	<u>General</u>	<u>9,165,000</u>	<u>9,165,000</u>
332.34	<u>Federal TANF</u>	<u>96,525,000</u>	<u>90,611,000</u>

333.1 **MFIP Consolidated Fund Grants.** The
333.2 TANF fund base is reduced by \$14,000,000
333.3 each year beginning in fiscal year 2012.

333.4 **Subsidized Employment Funding Through**
333.5 **ARRA.** The commissioner is authorized to
333.6 apply for TANF emergency fund grants for
333.7 subsidized employment activities. Growth
333.8 in expenditures for subsidized employment
333.9 within the supported work program and the
333.10 MFIP consolidated fund over the amount
333.11 expended in the calendar year quarters in
333.12 the TANF emergency fund base year shall
333.13 be used to leverage the TANF emergency
333.14 fund grants for subsidized employment and
333.15 to fund supported work. The commissioner
333.16 shall develop procedures to maximize
333.17 reimbursement of these expenditures over the
333.18 TANF emergency fund base year quarters,
333.19 and may contract directly with employers
333.20 and providers to maximize these TANF
333.21 emergency fund grants.

333.22 **Healthy Communities.** \$150,000 in fiscal
333.23 year 2012 and \$150,000 in fiscal year 2013
333.24 are appropriated from the general fund to
333.25 the commissioner of human services for
333.26 contracting with the Search Institute to
333.27 promote healthy community initiatives.
333.28 The commissioner may expend up to five
333.29 percent of the appropriation to provide for
333.30 the program evaluation.

333.31 **Circles of Support.** \$200,000 in fiscal year
333.32 2012 and \$200,000 in fiscal year 2013 are
333.33 appropriated from the general fund to the
333.34 commissioner of human services for the
333.35 purpose of providing grants to community

334.1	<u>action agencies for circles of support</u>		
334.2	<u>initiatives.</u>		
334.3	<u>Northern Connections.</u> \$100,000 is		
334.4	<u>appropriated in fiscal year 2012 and</u>		
334.5	<u>\$100,000 is appropriated in fiscal year 2013</u>		
334.6	<u>from the general fund to the commissioner</u>		
334.7	<u>of human services for a grant to expand</u>		
334.8	<u>Northern Connections workforce program</u>		
334.9	<u>that provides one-stop supportive services</u>		
334.10	<u>to individuals as they transition into the</u>		
334.11	<u>workforce to up to two interested counties in</u>		
334.12	<u>rural Minnesota.</u>		
334.13	<u>(b) Basic Sliding Fee Child Care Assistance</u>		
334.14	<u>Grants</u>	<u>37,771,000</u>	<u>39,686,000</u>
334.15	<u>Base Adjustment.</u> The general fund base is		
334.16	<u>decreased by \$1,131,000 in fiscal year 2014</u>		
334.17	<u>and \$1,126,000 in fiscal year 2015.</u>		
334.18	<u>Child Care and Development Fund</u>		
334.19	<u>Unexpended Balance.</u> In addition to		
334.20	<u>the amount provided in this section, the</u>		
334.21	<u>commissioner shall expend \$5,000,000</u>		
334.22	<u>in fiscal year 2012 from the federal child</u>		
334.23	<u>care and development fund unexpended</u>		
334.24	<u>balance for basic sliding fee child care under</u>		
334.25	<u>Minnesota Statutes, section 119B.03. The</u>		
334.26	<u>commissioner shall ensure that all child</u>		
334.27	<u>care and development funds are expended</u>		
334.28	<u>according to the federal child care and</u>		
334.29	<u>development fund regulations.</u>		
334.30	<u>(c) Child Care Development Grants</u>	<u>1,487,000</u>	<u>1,487,000</u>
334.31	<u>Child Care Development Funds.</u> The		
334.32	<u>commissioner of human services shall direct</u>		
334.33	<u>\$1,000,000 in federal child care development</u>		
334.34	<u>funds for the purpose of continuing the</u>		
334.35	<u>quality rating and improvement system as</u>		

335.1	<u>described in Minnesota Statutes, section</u>		
335.2	<u>119B.135, in the original pilot area and</u>		
335.3	<u>expanding the system to two new rural</u>		
335.4	<u>geographic locations.</u>		
335.5	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
335.6	<u>Federal Child Support Demonstration</u>		
335.7	<u>Grants.</u> <u>Federal administrative</u>		
335.8	<u>reimbursement resulting from the federal</u>		
335.9	<u>child support grant expenditures authorized</u>		
335.10	<u>under section 1115a of the Social Security</u>		
335.11	<u>Act is appropriated to the commissioner for</u>		
335.12	<u>this activity.</u>		
335.13	<u>(e) Children's Services Grants</u>		
335.14	<u>Appropriations by Fund</u>		
335.15	<u>General</u>	<u>45,427,000</u>	<u>45,127,000</u>
335.16	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
335.17	<u>Adoption Assistance and Relative Custody</u>		
335.18	<u>Assistance.</u> <u>The commissioner may transfer</u>		
335.19	<u>unencumbered appropriation balances for</u>		
335.20	<u>adoption assistance and relative custody</u>		
335.21	<u>assistance between fiscal years and between</u>		
335.22	<u>programs.</u>		
335.23	<u>Privatized Adoption Grants.</u> <u>Federal</u>		
335.24	<u>reimbursement for privatized adoption grant</u>		
335.25	<u>and foster care recruitment grant expenditures</u>		
335.26	<u>is appropriated to the commissioner for</u>		
335.27	<u>adoption grants and foster care and adoption</u>		
335.28	<u>administrative purposes.</u>		
335.29	<u>Adoption Assistance Incentive Grants.</u>		
335.30	<u>Federal funds available during fiscal year</u>		
335.31	<u>2012 and fiscal year 2013 for adoption</u>		
335.32	<u>incentive grants are appropriated to the</u>		
335.33	<u>commissioner for these purposes.</u>		
335.34	<u>(f) Children and Community Services Grants</u>	<u>64,301,000</u>	<u>64,301,000</u>

336.1 (g) Children and Economic Support Grants 16,505,000 15,315,000

336.2 Long-term homeless services. \$700,000

336.3 is appropriated from the federal TANF

336.4 fund for the biennium beginning July

336.5 1, 2011, to the commissioner of human

336.6 services for long-term homeless services

336.7 for low-income homeless families under

336.8 Minnesota Statutes, section 256K.26. This

336.9 is a onetime appropriation and is not added

336.10 to the base.

336.11 Base Adjustment. The general fund base

336.12 is increased by \$491,000 in fiscal year 2014

336.13 only.

336.14 (h) Health Care Grants

336.15	<u>Appropriations by Fund</u>		
336.16	<u>General</u>	<u>750,000</u>	<u>750,000</u>
336.17	<u>Health Care Access</u>	<u>900,000</u>	<u>900,000</u>

336.18 Surplus Appropriation Canceled. Of the

336.19 appropriation in Laws 2009, chapter 79,

336.20 article 13, section 3, subdivision 6, paragraph

336.21 (e), for the COBRA premium state subsidy

336.22 program, \$11,750,000 must be canceled in

336.23 fiscal year 2011. This provision is effective

336.24 the day following final enactment.

336.25 Grant Cancellation. Effective for the

336.26 biennium beginning July 1, 2011, the

336.27 following appropriations are canceled: (1) a

336.28 general fund appropriation of \$205,000 for

336.29 the U Special Kids program; (2) a general

336.30 fund appropriation of \$90,000 for medical

336.31 assistance outreach grants; and (3) a health

336.32 care access fund appropriation of \$40,000 for

336.33 MinnesotaCare outreach grants.

337.1 **State Subsidy Program for Community**
337.2 **Mental Health Centers.** \$100,000 is
337.3 appropriated from the general fund to
337.4 the commissioner of human services for
337.5 the biennium beginning July 1, 2011, to
337.6 provide onetime grants to establish new
337.7 community mental health centers that are
337.8 eligible for payment under Minnesota
337.9 Statutes, section 256B.0625, subdivision 5.
337.10 In awarding grants, the commissioner shall
337.11 give preference to areas of the state that
337.12 lack access to mental health services or are
337.13 underserved.

337.14	<u>(i) Aging and Adult Services Grants</u>	<u>18,834,000</u>	<u>19,010,000</u>

337.15 **Aging Grants Reduction.** Effective July
337.16 1, 2011, funding for grants made under
337.17 Minnesota Statutes, sections 256.9754 and
337.18 256B.0917, subdivision 13, is reduced by
337.19 \$3,600,000 for each year of the biennium.
337.20 These reductions are onetime and do
337.21 not affect base funding for the 2014-2015
337.22 biennium. Grants made during the 2012-2013
337.23 biennium under Minnesota Statutes, section
337.24 256B.9754, must not be used for new
337.25 construction or building renovation.

