

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, 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; imposing criminal penalties; 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.071, by adding a subdivision; 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; 148.108, by adding a subdivision; 148.191, subdivision 2; 148.212, subdivision 1; 148.231; 148B.17; 148B.33, subdivision 2; 148B.52; 150A.091, subdivisions 2, 3, 4, 5, 8, by adding a subdivision; 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; 152.027, by adding a subdivision; 152.12, subdivision 3; 157.15, by adding a subdivision; 157.20, by adding a subdivision; 169A.20, subdivisions 1, 1a, 1b, 1c; 245.50; 245A.14, subdivision 4; 246B.10; 252.025, subdivision 7; 252.27, subdivision 2a; 253B.212; 254B.03, subdivisions 1, 4; 254B.04, subdivision 1, by adding a subdivision; 254B.06, subdivision 2; 256.01, subdivisions 2b, 14b, 24, 29, by adding subdivisions; 256.045, subdivision 4a; 256.9657, subdivision 1; 256.969, subdivision 2b, by adding a subdivision; 256B.04, subdivisions 14a, 18; 256B.05, by adding a subdivision; 256B.055, subdivision 15; 256B.056, subdivisions 3, 4, by adding a subdivision; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8e, 13e, 13h, 17, 17a, 18, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.0644; 256B.0657; 256B.0659, subdivisions 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 a subdivision; 256B.48, subdivision 1; 256B.49, subdivisions 12,
13, 14, 15; 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.03, subdivision 3;
256D.031, subdivisions 6, 7, 10; 256D.05, subdivision 1; 256D.06, subdivisions
1, 1b, 2; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.46, subdivision
1; 256D.49, subdivision 3; 256G.02, subdivision 6; 256I.03, by adding a
subdivision; 256I.04, subdivision 2b; 256I.05, subdivisions 1a, 1e, by adding a
subdivision; 256J.20, subdivision 3; 256J.38, subdivision 1; 256J.49, subdivision
13; 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; 393.07,
subdivisions 10, 10a; 402A.10, subdivisions 4, 5; 402A.15; 402A.18; 402A.20;
518A.51; 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, 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 1; 62E; 62J; 62Q; 62U; 137;
144; 145; 148; 151; 256; 256B; 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; 256.979, subdivisions 5, 6, 7, 10; 256.9791; 256.9862,
subdivision 2; 256B.055, subdivision 15; 256B.057, subdivision 2c; 256D.46,
subdivisions 2, 3; 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; 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; 9500.1243, subpart 3; 9500.1261, subparts 3, items D, E, 4, 5.

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:

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

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

7.32 (c) A family or child care provider ~~may~~ must not be assessed an overpayment for an
7.33 absent day payment unless (1) there was an error in the amount of care authorized for the
7.34 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
7.35 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. **[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. The card must include the following statement: "It is unlawful to use this card to purchase tobacco products or alcoholic beverages." 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.

Subd. 3. Prohibited purchases. EBT debit cardholders in programs listed under subdivision 1 are prohibited from using the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in section 340A.101, subdivision 2. It is unlawful for an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic beverages with the cardholder's EBT card. Violation of this subdivision is a petty misdemeanor.

Sec. 11. 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, and 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. 12. 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. 13. 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~~

12.1 ~~9530.4000~~, and for whom discharge and work are part of a treatment plan; and (2)
12.2 ~~persons living in supervised apartments with services funded under Minnesota Rules,~~
12.3 ~~parts 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment~~
12.4 ~~plan; and (3) persons residing in group residential housing, as that term is defined in~~
12.5 section 256I.03, subdivision 3, for whom the county agency has approved a discharge plan
12.6 which includes work. The additional amount disregarded must be placed in a separate
12.7 savings account by the eligible individual, to be used upon discharge from the residential
12.8 facility into the community. ~~For individuals residing in a chemical dependency program~~
12.9 ~~licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from~~
12.10 ~~the savings account require the signature of the individual and for those individuals with~~
12.11 ~~an authorized representative payee, the signature of the payee. A maximum of \$1,000~~
12.12 \$2,000, including interest, of the money in the savings account must be excluded from
12.13 the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in
12.14 that account in excess of ~~\$1,000~~ \$2,000 must be applied to the resident's cost of care. If
12.15 excluded money is removed from the savings account by the eligible individual at any
12.16 time before the individual is discharged from the facility into the community, the money is
12.17 income to the individual in the month of receipt and a resource in subsequent months. If
12.18 an eligible individual moves from a community facility to an inpatient hospital setting,
12.19 the separate savings account is an excluded asset for up to 18 months. During that time,
12.20 amounts that accumulate in excess of the ~~\$1,000~~ \$2,000 savings limit must be applied to
12.21 the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the
12.22 18-month period, the entire account must be applied to the patient's cost of care.