337.26 **Essential Community Support Grant**
337.27 **Delay.** Essential community supports
337.28 grants under Minnesota Statutes, section
337.29 256B.0917, subdivision 14, is reduced
337.30 by \$6,410,000 in fiscal year 2012 and
337.31 \$7,279,000 in fiscal year 2013. Base level
337.32 funding for fiscal year 2014 is reduced by
337.33 \$5,919,000. These reductions are onetime
337.34 and do not affect base level funding for fiscal
337.35 year 2015.

338.1	<u>(j) Deaf and Hard-of-Hearing Grants</u>	<u>1,936,000</u>	<u>1,767,000</u>
338.2	<u>(k) Disabilities Grants</u>	<u>21,700,000</u>	<u>23,538,000</u>
338.3	<u>Local Planning Grants for Creating</u>		
338.4	<u>Alternatives to Congregate Living for</u>		
338.5	<u>Individuals with Lower Needs. The</u>		
338.6	<u>commissioner shall make available a total</u>		
338.7	<u>of \$250,000 per year in local planning</u>		
338.8	<u>grants, beginning July 1, 2011, to assist</u>		
338.9	<u>lead agencies and provider organizations in</u>		
338.10	<u>developing alternatives to congregate living</u>		
338.11	<u>within the available level of resources for the</u>		
338.12	<u>home and community-based services waivers</u>		
338.13	<u>for persons with disabilities.</u>		
338.14	<u>(l) Adult Mental Health Grants</u>		
338.15	<u>Appropriations by Fund</u>		
338.16	<u>General</u> <u>76,789,000</u>	<u>76,789,000</u>	
338.17	<u>Lottery Prize Fund</u> <u>1,427,000</u>	<u>1,430,000</u>	
338.18	<u>Funding Usage. Up to 75 percent of a fiscal</u>		
338.19	<u>year's appropriation for adult mental health</u>		
338.20	<u>grants may be used to fund allocations in that</u>		
338.21	<u>portion of the fiscal year ending December</u>		
338.22	<u>31.</u>		
338.23	<u>Base Adjustment. The lottery prize fund</u>		
338.24	<u>base for this program shall be increased by</u>		
338.25	<u>\$78,000 in each of fiscal years 2014 and</u>		
338.26	<u>2015.</u>		
338.27	<u>(m) Children's Mental Health Grants</u>	<u>16,682,000</u>	<u>16,682,000</u>
338.28	<u>Funding Usage. Up to 75 percent of a fiscal</u>		
338.29	<u>year's appropriation for children's mental</u>		
338.30	<u>health grants may be used to fund allocations</u>		
338.31	<u>in that portion of the fiscal year ending</u>		
338.32	<u>December 31.</u>		
338.33	<u>(n) Chemical Dependency Nonentitlement</u>		
338.34	<u>Grants</u>	<u>1,336,000</u>	<u>1,336,000</u>

339.1 Subd. 5. State-Operated Services

339.2 Transfer Authority Related to

339.3 State-Operated Services. Money

339.4 appropriated for state-operated services

339.5 may be transferred between fiscal years

339.6 of the biennium with the approval of the

339.7 commissioner of management and budget.

339.8	<u>(a) State-Operated Services Mental Health</u>	<u>115,196,000</u>	<u>80,603,000</u>

339.9 State-Operated Services. To achieve these

339.10 savings, the commissioner shall close the

339.11 Willmar Community Behavioral Health

339.12 Hospital no later than October 1, 2011, and

339.13 shall close the inpatient child and adolescent

339.14 behavioral health service program in

339.15 Willmar, the subacute mental health facility

339.16 in Wadena, and the community behavioral

339.17 health hospitals in Alexandria, Annandale,

339.18 Baxter, Bemidji, Fergus Falls, and Rochester

339.19 no later than October 1, 2012.

339.20 Base Adjustment. The general fund base is

339.21 reduced by \$8,443,000 in fiscal year 2014

339.22 and \$11,543,000 in fiscal year 2015.

339.23	<u>(b) Minnesota Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>

339.24	<u>Subd. 6. Sex Offender Program</u>	<u>68,787,000</u>	<u>65,941,000</u>

339.25 Transfer Authority Related to Minnesota

339.26 Sex Offender Program. Money

339.27 appropriated for the Minnesota sex offender

339.28 program may be transferred between fiscal

339.29 years of the biennium with the approval

339.30 of the commissioner of management and

339.31 budget.

339.32 Minnesota Sex Offender Program

339.33 Reduction. The fiscal year 2011 general

339.34 fund appropriation for Minnesota sex

340.1	<u>offender services under Laws 2009, chapter</u>		
340.2	<u>79, article 13, section 3, subdivision 10,</u>		
340.3	<u>paragraph (b), is reduced by \$3,000,000.</u>		
340.4	<u>Subd. 7. Technical Activities</u>	<u>78,206,000</u>	<u>102,551,000</u>
340.5	<u>This appropriation is from the federal TANF</u>		
340.6	<u>fund.</u>		
340.7	<u>Sec. 4. COMMISSIONER OF HEALTH</u>		
340.8	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 147,845,000</u>	<u>\$ 136,538,000</u>
340.9	<u>Appropriations by Fund</u>		
340.10		<u>2012</u>	<u>2013</u>
340.11	<u>General</u>	<u>77,603,000</u>	<u>72,707,000</u>
340.12	<u>State Government</u>		
340.13	<u>Special Revenue</u>	<u>45,268,000</u>	<u>45,325,000</u>
340.14	<u>Health Care Access</u>	<u>13,711,000</u>	<u>9,099,000</u>
340.15	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
340.16	<u>The amounts that may be spent for each</u>		
340.17	<u>purpose are specified in the following</u>		
340.18	<u>subdivisions.</u>		
340.19	<u>Subd. 2. Community and Family Health</u>		
340.20	<u>Promotion</u>		
340.21	<u>Appropriations by Fund</u>		
340.22	<u>General</u>	<u>50,430,000</u>	<u>45,690,000</u>
340.23	<u>State Government</u>		
340.24	<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>
340.25	<u>Health Care Access</u>	<u>2,918,000</u>	<u>2,459,000</u>
340.26	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
340.27	<u>TANF Appropriations. (1) \$1,156,000 of</u>		
340.28	<u>the TANF funds is appropriated each year to</u>		
340.29	<u>the commissioner for family planning grants</u>		
340.30	<u>under Minnesota Statutes, section 145.925.</u>		
340.31	<u>(2) \$3,579,000 of the TANF funds is</u>		
340.32	<u>appropriated each year to the commissioner</u>		
340.33	<u>for home visiting and nutritional services</u>		
340.34	<u>listed under Minnesota Statutes, section</u>		
340.35	<u>145.882, subdivision 7, clauses (6) and (7).</u>		
340.36	<u>Funds must be distributed to community</u>		

341.1 health boards according to Minnesota
341.2 Statutes, section 145A.131, subdivision 1.
341.3 (3) \$2,000,000 of the TANF funds is
341.4 appropriated each year to the commissioner
341.5 for decreasing racial and ethnic disparities
341.6 in infant mortality rates under Minnesota
341.7 Statutes, section 145.928, subdivision 7.
341.8 (4) \$4,978,000 of the TANF funds is
341.9 appropriated each year to the commissioner
341.10 for the family home visiting grant program
341.11 according to Minnesota Statutes, section
341.12 145A.17. \$4,000,000 of the funding must
341.13 be distributed to community health boards
341.14 according to Minnesota Statutes, section
341.15 145A.131, subdivision 1. \$978,000 of
341.16 the funding must be distributed to tribal
341.17 governments based on Minnesota Statutes,
341.18 section 145A.14, subdivision 2a.
341.19 (5) The commissioner may use up to 6.23
341.20 percent of the funds appropriated each fiscal
341.21 year to conduct the ongoing evaluations
341.22 required under Minnesota Statutes, section
341.23 145A.17, subdivision 7, and training and
341.24 technical assistance as required under
341.25 Minnesota Statutes, section 145A.17,
341.26 subdivisions 4 and 5.
341.27 **TANF Carryforward. Any unexpended**
341.28 **balance of the TANF appropriation in the**
341.29 **first year of the biennium does not cancel but**
341.30 **is available for the second year.**
341.31 **Subd. 3. Policy Quality and Compliance**
341.32 Appropriations by Fund
341.33 General 10,403,000 10,199,000

342.1	<u>State Government</u>		
342.2	<u>Special Revenue</u>	<u>14,026,000</u>	<u>14,083,000</u>
342.3	<u>Health Care Access</u>	<u>10,793,000</u>	<u>6,640,000</u>

342.4 **MERC Fund Transfers.** The commissioner
342.5 of management and budget shall transfer
342.6 \$9,800,000 from the MERC fund to the
342.7 general fund by October 1, 2011.

342.8 **Unused Federal Match Funds.** Of the
342.9 funds appropriated in Laws 2009, chapter
342.10 79, article 13, section 4, subdivision 3, for
342.11 state matching funds for the federal Health
342.12 Information Technology for Economic and
342.13 Clinical Health Act, \$2,800,000 is transferred
342.14 to the health care access fund by October 1,
342.15 2011.

342.16 **Advisory Committee on Patient and**
342.17 **Community Engagement.** \$50,000 is
342.18 appropriated to the commissioner of health
342.19 to provide a grant to a private sector
342.20 organization designated as the advisory
342.21 committee on patient and community
342.22 engagement to be used by the organization
342.23 for:

342.24 (1) per diems and expenses for persons who
342.25 serve on the designated organization's board;
342.26 and

342.27 (2) expenses for conducting focus groups,
342.28 community engagement events, surveys, and
342.29 other activities undertaken by the designated
342.30 organization to obtain information, input,
342.31 and preferences from diverse communities
342.32 for purposes of community engagement in
342.33 health system issues.

342.34 **Health Careers Opportunities Grants.**
342.35 \$447,000 each year is appropriated to the

343.1 commissioner of health from the health
343.2 care access fund for the health careers
343.3 opportunities grant program under Minnesota
343.4 Statutes, section 144.1499.

343.5 **Health Professions Opportunities**
343.6 **Scholarship Program.** \$63,000 each year is
343.7 appropriated to the commissioner of health
343.8 from the health care access fund for the
343.9 health professions opportunities scholarship
343.10 program under Minnesota Statutes, section
343.11 144.1503. \$138,000 in fiscal year 2012 and
343.12 \$276,000 each year thereafter is appropriated
343.13 to the commissioner of health from the
343.14 general fund for the health professions
343.15 opportunities scholarship program under
343.16 Minnesota Statutes, section 144.1503.

343.17 **Base Level Adjustment.** The state
343.18 government special revenue fund base shall
343.19 be reduced by \$141,000 in fiscal years 2014
343.20 and 2015. The health care access base shall
343.21 be increased by \$600,000 in fiscal year 2014.

343.22 **Subd. 4. Health Protection**

343.23	<u>Appropriations by Fund</u>		
343.24	<u>General</u>	<u>9,370,000</u>	<u>9,370,000</u>
343.25	<u>State Government</u>		
343.26	<u>Special Revenue</u>	<u>30,209,000</u>	<u>30,209,000</u>

343.27	<u>Subd. 5. Administrative Support Services</u>	<u>7,440,000</u>	<u>7,488,000</u>

343.28	<u>Sec. 5. COUNCIL ON DISABILITY</u>	<u>\$ 524,000</u>	<u>\$ 524,000</u>

343.29	<u>Sec. 6. OMBUDSMAN FOR MENTAL</u>		
343.30	<u>HEALTH AND DEVELOPMENTAL</u>		
343.31	<u>DISABILITIES</u>	<u>\$ 1,655,000</u>	<u>\$ 1,655,000</u>

343.32 Funds appropriated for fiscal year 2011 are
343.33 available until expended.

343.34	<u>Sec. 7. OMBUDSPERSON FOR FAMILIES</u>	<u>\$ 265,000</u>	<u>\$ 265,000</u>

344.1 Sec. 8. **HEALTH-RELATED BOARDS**

344.2	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>17,365,000</u>	<u>\$</u>	<u>17,264,000</u>

344.3 This appropriation is from the state344.4 government special revenue fund. The344.5 amounts that may be spent for each purpose344.6 are specified in the following subdivisions.

344.7	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>469,000</u>	<u>469,000</u>

344.8	<u>Subd. 3. Board of Dentistry</u>	<u>1,959,000</u>	<u>1,914,000</u>

344.9 **Health Professional Services Program.**344.10 \$834,000 in fiscal year 2012 and \$804,000 in344.11 fiscal year 2013 from the state government344.12 special revenue fund are for the health344.13 professional services program.344.14 **Subd. 4. Board of Dietetic and Nutrition**

344.15	<u>Practice</u>	<u>110,000</u>	<u>110,000</u>

344.16 **Subd. 5. Board of Marriage and Family**

344.17	<u>Therapy</u>	<u>192,000</u>	<u>167,000</u>

344.18 **Rulemaking.** Of this appropriation, \$25,000344.19 in fiscal year 2012 is for rulemaking. This is344.20 a onetime appropriation.

344.21	<u>Subd. 6. Board of Medical Practice</u>	<u>3,866,000</u>	<u>3,866,000</u>

344.22	<u>Subd. 7. Board of Nursing</u>	<u>3,545,000</u>	<u>3,545,000</u>

344.23 **Subd. 8. Board of Nursing Home**

344.24	<u>Administrators</u>	<u>2,153,000</u>	<u>2,145,000</u>

344.25 **Rulemaking.** Of this appropriation, \$44,000344.26 in fiscal year 2012 is for rulemaking. This is344.27 a onetime appropriation.344.28 **Electronic Licensing System Adaptors.**344.29 Of this appropriation, \$761,000 in fiscal344.30 year 2013 from the state government special344.31 revenue fund is to the administrative services344.32 unit to cover the costs to connect to the344.33 e-licensing system. Minnesota Statutes,

345.1 section 16E.22. Base level funding for this
345.2 activity in fiscal year 2014 shall be \$100,000.
345.3 Base level funding for this activity in fiscal
345.4 year 2015 shall be \$50,000.

345.5 **Development and Implementation of a**
345.6 **Disciplinary, Regulatory, Licensing and**
345.7 **Information Management System.** Of this
345.8 appropriation, \$800,000 in fiscal year 2012
345.9 and \$300,000 in fiscal year 2013 are for the
345.10 development of a shared system. Base level
345.11 funding for this activity in fiscal year 2014
345.12 shall be \$50,000.

345.13 **Administrative Services Unit - Operating**
345.14 **Costs.** Of this appropriation, \$526,000
345.15 in fiscal year 2012 and \$526,000 in
345.16 fiscal year 2013 are for operating costs
345.17 of the administrative services unit. The
345.18 administrative services unit may receive
345.19 and expend reimbursements for services
345.20 performed by other agencies.

345.21 **Administrative Services Unit - Retirement**
345.22 **Costs.** Of this appropriation in fiscal year
345.23 2012, \$225,000 is for onetime retirement
345.24 costs in the health-related boards. This
345.25 funding may be transferred to the health
345.26 boards incurring those costs for their
345.27 payment. These funds are available either
345.28 year of the biennium.

345.29 **Administrative Services Unit - Volunteer**
345.30 **Health Care Provider Program.** Of this
345.31 appropriation, \$150,000 in fiscal year 2012
345.32 and \$150,000 in fiscal year 2013 are to pay
345.33 for medical professional liability coverage
345.34 required under Minnesota Statutes, section
345.35 214.40.

346.1	<u>Administrative Services Unit - Contested</u>		
346.2	<u>Cases and Other Legal Proceedings.</u>		
346.3	<u>Of this appropriation, \$200,000 in fiscal</u>		
346.4	<u>year 2012 and \$200,000 in fiscal year</u>		
346.5	<u>2013 are for costs of contested case</u>		
346.6	<u>hearings and other unanticipated costs of</u>		
346.7	<u>legal proceedings involving health-related</u>		
346.8	<u>boards funded under this section. Upon</u>		
346.9	<u>certification of a health-related board to the</u>		
346.10	<u>administrative services unit that the costs</u>		
346.11	<u>will be incurred and that there is insufficient</u>		
346.12	<u>money available to pay for the costs out of</u>		
346.13	<u>money currently available to that board, the</u>		
346.14	<u>administrative services unit is authorized</u>		
346.15	<u>to transfer money from this appropriation</u>		
346.16	<u>to the board for payment of those costs</u>		
346.17	<u>with the approval of the commissioner of</u>		
346.18	<u>finance. This appropriation does not cancel.</u>		
346.19	<u>Any unencumbered and unspent balances</u>		
346.20	<u>remain available for these expenditures in</u>		
346.21	<u>subsequent fiscal years.</u>		
346.22	<u>Subd. 9. Board of Optometry</u>	<u>106,000</u>	<u>106,000</u>
346.23	<u>Subd. 10. Board of Pharmacy</u>	<u>1,977,000</u>	<u>1,980,000</u>
346.24	<u>Prescription Electronic Reporting. Of</u>		
346.25	<u>this appropriation, \$356,000 in fiscal year</u>		
346.26	<u>2012 and \$356,000 in fiscal year 2013 from</u>		
346.27	<u>the state government special revenue fund</u>		
346.28	<u>are to the board to operate the prescription</u>		
346.29	<u>electronic reporting system in Minnesota</u>		
346.30	<u>Statutes, section 152.126. Base level funding</u>		
346.31	<u>for this activity in fiscal year 2014 shall be</u>		
346.32	<u>\$356,000.</u>		
346.33	<u>Subd. 11. Board of Physical Therapy</u>	<u>389,000</u>	<u>345,000</u>