12.23 Sec. 14. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:

12.24 Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a
12.25 grant of emergency general assistance shall, to the extent funds are available, be made to
12.26 an eligible single adult, married couple, or family for an emergency need, ~~as defined in~~
12.27 ~~rules promulgated by the commissioner,~~ where the recipient requests temporary assistance
12.28 not exceeding 30 days if an emergency situation appears to exist ~~and the individual or~~
12.29 ~~family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP under~~
12.30 written criteria adopted by the county agency. If an applicant or recipient relates facts
12.31 to the county agency which may be sufficient to constitute an emergency situation, the
12.32 county agency shall, to the extent funds are available, advise the person of the procedure
12.33 for applying for assistance according to this subdivision.

12.34 (b) The applicant must be ineligible for assistance under chapter 256J, must have
12.35 annual net income no greater than 200 percent of the federal poverty guidelines for the

13.1 ~~previous calendar year, and may receive an emergency general assistance grant is available~~
13.2 ~~to a recipient~~ not more than once in any 12-month period.

13.3 (c) Funding for an emergency general assistance program is limited to the
13.4 appropriation. Each fiscal year, the commissioner shall allocate to counties the money
13.5 appropriated for emergency general assistance grants based on each county agency's
13.6 average share of state's emergency general expenditures for the immediate past three fiscal
13.7 years as determined by the commissioner, and may reallocate any unspent amounts to
13.8 other counties. No county shall be allocated less than \$1,000 for a fiscal year.

13.9 (d) Any emergency general assistance expenditures by a county above the amount of
13.10 the commissioner's allocation to the county must be made from county funds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.9 (d) The county agency shall continue to pay a monthly allowance of \$68 for
14.10 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
14.11 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
14.12 until the person has not received Minnesota supplemental aid for one full calendar month
14.13 or until the person's living arrangement changes and the person no longer meets the criteria
14.14 for the restaurant meal allowance, whichever occurs first.

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

14.20 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
14.21 maximum allotment authorized by the federal Food Stamp Program for a single individual
14.22 which is in effect on the first day of July of each year will be added to the standards of
14.23 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
14.24 as shelter needy and are: (i) relocating from an institution, or an adult mental health
14.25 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
14.26 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
14.27 community-based waiver recipients living in their own home or rented or leased apartment
14.28 which is not owned, operated, or controlled by a provider of service not related by blood
14.29 or marriage, unless allowed under paragraph (g).

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

14.34 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
14.35 exceed 40 percent of the assistance unit's gross income before the application of this
14.36 special needs standard. "Gross income" for the purposes of this section is the applicant's or

15.1 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
15.2 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or
15.3 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
15.4 considered shelter needy for purposes of this paragraph.

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

15.11 Sec. 16. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

15.12 Subdivision 1. **Eligibility.** ~~A county agency must grant emergency Minnesota~~
15.13 ~~supplemental aid, to the extent funds are available, if the recipient is without adequate~~
15.14 ~~resources to resolve an emergency that, if unresolved, will threaten the health or safety of~~
15.15 ~~the recipient. For the purposes of this section, the term "recipient" includes persons for~~
15.16 ~~whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.~~
15.17 Applicants for or recipients of SSI or Minnesota supplemental aid who have emergency
15.18 need may apply for emergency general assistance under section 256D.06, subdivision 2.