347.1	<u>Rulemaking.</u> Of this appropriation, \$44,000		
347.2	<u>in fiscal year 2012 is for rulemaking. This is</u>		
347.3	<u>a onetime appropriation.</u>		
347.4	Subd. 12. <u>Board of Podiatry</u>	<u>75,000</u>	<u>75,000</u>
347.5	Subd. 13. <u>Board of Psychology</u>	<u>846,000</u>	<u>846,000</u>
347.6	Subd. 14. <u>Board of Social Work</u>	<u>1,036,000</u>	<u>1,053,000</u>
347.7	Subd. 15. <u>Board of Veterinary Medicine</u>	<u>228,000</u>	<u>229,000</u>
347.8	Subd. 16. <u>Board of Behavioral Health and</u>		
347.9	<u>Therapy</u>	<u>414,000</u>	<u>414,000</u>
347.10	Sec. 9. <u>EMERGENCY MEDICAL SERVICES</u>		
347.11	<u>BOARD</u>	<u>\$ 2,742,000</u>	<u>\$ 2,742,000</u>
347.12	<u>Of the appropriation, \$700,000 in fiscal year</u>		
347.13	<u>2012 and \$700,000 in fiscal year 2013 are</u>		
347.14	<u>for the Cooper/Sams volunteer ambulance</u>		
347.15	<u>program under Minnesota Statutes, section</u>		
347.16	<u>144E.40.</u>		
347.17	Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision		
347.18	to read:		
347.19	Subd. 33. <u>Federal administrative reimbursement dedicated.</u> <u>Federal</u>		
347.20	<u>administrative reimbursement resulting from the following activities is appropriated to the</u>		
347.21	<u>commissioner for the designated purposes:</u>		
347.22	<u>(1) reimbursement for the Minnesota senior health options project; and</u>		
347.23	<u>(2) reimbursement related to prior authorization and inpatient admission certification</u>		
347.24	<u>by a professional review organization. A portion of these funds must be used for activities</u>		
347.25	<u>to decrease unnecessary pharmaceutical costs in medical assistance.</u>		
347.26	Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision		
347.27	6, is amended to read:		
347.28	Subd. 6. <u>Continuing Care Grants</u>		
347.29	(a) <u>Aging and Adult Services Grants</u>	<u>(3,600,000)</u>	<u>(3,600,000)</u>
347.30	<u>Community Service/Service Development</u>		
347.31	<u>Grants Reduction.</u> Effective retroactively		

348.1 from July 1, 2009, funding for grants made
348.2 under Minnesota Statutes, sections 256.9754
348.3 and 256B.0917, subdivision 13, is reduced
348.4 by \$5,807,000 for each year of the biennium.
348.5 Grants made during the biennium under
348.6 Minnesota Statutes, section 256.9754, shall
348.7 not be used for new construction or building
348.8 renovation.

348.9 **Aging Grants Delay.** Aging grants must be
348.10 reduced by \$917,000 in fiscal year 2011 and
348.11 increased by \$917,000 in fiscal year 2012.
348.12 These adjustments are onetime and must not
348.13 be applied to the base. This provision expires
348.14 June 30, 2012.

348.15	(b) Medical Assistance Long-Term Care		
348.16	Facilities Grants	(3,827,000)	(2,745,000)

348.17 **ICF/MR Variable Rates Suspension.**
348.18 Effective retroactively from July 1, 2009,
348.19 to June 30, 2010, no new variable rates
348.20 shall be authorized for intermediate care
348.21 facilities for persons with developmental
348.22 disabilities under Minnesota Statutes, section
348.23 256B.5013, subdivision 1.

348.24 **ICF/MR Occupancy Rate Adjustment**
348.25 **Suspension.** Effective retroactively from
348.26 July 1, 2009, to June 30, 2011, approval
348.27 of new applications for occupancy rate
348.28 adjustments for unoccupied short-term
348.29 beds under Minnesota Statutes, section
348.30 256B.5013, subdivision 7, is suspended.

348.31	(c) Medical Assistance Long-Term Care	(2,318,000)	(5,807,000)
348.32	Waivers and Home Care Grants		

348.33 **Developmental Disability Waiver Acuity**
348.34 **Factor.** Effective retroactively from January
348.35 1, 2010, the January 1, 2010, one percent

349.1 growth factor in the developmental disability
 349.2 waiver allocations under Minnesota Statutes,
 349.3 section 256B.092, subdivisions 4 and 5,
 349.4 that is attributable to changes in acuity, is
 349.5 ~~suspended to June 30, 2011~~ eliminated.
 349.6 Notwithstanding any law to the contrary, this
 349.7 provision does not expire.

349.8	(d) Adult Mental Health Grants	(5,000,000)	-0-
349.9	(e) Chemical Dependency Entitlement Grants	(3,622,000)	(3,622,000)
349.10	(f) Chemical Dependency Nonentitlement		
349.11	Grants	(393,000)	(393,000)
349.12			~~(2,500,000)~~
349.13	(g) Other Continuing Care Grants	-0-	<u>(1,414,000)</u>

349.14 **Other Continuing Care Grants Delay.**
 349.15 Other continuing care grants must be reduced
 349.16 by \$1,414,000 in fiscal year 2011 and
 349.17 increased by \$1,414,000 in fiscal year 2012.
 349.18 These adjustments are onetime and must not
 349.19 be applied to the base. This provision expires
 349.20 June 30, 2012.

349.21	<u>(h) Deaf and Hard-of-Hearing Grants</u>	<u>-0-</u>	<u>(169,000)</u>

349.22 **Deaf and Hard-of-Hearing Grants Delay.**
 349.23 Effective retroactively from July 1, 2010,
 349.24 deaf and hard-of-hearing grants must be
 349.25 reduced by \$169,000 in fiscal year 2011 and
 349.26 increased by \$169,000 in fiscal year 2012.
 349.27 These adjustments are onetime and must not
 349.28 be applied to the base. This provision expires
 349.29 June 30, 2012.

349.30 **Sec. 12. TRANSFERS.**

349.31 Subdivision 1. **Grants.** The commissioner of human services, with the approval
 349.32 of the commissioner of management and budget, and after notification of the chairs of
 349.33 the senate health and human services budget and policy committee and the house of
 349.34 representatives health and human services finance committee, may transfer unencumbered

appropriation balances for the biennium ending June 30, 2013, within fiscal years among the MFIP; general assistance; general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; medical assistance; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid; and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee quarterly about transfers made under this provision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2011, unless a different effective date is specified.

ARTICLE 11

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT APPROPRIATIONS.**

The sums shown are added to, or if shown in parentheses, are subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2; Laws 2010, First Special Session chapter 1, articles 15, 23, and 25; and Laws 2010, Second Special Session chapter 1, article 3, to the commissioner of human services and for the purposes specified in this article. The appropriations are from the general fund or another named fund and are available for the fiscal year indicated for

351.1 each purpose. The figure "2011" used in this article means that the appropriation or
351.2 appropriations listed are available for the fiscal year ending June 30, 2011.

351.3 Sec. 2. **COMMISSIONER OF HUMAN**
351.4 **SERVICES**

351.5 Subdivision 1. **Total Appropriation** \$ (235,463,000)

351.6	<u>Appropriations by Fund</u>	
351.7		<u>2011</u>
351.8	<u>General</u>	<u>(381,869,000)</u>
351.9	<u>Health Care Access</u>	<u>169,514,000</u>
351.10	<u>Federal TANF</u>	<u>(23,108,000)</u>

351.11 The amounts that may be spent for each
351.12 purpose are specified in the following
351.13 subdivisions.

351.14 Subd. 2. **Revenue and Pass-through** 732,000

351.15 This appropriation is from the federal TANF
351.16 fund.

351.17 Subd. 3. **Children and Economic Assistance**
351.18 **Grants**

351.19	<u>Appropriations by Fund</u>	
351.20	<u>General</u>	<u>(7,098,000)</u>
351.21	<u>Federal TANF</u>	<u>(23,840,000)</u>

351.22 (a) **MFIP/DWP Grants**

351.23	<u>Appropriations by Fund</u>	
351.24	<u>General</u>	<u>18,715,000</u>
351.25	<u>Federal TANF</u>	<u>(23,840,000)</u>

351.26 (b) **MFIP Child Care Assistance Grants** (24,394,000)

351.27 (c) **General Assistance Grants** (664,000)

351.28 (d) **Minnesota Supplemental Aid Grants** 793,000

351.29 (e) **Group Residential Housing Grants** (1,548,000)

351.30 Subd. 4. **Basic Health Care Grants**

351.31	<u>Appropriations by Fund</u>	
351.32	<u>General</u>	<u>(335,050,000)</u>
351.33	<u>Health Care Access</u>	<u>169,514,000</u>

351.34 (a) **MinnesotaCare Grants** 169,514,000

352.1	<u>This appropriation is from the health care</u>		
352.2	<u>access fund.</u>		
352.3	<u>(b) Medical Assistance Basic Health Care -</u>		
352.4	<u>Families and Children</u>		<u>(49,368,000)</u>
352.5	<u>(c) Medical Assistance Basic Health Care -</u>		
352.6	<u>Elderly and Disabled</u>		<u>(43,258,000)</u>
352.7	<u>(d) Medical Assistance Basic Health Care -</u>		
352.8	<u>Adults without Children</u>		<u>(242,424,000)</u>
352.9	<u>Subd. 5. Continuing Care Grants</u>		<u>(39,721,000)</u>
352.10	<u>(a) Medical Assistance Long-Term Care</u>		
352.11	<u>Facilities</u>		<u>(14,627,000)</u>
352.12	<u>(b) Medical Assistance Long-Term Care</u>		
352.13	<u>Waivers</u>		<u>(44,718,000)</u>
352.14	<u>(c) Chemical Dependency Entitlement Grants</u>		<u>19,624,000</u>
352.15	Sec. 3. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6,		
352.16	is amended to read:		
352.17	Subd. 6. Health Care Grants		
352.18	(a) MinnesotaCare Grants	998,000	(13,376,000)
352.19	This appropriation is from the health care		
352.20	access fund.		
352.21	Health Care Access Fund Transfer to		
352.22	General Fund. The commissioner of		
352.23	management and budget shall transfer the		
352.24	following amounts in the following years		
352.25	from the health care access fund to the		
352.26	general fund: ~~\$998,000~~ <u>\$0</u> in fiscal year		
352.27	2010; ~~\$176,704,000~~ <u>\$59,901,000</u> in fiscal		
352.28	year 2011; \$141,041,000 in fiscal year 2012;		
352.29	and \$286,150,000 in fiscal year 2013. If at		
352.30	any time the governor issues an executive		
352.31	order not to participate in early medical		
352.32	assistance expansion, no funds shall be		
352.33	transferred from the health care access		
352.34	fund to the general fund until early medical		

353.1 assistance expansion takes effect. This
353.2 paragraph is effective the day following final
353.3 enactment.

353.4 **MinnesotaCare Ratable Reduction.**
353.5 Effective for services rendered on or after
353.6 July 1, 2010, to December 31, 2013,
353.7 MinnesotaCare payments to managed care
353.8 plans under Minnesota Statutes, section
353.9 256L.12, for single adults and households
353.10 without children whose income is greater
353.11 than 75 percent of federal poverty guidelines
353.12 shall be reduced by 15 percent. Effective
353.13 for services provided from July 1, 2010, to
353.14 June 30, 2011, this reduction shall apply to
353.15 all services. Effective for services provided
353.16 from July 1, 2011, to December 31, 2013, this
353.17 reduction shall apply to all services except
353.18 inpatient hospital services. Notwithstanding
353.19 any contrary provision of this article, this
353.20 paragraph shall expire on December 31,
353.21 2013.

353.22	(b) Medical Assistance Basic Health Care		
353.23	Grants - Families and Children	-0-	295,512,000

353.24 **Critical Access Dental.** Of the general
353.25 fund appropriation, \$731,000 in fiscal year
353.26 2011 is to the commissioner for critical
353.27 access dental provider reimbursement
353.28 payments under Minnesota Statutes, section
353.29 256B.76 subdivision 4. This is a onetime
353.30 appropriation.

353.31 **Nonadministrative Rate Reduction.** For
353.32 services rendered on or after July 1, 2010,
353.33 to December 31, 2013, the commissioner
353.34 shall reduce contract rates paid to managed
353.35 care plans under Minnesota Statutes,
353.36 sections 256B.69 and 256L.12, and to

354.1	county-based purchasing plans under		
354.2	Minnesota Statutes, section 256B.692, by		
354.3	three percent of the contract rate attributable		
354.4	to nonadministrative services in effect on		
354.5	June 30, 2010. Notwithstanding any contrary		
354.6	provision in this article, this rider expires on		
354.7	December 31, 2013.		
354.8	(c) Medical Assistance Basic Health Care		
354.9	Grants - Elderly and Disabled	-0-	(30,265,000)
354.10			~~(75,389,000)~~
354.11	(d) General Assistance Medical Care Grants	-0-	<u>(59,583,000)</u>
354.12	<u>The reduction to general assistance medical</u>		
354.13	<u>care grants is contingent upon the effective</u>		
354.14	<u>date in Laws 2010, First Special Session</u>		
354.15	<u>chapter 1, article 16, section 48. The</u>		
354.16	<u>reduction shall be reestimated based upon</u>		
354.17	<u>the actual effective date of the law. The</u>		
354.18	<u>commissioner of management and budget</u>		
354.19	<u>shall make adjustments in fiscal year</u>		
354.20	<u>2011 to general assistance medical care</u>		
354.21	<u>appropriations to conform to the total</u>		
354.22	<u>expected expenditure reductions specified in</u>		
354.23	<u>this section.</u>		
354.24	(e) Other Health Care Grants	-0-	(7,000,000)
354.25	Cobra Carryforward. Unexpended funds		
354.26	appropriated in fiscal year 2010 for COBRA		
354.27	grants under Laws 2009, chapter 79, article		
354.28	5, section 78, do not cancel and are available		
354.29	to the commissioner for fiscal year 2011		
354.30	COBRA grant expenditures. Up to \$111,000		
354.31	of the fiscal year 2011 appropriation for		
354.32	COBRA grants provided in Laws 2009,		
354.33	chapter 79, article 13, section 3, subdivision		
354.34	6, may be used by the commissioner for costs		
354.35	related to administration of the COBRA		
354.36	grants.		

- 355.1 Sec. 4. EFFECTIVE DATE.
- 355.2 This article is effective the day following final enactment.

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Article locations in H0927-1

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ARTICLE 2	DEPARTMENT OF HEALTH	Page.Ln 27.14
ARTICLE 3	HEALTH BOARDS	Page.Ln 61.1
ARTICLE 4	MISCELLANEOUS	Page.Ln 86.17
ARTICLE 5	HEALTH LICENSING FEES	Page.Ln 95.8
ARTICLE 6	HEALTH CARE	Page.Ln 110.9
ARTICLE 7	CONTINUING CARE	Page.Ln 207.30
ARTICLE 8	REDESIGNING SERVICE DELIVERY	Page.Ln 290.1
ARTICLE 9	CHEMICAL AND MENTAL HEALTH	Page.Ln 310.27
ARTICLE 10	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 318.12
ARTICLE 11	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 350.22

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The Legislative Commission on Health Care Access shall make recommendations to the legislature on how to achieve the goal of universal health coverage as described in section 62Q.165. The recommendations shall include a timetable in which measurable progress must be achieved toward this goal. The commission shall submit to the legislature by January 15, 2008, the recommendations and corresponding timetable.

Subd. 2. **Membership.** The Legislative Commission on Health Care Access consists of five members of the senate appointed under the rules of the senate and five members of the house of representatives appointed under the rules of the house of representatives. The Legislative Commission on Health Care Access must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **Reports to the commission.** The commissioners of health, human services, commerce, and other state agencies shall provide assistance and technical support to the commission at the request of the commission. The commission may convene subcommittees to provide additional assistance and advice to the commission.

62J.17 EXPENDITURE REPORTING.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

Subd. 3. **Hospital and nursing home moratoria preserved; nursing homes exempt.** Nothing in this section supersedes or limits the applicability of section 144.551 or 144A.071. This section does not apply to major spending commitments made by nursing homes or intermediate care facilities that are related to the provision of long-term care services to residents.

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review. The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The provider

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may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7.

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Subd. 8. **Radiation therapy facilities.** This subdivision shall apply only to those major spending commitments that are related to the purchase, construction, or leasing of a radiation therapy facility.

(a) The term "provider" shall mean:

(1) a provider as defined in section 62J.03, subdivision 8;

(2) a person or organization that, upon engaging in an activity related to a major spending commitment, will become a provider as defined in section 62J.03, subdivision 8;

(3) an organization under common control with an organization described in clause (1) or (2); or

(4) an organization that manages a person or organization described in clause (1), (2), or (3).

(b) In conducting the retrospective or prospective review, the commissioner shall consider the criteria described in subdivision 5a, paragraph (a), in determining whether the major spending commitment was appropriate. In addition, the commissioner shall consider the following criteria:

(1) the alternatives available to patients in terms of avoiding an unwarranted duplication based on whether additional capacity is needed of services, facilities, or equipment in and around the location of the major spending commitment; and

(2) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the major spending commitment.

(c) In addition to subdivision 6a, paragraph (c), the commissioner has the authority to pursue the following remedies:

(1) assessment of fines against providers violating subdivision 6a, paragraph (a), of up to triple the amount of the major spending commitment;

(2) securing a permanent injunction against providers violating subdivision 6a, paragraph (a), halting the purchase or construction of a facility, prohibiting the operation of a facility, or the providing of a service related to the major spending commitment; and

(3) obtaining a court order to invalidate any purchase agreement, management agreement, lease, or other contract relating to the major spending commitment or the conduct of any activity relating to the major spending commitment.