15.19 Sec. 17. Minnesota Statutes 2010, section 256I.03, is amended by adding a subdivision
15.20 to read:

15.21 Subd. 8. **Supplementary services.** "Supplementary services" means services
15.22 provided to residents of group residential housing providers in addition to room and
15.23 board including, but not limited to, oversight and up to 24-hour supervision, medication
15.24 reminders, assistance with transportation, arranging for meetings and appointments, and
15.25 arranging for medical and social services.

15.26 Sec. 18. Minnesota Statutes 2010, section 256I.04, subdivision 2b, is amended to read:

15.27 Subd. 2b. **Group residential housing agreements.** (a) Agreements between county
15.28 agencies and providers of group residential housing must be in writing and must specify
15.29 the name and address under which the establishment subject to the agreement does
15.30 business and under which the establishment, or service provider, if different from the
15.31 group residential housing establishment, is licensed by the Department of Health or the
15.32 Department of Human Services; the specific license or registration from the Department
15.33 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 are licensed as board and lodging with special services and that do not include a residency requirement of at least 20 hours per month 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. 19. 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 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. 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).

(d) Beginning July 1, 2011, counties must not negotiate supplementary service rates with providers of group residential housing that are licensed as board and lodging with special services and that do not enforce a policy of sobriety on their premises.

Sec. 20. Minnesota Statutes 2010, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** (a) 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.

(b) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2011, 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 the group residential provider described under paragraph (a), not to exceed an additional 175 beds.

18.1 Sec. 21. Minnesota Statutes 2010, section 256I.05, is amended by adding a subdivision
18.2 to read:

18.3 Subd. 1o. **Supplemental rate adjustment.** Notwithstanding any other provision to
18.4 the contrary, board and lodging with services providers that receive a supplemental service
18.5 rate in excess of the supplemental service rate established under subdivision 1, shall be
18.6 reduced no more than \$10.42 per bed per month.

18.7 Sec. 22. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

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

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

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

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

18.32 (4) the value of personal property needed to produce earned income, including
18.33 tools, implements, farm animals, inventory, business loans, business checking and
18.34 savings accounts used at least annually and used exclusively for the operation of a

- 19.1 self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use
19.2 is to produce income and if the vehicles are essential for the self-employment business;
- 19.3 (5) the value of personal property not otherwise specified which is commonly
19.4 used by household members in day-to-day living such as clothing, necessary household
19.5 furniture, equipment, and other basic maintenance items essential for daily living;
- 19.6 (6) the value of real and personal property owned by a recipient of Supplemental
19.7 Security Income or Minnesota supplemental aid;
- 19.8 (7) the value of corrective payments, but only for the month in which the payment
19.9 is received and for the following month;
- 19.10 (8) a mobile home or other vehicle used by an applicant or participant as the
19.11 applicant's or participant's home;
- 19.12 (9) money in a separate escrow account that is needed to pay real estate taxes or
19.13 insurance and that is used for this purpose;
- 19.14 (10) money held in escrow to cover employee FICA, employee tax withholding,
19.15 sales tax withholding, employee worker compensation, business insurance, property rental,
19.16 property taxes, and other costs that are paid at least annually, but less often than monthly;
- 19.17 (11) monthly assistance payments for the current month's or short-term emergency
19.18 needs under section 256J.626, subdivision 2;
- 19.19 (12) the value of school loans, grants, or scholarships for the period they are
19.20 intended to cover;
- 19.21 (13) payments listed in section 256J.21, subdivision 2, clause (9), which are held
19.22 in escrow for a period not to exceed three months to replace or repair personal or real
19.23 property;
- 19.24 (14) income received in a budget month through the end of the payment month;
- 19.25 (15) savings from earned income of a minor child or a minor parent that are set aside
19.26 in a separate account designated specifically for future education or employment costs;
- 19.27 (16) the federal earned income credit, Minnesota working family credit, state and
19.28 federal income tax refunds, state homeowners and renters credits under chapter 290A,
19.29 property tax rebates and other federal or state tax rebates in the month received and the
19.30 following month;
- 19.31 (17) payments excluded under federal law as long as those payments are held in a
19.32 separate account from any nonexcluded funds;
- 19.33 (18) the assets of children ineligible to receive MFIP benefits because foster care or
19.34 adoption assistance payments are made on their behalf; and
- 19.35 (19) the assets of persons whose income is excluded under section 256J.21,
19.36 subdivision 2, clause (43).