(d) If a provider fails the retrospective review of a major spending commitment that is identified under this subdivision, the prospective review and approval required under subdivision 6a shall be limited to major spending commitments that are identified under this subdivision.

(e) The provisions of this subdivision do not apply to radiation therapy facilities owned and operated or managed by a hospital licensed under chapter 144.

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

Subd. 5a. **Prescription drug price disclosure data.** Notwithstanding subdivisions 1 and 5, data collected under section 62J.381 shall be classified as public data.

62J.381 PRESCRIPTION DRUG PRICE DISCLOSURE.

By April 1, 1999, and annually thereafter, hospitals licensed under chapter 144 and group purchasers required to file a full report under section 62J.38 and the rules promulgated thereunder, must submit to the commissioner of health the total amount of:

(1) aggregate purchases of or payments for prescription drugs; and

(2) aggregate cash rebates, discounts, other payments received, and any fees associated with education, data collection, research, training, or market share movement, which are received

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during the previous calendar year from a manufacturer as defined under section 151.44, paragraph (c), or wholesale drug distributor as defined under section 151.44, paragraph (d). The data collected under this section shall be distributed through the information clearinghouse under section 62J.2930. The identification of individual manufacturers or wholesalers or specific drugs shall not be required under this section.

62J.41 DATA FROM PROVIDERS.

Subdivision 1. **Cost containment data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

- (1) the total number of patients served;
- (2) the total number of patients served by state of residence and Minnesota county;
- (3) the site or sites where the health care provider provides services;
- (4) the number of individuals employed, by type of employee, by the health care provider;
- (5) the services and their costs for which no payment was received;
- (6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, health maintenance organizations, and individual patients;
- (7) revenue from research activities;
- (8) revenue from educational activities;
- (9) revenue from out-of-pocket payments by patients;
- (10) revenue from donations;
- (11) a report on health care capital expenditures during the previous year, as required by section 62J.17; and
- (12) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs.

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

Subd. 2. **Annual monitoring and estimates.** The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by April 1, 1994. Health care providers shall submit data for the 1994 calendar year by April 1, 1995, and each April 1 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioners of health and revenue shall have the authority to share data collected pursuant to this section.

144.1464 SUMMER HEALTH CARE INTERNS.

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and postsecondary summer health care intern program. The purpose of the program is to expose interested secondary and postsecondary pupils to various careers within the health care profession.

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals, clinics, nursing facilities, and home care providers that agree to:

- (1) provide secondary and postsecondary summer health care interns with formal exposure to the health care profession;
- (2) provide an orientation for the secondary and postsecondary summer health care interns;
- (3) pay one-half the costs of employing the secondary and postsecondary summer health care intern;
- (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks and a maximum of 12 weeks; and
- (5) employ at least one secondary student for each postsecondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital, clinic, nursing facility, or home care provider, a pupil must:

- (1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

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(2) be from a school district in proximity to the facility.

(c) In order to be eligible to be hired as a postsecondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility.

(d) Hospitals, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and postsecondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be postsecondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or postsecondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. **Contract.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and postsecondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

145A.14 SPECIAL GRANTS.

Subdivision 1. **Migrant health grants.** (a) The commissioner may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to establish, operate, or subsidize clinic facilities and services, including mobile clinics, to furnish health services for migrant agricultural workers and their families in areas of the state where significant numbers of migrant workers are located. "Migrant agricultural worker" means any individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the past 24 months, and who has established a temporary residence for the purpose of such employment.

(b) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Subd. 2. **Indian health grants.** (a) The commissioner may make special grants to establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians who reside off reservations.

(b) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

150A.22 DONATED DENTAL SERVICES.

(a) The commissioner of health shall contract with the Minnesota Dental Association, or another appropriate and qualified organization to develop and operate a donated dental services program to provide dental care to public program recipients and the uninsured through dentists who volunteer their services without compensation. As part of the contract, the commissioner shall include specific performance and outcome measures that the contracting organization must meet. The donated dental services program shall:

(1) establish a network of volunteer dentists, including dental specialties, to donate dental services to eligible individuals;

(2) establish a system to refer eligible individuals to the appropriate volunteer dentists; and

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(3) develop and implement a public awareness campaign to educate eligible individuals about the availability of the program.

(b) Funding for the program may be used for administrative or technical support. The organization contracting with the commissioner shall provide an annual report that accounts for funding appropriated to the program by the state, documents the number of individuals served by the program and the number of dentists participating as program providers, and provides data on meeting the specific performance and outcome measures identified by the commissioner.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 2b. **Performance payments.** The commissioner shall develop and implement a pay-for-performance system to provide performance payments to eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors, including consumer surveys, studies, and external quality reviews as required by the federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external quality review. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

256.979 CHILD SUPPORT INCENTIVES.

Subd. 5. **Bonus incentive program.** (a) A bonus incentive program is created to increase the number of paternity establishments and establishment and modifications of child support orders done by county child support enforcement agencies.

(b) A bonus must be awarded to a county child support agency for each child for which the agency completes a paternity order or for each case in which child support is established or modified through judicial or expedited processes.

(c) The rate of bonus incentive is \$100 per child for each paternity established, or \$100 per case for each child support order established or modified, which is set in a specific dollar amount.

(d) No bonus shall be paid for a modification that is a result of a termination of child care costs according to section 518A.40, subdivision 4, or due solely to a reduction of child care expenses.

Subd. 6. **Claims for bonus incentive.** (a) The commissioner of human services and the county agency shall develop procedures for the claims process and criteria using automated systems where possible.

(b) Only one county agency may receive a bonus per paternity establishment or child support establishment or modification order. The county agency completing the action or procedure needed to establish paternity or a child support order or modify an order is the county agency entitled to claim the bonus incentive.

(c) Disputed claims must be submitted to the commissioner of human services and the commissioner's decision is final.

Subd. 7. **Distribution.** (a) Bonus incentives must be issued to the county agency quarterly, within 45 days after the last day of each quarter for which a bonus incentive is being claimed, and must be paid in the order in which claims are received.

(b) Bonus incentive funds under this section must be reinvested in the county child support enforcement program and a county may not reduce funding of the child support enforcement program by the amount of the bonus earned.

(c) The county agency shall repay any bonus erroneously issued.

(d) A county agency shall maintain a record of bonus incentives claimed and received for each quarter.

(e) Payment of bonus incentives is limited by the amount of the appropriation for this purpose. If the appropriation is insufficient to cover all claims, the commissioner of human services may prorate payments among the county agencies.

Subd. 10. **Transferability between bonus incentive accounts and grants to county agencies.** The commissioner of human services may transfer money appropriated for child support enforcement county performance incentives under this section and section 256.9791 among county performance incentive accounts. Incentive funds to counties transferred under this

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section must be reinvested in the child support enforcement program and may not be used to supplant money now spent by counties for child support enforcement.

256.9791 MEDICAL SUPPORT BONUS INCENTIVES.

Subdivision 1. **Bonus incentive.** (a) A bonus incentive program is created to increase the identification and enforcement by county agencies of dependent health insurance coverage for persons who are receiving medical assistance under section 256B.055 and for whom the county agency is providing child support enforcement services.

(b) The bonus shall be awarded to a county child support agency for each person for whom coverage is identified and enforced by the child support enforcement program when the obligor is under a court order to provide dependent health insurance coverage.

(c) Bonus incentive funds under this section must be reinvested in the county child support enforcement program and a county may not reduce funding of the child support enforcement program by the amount of the bonus earned.

Subd. 2. **Definitions.** For the purpose of this section, the following definitions apply.

(a) "Case" means a family unit that is receiving medical assistance under section 256B.055 and for whom the county agency is providing child support enforcement services.

(b) "Commissioner" means the commissioner of the Department of Human Services.

(c) "County agency" means the county child support enforcement agency.

(d) "Coverage" means initial dependent health insurance benefits for a case or individual member of a case.

(e) "Enforce" or "enforcement" means obtaining proof of current or future dependent health insurance coverage through an overt act by the county agency.

(f) "Enforceable order" means a child support court order containing the statutory language in section 518A.41 or other language ordering an obligor to provide dependent health insurance coverage.

(g) "Identify" or "identification" means obtaining proof of dependent health insurance coverage through an overt act by the county agency.

Subd. 3. **Eligibility; reporting requirements.** (a) In order for a county to be eligible to claim a bonus incentive payment, the county agency must provide the required information for each public assistance case no later than June 30 of each year to determine eligibility. The public authority shall use the information to establish for each county the number of cases in which (1) the court has established an obligation for coverage by the obligor, and (2) coverage was in effect as of June 30.

(b) A county that fails to provide the required information by June 30 of each fiscal year is not eligible for any bonus payments under this section for that fiscal year.

Subd. 4. **Rate of bonus incentive.** The rate of the bonus incentive shall be determined according to paragraph (a).

(a) When a county agency has identified or enforced coverage, the county shall receive \$50 for each additional person for whom coverage is identified or enforced.

(b) Bonus payments according to paragraph (a) are limited to one bonus for each covered person each time the county agency identifies or enforces previously unidentified health insurance coverage and apply only to coverage identified or enforced after July 1, 1990.

Subd. 5. **Claims for bonus incentive.** (a) Beginning July 1, 1990, county agencies shall file a claim for a medical support bonus payment by reporting to the commissioner the following information for each case where dependent health insurance is identified or enforced as a result of an overt act of the county agency:

(1) child support enforcement system case number or county specific case number;

(2) names and dates of birth for each person covered; and

(3) the effective date of coverage.

(b) The report must be made upon enrollment in coverage but no later than September 30 for coverage identified or established during the preceding fiscal year.

(c) The county agency making the initial contact resulting in the establishment of coverage is the county agency entitled to claim the bonus incentive even if the case is transferred to another county agency prior to the time coverage is established.

(d) Disputed claims must be submitted to the commissioner and the commissioner's decision is final.

Subd. 6. **Distribution.** (a) Bonus incentives must be issued to the county agency quarterly, within 45 days after the last day of each quarter for which a bonus incentive is being claimed, and must be paid up to the limit of the appropriation in the order in which claims are received.

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(b) Total bonus incentives must be computed by multiplying the number of persons included in claims submitted in accordance with this section by the applicable bonus payment as determined in subdivision 4.

(c) The county agency must repay any bonus erroneously issued.

(d) A county agency must maintain a record of bonus incentives claimed and received for each quarter.

256.9862 ASSISTANCE TRANSACTION CARD FEE.

Subd. 2. **Transaction fee.** The commissioner may charge transaction fees in accordance with this subdivision up to a maximum of \$10 in transaction fees per cardholder per month. In a given month, the first four cash withdrawals made by an individual cardholder are free. For subsequent cash withdrawals, \$1 may be charged. No transaction fee can be charged if the card is used to purchase goods or services on a point of sale basis. A transaction fee subsequently set by the federal government may supersede a fee established under this subdivision. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 15. **Adults without children.** Medical assistance may be paid for a person who is:

(1) at least age 21 and under age 65;

(2) not pregnant;

(3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII of the Social Security Act;

(4) not an adult in a family with children as defined in section 256L.01, subdivision 3a; and

(5) not described in another subdivision of this section.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 2c. **Seamless coverage for MinnesotaCare eligible children.** A child receiving medical assistance under subdivision 2, who becomes ineligible due to excess income, is eligible for seamless coverage between medical assistance and MinnesotaCare. The child shall remain eligible under this section for two additional months and is deemed automatically eligible for MinnesotaCare until renewal. MinnesotaCare coverage begins in accordance with section 256L.05, subdivision 3. Eligibility under this section is effective following any coverage available under section 256B.0635.

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148,

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or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

256I.05 MONTHLY RATES.

Subd. 1d. Certain facilities for mental illness or chemical dependency; rates.

Notwithstanding the provisions of subdivisions 1a and 1c, a county agency may negotiate a supplementary service rate in addition to the board and lodging rate for facilities licensed and registered by the Minnesota Department of Health under section 157.17 prior to December 31, 1996, if the facility meets the following criteria:

- (1) at least 75 percent of the residents have a primary diagnosis of mental illness, chemical dependency, or both, and have related special needs;
- (2) the facility provides 24-hour, on-site, year-round supportive services by qualified staff capable of intervention in a crisis of persons with late-state inebriety or mental illness who are vulnerable to abuse or neglect;
- (3) the services at the facility include, but are not limited to:
 - (i) secure central storage of medication;
 - (ii) reminders and monitoring of medication for self-administration;
 - (iii) support for developing an individual medical and social service plan, updating the plan, and monitoring compliance with the plan; and
 - (iv) assistance with setting up meetings, appointments, and transportation to access medical, chemical health, and mental health service providers;
- (4) each resident has a documented need for at least one of the services provided;
- (5) each resident has been offered an opportunity to apply for admission to a licensed residential treatment program for mental illness, chemical dependency, or both, have refused that offer, and the offer and their refusal has been documented to writing; and
- (6) the residents are not eligible for home and community-based services waivers because of their unique need for community support.

Until June 30, 2002, the supplementary service rate of qualifying facilities under this subdivision may be increased by up to 15 percent of the supplementary service rate in effect on January 1, 2001, for the facility. Qualifying facilities with no supplementary service rate may negotiate a supplementary service rate not to exceed \$300 per month.

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

- (1) is located in Hennepin County and has had a group residential housing contract with the county since June 1996;
- (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed facility; and
- (3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

Subd. 1f. Supplementary service rate increases on or after July 1, 2001. Until June 30, 2002, the supplementary service rate for recipients of assistance under section 256I.04 who reside in a residence that is licensed by the commissioner of health as a boarding care home but is not certified for purposes of the medical assistance program may be increased by up to 32 percent of the supplementary service rate in effect for that facility on January 1, 2001. The new rate shall not exceed the nonfederal share of the statewide weighted average monthly medical assistance nursing facility payment rate for case mix A in effect on January 1, 2001.

Subd. 1g. Supplementary service rate for certain facilities. On or after July 1, 2005, a county agency may negotiate a supplementary service rate for recipients of assistance under section 256I.04, subdivision 1, paragraph (b), who relocate from a homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota Department of Health under section 157.17, to a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, not to exceed \$456.75.

Subd. 1h. Supplementary rate for certain facilities serving chemically dependent males. Notwithstanding subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed

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\$737.87 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Ramsey County and has had a group residential housing contract with the county since 1982 and has been licensed as a board and lodge facility with special services since 1979; and

(2) serves recovering and chemically dependent males, providing 24-hour-a-day supervision.

Subd. 1i. **Supplementary rate for certain facilities; Hennepin County.** Notwithstanding the provisions of subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, up to the available appropriation, for a facility located in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in January of 2006.

Subd. 1k. **Supplementary rate for certain facilities; Stearns, Sherburne, or Benton County.** Notwithstanding the provisions of this section, beginning July 1, 2009, a county agency shall negotiate a supplementary service rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider located in Stearns, Sherburne, or Benton County that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision.

Subd. 1l. **Supplementary rate for certain facilities; St. Louis County.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplementary service rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider located in St. Louis County that operates a 30-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision.

Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.** (a) Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month or the existing monthly rate, whichever is higher, including any legislatively authorized inflationary adjustments, for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, which provide community support and serve the mental health needs of individuals who have chronically lived unsheltered, providing 24-hour-per-day supervision.

(b) An individual who has lived in one of the facilities under paragraph (a), who is being transitioned to independent living as part of the program plan continues to be eligible for group residential housing and the supplemental service rate negotiated with the county under paragraph (a).

Subd. 1n. **Supplemental rate; Mahnomon County.** Notwithstanding the provisions of this section, for the rate period July 1, 2010, to June 30, 2011, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed \$753 per month or the existing rate, including any legislative authorized inflationary adjustments, for a group residential provider located in Mahnomon County that operates a 28-bed facility providing 24-hour care to individuals who are homeless, disabled, chemically dependent, mentally ill, or chronically homeless.

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Subd. 7. **Exception for certain children.** Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

402A.30 DESIGNATION OF SERVICE DELIVERY AUTHORITY.

Subdivision 1. **Establishment.** After certification by the council and approval by the commissioner, in accordance with subdivision 4, a county or consortium of counties may establish a service delivery authority to redesign the delivery of some or all essential services. Once a county or consortium of counties establishes a service delivery authority, no county that is a participant in the service delivery authority may participate in or be a member of any other service delivery authority. The service delivery authority may allow an additional county or counties to join the service delivery authority subject to the approval of the council and the commissioner.

Subd. 2. **New state-county governance framework.** (a) To establish a service delivery authority, each participating county and the state must enter into a binding memorandum of understanding to establish a joint state-county service delivery framework:

(b) The memorandum of understanding must:

(1) comply with current state and federal law except where waivers are approved under clause (7);

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of services over which the service delivery authority has jurisdiction and identify a single administrative agent for purposes of contact and communication with the department;

(4) define measurable performance and outcome goals in key operational areas that the service delivery authority is expected to achieve, provided that the performance goals must, at a minimum, satisfy performance outcomes recommended by the steering committee and enacted into law;

(5) identify the state and local resources, including funding and administrative and information technology support, and other requirements necessary for the service delivery authority to achieve the performance and outcome goals;

(6) state the relief available to the service delivery authority if the resource commitments identified in clause (5) are not met;

(7) identify in the agreement the waivers from statutory requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals and the date by which the commissioner shall grant the identified waivers;

(8) set forth a graduated accountability process and penalties for responding to a county's failure to make adequate progress on achieving performance and outcome goals;

(9) set forth a reasonable level of targeted reductions in overhead and administrative costs for each county participating in the service delivery authority; and

(10) set forth the terms under which a county may withdraw from participation.