20.1 Sec. 23. Minnesota Statutes 2010, section 256J.49, subdivision 13, is amended to read:

20.2 Subd. 13. **Work activity.** (a) "Work activity" means any activity in a participant's
20.3 approved employment plan that leads to employment. For purposes of the MFIP program,
20.4 this includes activities that meet the definition of work activity under the participation
20.5 requirements of TANF. Work activity includes:

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

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

20.11 (3) unpaid work experience, including community service, volunteer work,
20.12 the community work experience program as specified in section 256J.67, unpaid
20.13 apprenticeships or internships, and supported work when a wage subsidy is not provided.
20.14 Unpaid work experience is only an option if the participant has been unable to obtain or
20.15 maintain paid employment in the competitive labor market, and no paid work experience
20.16 programs are available to the participant. Prior to placing a participant in unpaid work,
20.17 the county must inform the participant that the participant will be notified if a paid work
20.18 experience or supported work position becomes available. Unless a participant consents in
20.19 writing to participate in unpaid work experience, the participant's employment plan may
20.20 only include unpaid work experience if including the unpaid work experience in the plan
20.21 will meet the following criteria:

20.22 (i) the unpaid work experience will provide the participant specific skills or
20.23 experience that cannot be obtained through other work activity options where the
20.24 participant resides or is willing to reside; and

20.25 (ii) the skills or experience gained through the unpaid work experience will result
20.26 in higher wages for the participant than the participant could earn without the unpaid
20.27 work experience;

20.28 (4) job search including job readiness assistance, job clubs, job placement,
20.29 job-related counseling, and job retention services;

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

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

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

21.6 (8) activities included in the employment plan that is developed under section
21.7 256J.521, subdivision 3; and

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

21.11 (b) "Work activity" does not include activities done for political purposes as defined
21.12 in section 211B.01, subdivision 6.

21.13 Sec. 24. Minnesota Statutes 2010, section 256J.53, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

21.34 Sec. 25. Minnesota Statutes 2010, section 260C.157, subdivision 3, is amended to read:

22.1 Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services
22.2 agency shall establish a juvenile treatment screening team to conduct screenings and
22.3 prepare case plans under ~~this subdivision~~ section 245.487, subdivision 3, and chapters
22.4 260C and 260D. Screenings shall be conducted within 15 days of a request for a screening.
22.5 The team, which may be the team constituted under section 245.4885 or 256B.092 or
22.6 Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile
22.7 justice professionals, and persons with expertise in the treatment of juveniles who are
22.8 emotionally disabled, chemically dependent, or have a developmental disability. ~~The team~~
22.9 ~~shall involve parents or guardians in the screening process as appropriate, and the child's~~
22.10 parent, guardian, or permanent legal custodian under section 260C.201, subdivision 11.
22.11 The team may be the same team as defined in section 260B.157, subdivision 3.

22.12 (b) The social services agency shall determine whether a child brought to its
22.13 attention for the purposes described in this section is an Indian child, as defined in section
22.14 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as
22.15 defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child,
22.16 the team provided in paragraph (a) shall include a designated representative of the Indian
22.17 child's tribe, unless the child's tribal authority declines to appoint a representative. The
22.18 Indian child's tribe may delegate its authority to represent the child to any other federally
22.19 recognized Indian tribe, as defined in section 260.755, subdivision 12.