The memorandum of understanding may be later amended to add additional services over which the service delivery authority has jurisdiction.

(c) Nothing in this chapter precludes local governments from utilizing sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Any agreement under paragraph (b) must be governed by this chapter. Nothing in this chapter limits the authority of a county board to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Subd. 3. **Duties.** The service delivery authority shall:

(1) within the scope of essential services set forth in the memorandum of understanding establishing the authority, carry out the responsibilities required of local agencies under chapter 393 and human services boards under chapter 402;

(2) manage the public resources devoted to human services and other public services delivered or purchased by the counties that are subsidized or regulated by the Department of Human Services under chapters 245 and 267;

(3) employ staff to assist in carrying out its duties;

(4) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human services functions in the event of any business interruption according to local, state, and federal emergency planning requirements;

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(5) receive and expend funds received for the redesign process under the memorandum of understanding;

(6) plan and deliver services directly or through contract with other governmental or nongovernmental providers;

(7) rent, purchase, sell, and otherwise dispose of real and personal property as necessary to carry out the redesign; and

(8) carry out any other service designated as a responsibility of a county.

Subd. 4. **Process for establishing a service delivery authority.** (a) The county or consortium of counties proposing to form a service delivery authority shall, in conjunction with the commissioner, present a proposed memorandum of understanding to the council accompanied by a resolution from the board of commissioners of each participating county stating the county's intent to participate in a service delivery authority.

(b) The council shall certify a county or consortium of counties as a service delivery authority if:

(1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and

(2) the county or consortium of counties are:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more and the counties comprising the consortium are in reasonable geographic proximity; or

(iii) four or more counties in reasonable geographic proximity without regard to population.

The council may recommend that the commissioner of human services exempt a single county or multicounty service delivery authority from the minimum population standard if that service delivery authority can demonstrate that it can otherwise meet the requirements of this chapter.

(c) After the council has certified a county or consortium of counties as a service delivery authority, the commissioner may enter into the memorandum of understanding with the participating counties to form the service delivery authority.

Subd. 5. **Single county service delivery authority.** For counties with populations over 55,000, the board of county commissioners may be the service delivery authority and retain existing authority under law.

402A.45 ESSENTIAL SERVICES OUTSIDE JURISDICTION OF SERVICE DELIVERY AUTHORITY.

(a) With the approval of the council, a county that is a participant in a service delivery authority may enter into cooperative arrangements with other service delivery authorities or other counties to provide essential services that are not within the jurisdiction and duties of the service delivery authority.

(b) With the approval of the council, a service delivery authority may enter into a cooperative arrangement with a nonparticipating county to provide an essential service within the jurisdiction and duties of the service delivery authority.

Laws 2008, chapter 358, article 3, section 8

Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Laws 2008, chapter 358, article 3, section 9

Sec. 9. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Laws 2009, chapter 79, article 3, section 18, as amended by Laws 2010, First Special Session chapter 1, article 19, section 19

Sec. 19. Laws 2009, chapter 79, article 3, section 18, is amended to read:

Sec. 18. REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE ANOKA-METRO REGIONAL TREATMENT CENTER.

The Chemical and Mental Health Services Transformation Advisory Task Force shall recommend an array of community-based services in the metro area to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center. The community-based services may be established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers, and community partnerships, and must be staffed by state employees. The planning for this transition must be completed by October 1, 2010, with a report detailing the transition plan, services that will be provided, including incorporating peer specialists where appropriate, the location of the services, and the number of patients that will be served, to the committee chairs of health and human services by November 30, 2010. The individuals employed by the community-based services under this section are state employees supervised by the commissioner of human services. No layoffs shall occur as a result of restructuring under this section. Savings generated as a result of transitioning patients from the Anoka-Metro Regional Treatment Center to community-based services may be used to fund supportive housing staffed by state employees.

Laws 2009, chapter 79, article 5, section 55, as amended

Sec. 55. Minnesota Statutes 2008, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.

(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

(f) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision 8, are exempt from the eligibility requirements of this subdivision.

Laws 2009, chapter 79, article 5, section 56

Sec. 56. Minnesota Statutes 2008, section 256L.04, is amended by adding a subdivision to read:

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 57

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Sec. 57. Minnesota Statutes 2008, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 60

Sec. 60. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision to read:

Subd. 1c. **Open enrollment and streamlined application and enrollment process.** (a) The commissioner and local agencies working in partnership must develop a streamlined and efficient application and enrollment process for medical assistance and MinnesotaCare enrollees that meets the criteria specified in this subdivision.

(b) The commissioners of human services and education shall provide recommendations to the legislature by January 15, 2010, on the creation of an open enrollment process for medical assistance and MinnesotaCare that is coordinated with the public education system. The recommendations must:

(1) be developed in consultation with medical assistance and MinnesotaCare enrollees and representatives from organizations that advocate on behalf of children and families, low-income persons and minority populations, counties, school administrators and nurses, health plans, and health care providers;

(2) be based on enrollment and renewal procedures best practices, including express lane eligibility as required under subdivision 1d;

(3) simplify the enrollment and renewal processes wherever possible; and

(4) establish a process:

(i) to disseminate information on medical assistance and MinnesotaCare to all children in the public education system, including prekindergarten programs; and

(ii) for the commissioner of human services to enroll children and other household members who are eligible.

The commissioner of human services in coordination with the commissioner of education shall implement an open enrollment process by August 1, 2010, to be effective beginning with the 2010-2011 school year.

(c) The commissioner and local agencies shall develop an online application process for medical assistance and MinnesotaCare.

(d) The commissioner shall develop an application that is easily understandable and does not exceed four pages in length.

(e) The commissioner of human services shall present to the legislature, by January 15, 2010, an implementation plan for the open enrollment period and online application process.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, which must be requested by the commissioner, whichever is later.

Laws 2009, chapter 79, article 5, section 61

Sec. 61. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure

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coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, is the first day of the month following the last day of general assistance medical care coverage.

(f) The effective date of coverage for children eligible under section 256L.07, subdivision 8, is the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 62

Sec. 62. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) Notwithstanding paragraph (e), an enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

(e) Children in families with family income equal to or below 275 percent of federal poverty guidelines who fail to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for the program. The commissioner shall use the means described in subdivision 2 or any other means available to verify family income. If the commissioner determines that there has been a change in income in which premium payment is required to remain enrolled, the commissioner shall notify the family of the premium payment, and that the children will be disenrolled if the premium payment is not received effective the first day of the calendar month following the calendar month for which the premium is due.

(f) For children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the first period of renewal begins the month the enrollee turns 21 years of age.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 63

Sec. 63. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 200 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance.

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Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period of eligibility.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 64 Subdivisions null, null,

Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. This subdivision does not apply to children with family gross incomes that are equal to or less than 200 percent of federal poverty guidelines.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. This subdivision does not apply to children with family gross incomes that are equal to or less than 200 percent of federal poverty guidelines.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

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EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 65 Subdivisions null, null,

Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled. Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

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

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

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

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled. Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

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

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

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

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 66

Sec. 66. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

Subd. 8. **Automatic eligibility for certain children.** Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release until the child reaches the age of 21, and is exempt from the requirements of this section and section 256L.15. To be enrolled under this section, a child must complete an initial application for MinnesotaCare. The commissioner shall contact individuals enrolled under this section annually to ensure the individual continues to reside in the state and is interested in continuing MinnesotaCare coverage.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 68 Subdivisions null, null,

Sec. 68. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Sec. 68. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two

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enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d), "minimum" means a monthly premium of \$4.

(d) The following premium scale is established for individuals and families with gross family incomes of 300 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	1.1%
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274%	7.2%
275-300%	8.0%

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 68. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d), "minimum" means a monthly premium of \$4.

(d) The following premium scale is established for individuals and families with gross family incomes of 300 percent of the federal poverty guidelines or less:

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Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	1.1%
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274%	7.2%
275-300%	8.0%

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 69

Sec. 69. Minnesota Statutes 2008, section 256L.15, subdivision 3, is amended to read:

Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below 200 percent of the federal poverty guidelines shall pay no monthly premiums.

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later.

Laws 2009, chapter 79, article 5, section 79

Sec. 79. **FEDERAL APPROVAL.**

The commissioner of human services shall resubmit for federal approval the elimination of depreciation for self-employed farmers in determining income eligibility for MinnesotaCare passed in Laws 2007, chapter 147, article 5, section 19.

Laws 2010, First Special Session chapter 1, article 16, section 6

Sec. 6. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;
- (3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;
- (4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; and
- (5) effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (c).

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(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

Laws 2010, First Special Session chapter 1, article 16, section 7

Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size.

(e) In computing income to determine eligibility of persons under paragraphs (a) to (d) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.