22.20 (c) If the court, prior to, or as part of, a final disposition, proposes to place a child:
22.21 (1) for the primary purpose of treatment for an emotional disturbance, a
22.22 developmental disability, or chemical dependency in a residential treatment facility out
22.23 of state or in one which is within the state and licensed by the commissioner of human
22.24 services under chapter 245A; or
22.25 (2) in any out-of-home setting potentially exceeding 30 days in duration, including a
22.26 postdispositional placement in a facility licensed by the commissioner of corrections or
22.27 human services, the court shall ascertain whether the child is an Indian child and shall
22.28 notify the county welfare agency and, if the child is an Indian child, shall notify the Indian
22.29 child's tribe. The county's juvenile treatment screening team must either: (i) screen and
22.30 evaluate the child and file its recommendations with the court within 14 days of receipt
22.31 of the notice; or (ii) elect not to screen a given case and notify the court of that decision
22.32 within three working days.

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

23.1 state nor in a residential treatment facility within the state that is licensed under chapter
23.2 245A, unless one of the following conditions applies:

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

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

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

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

23.20 (f) When the Indian child's tribe or tribal health care services provider or Indian
23.21 Health Services provider proposes to place a child for the primary purpose of treatment
23.22 for an emotional disturbance, a developmental disability, or co-occurring emotional
23.23 disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by
23.24 the child's tribe shall submit necessary documentation to the county juvenile treatment
23.25 screening team, which must invite the Indian child's tribe to designate a representative to
23.26 the screening team.

23.27 Sec. 26. Minnesota Statutes 2010, section 260D.01, is amended to read:

23.28 **260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.**

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

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

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

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

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

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

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

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

24.20 (ii) due to a determination regarding the level of services needed by the responsible
24.21 social services' screening team under section 256B.092, and Minnesota Rules, parts
24.22 9525.0004 to 9525.0016.

24.23 (d) This chapter does not apply when there is a current determination under section
24.24 626.556 that the child requires child protective services or when the child is in foster care
24.25 for any reason other than treatment for the child's emotional disturbance or developmental
24.26 disability or related condition. When there is a determination under section 626.556 that
24.27 the child requires child protective services based on an assessment that there are safety
24.28 and risk issues for the child that have not been mitigated through the parent's engagement
24.29 in services or otherwise, or when the child is in foster care for any reason other than
24.30 the child's emotional disturbance or developmental disability or related condition, the
24.31 provisions of chapter 260C apply.

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

24.35 (1) to ensure a child with a disability is provided the services necessary to treat or
24.36 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. 27. 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~~ benefits.

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. 28. Minnesota Statutes 2010, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) An application fee of \$25 shall be paid by the person who applies for child support and maintenance collection services, except persons who are receiving public assistance as defined in section 256.741 and the diversionary work program under section 256J.95, persons who transfer from public assistance to nonpublic assistance status, and minor parents and parents enrolled in a public secondary school, area learning center, or alternative learning program approved by the commissioner of education.

(c) In the case of an individual who has never received assistance under a state program funded under Title IV-A of the Social Security Act and for whom the public authority has collected at least \$500 of support, the public authority must impose an annual federal collections fee of \$25 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first \$500 collected.

(d) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of one percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(e) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of one percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(f) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of \$25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(g) Federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e), retained by the commissioner of human services, shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established under paragraph (i). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

(h) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under Title IV-A and Title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(i) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e). A portion of the nonfederal share of these fees may be retained for expenditures necessary to administer the fees and must be transferred to the child support system special revenue account. ~~The remaining nonfederal share of the federal collections fees and cost recovery fees must be retained by the commissioner and dedicated to the child support general fund county performance-based grant account authorized under sections 256.979 and 256.9791.~~ The commissioner shall distribute the remaining nonfederal share of these fees to the counties quarterly using the methodology specified in section 256.979, subdivision 11. The funds received by the

28.1 counties must be reinvested in the child support enforcement program, and the counties
28.2 shall not reduce the funding of their child support programs by the amount of funding
28.3 distributed.

28.4 Sec. 29. **GRANT PROGRAM TO PROMOTE HEALTHY COMMUNITY**
28.5 **INITIATIVES.**

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

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

28.29 (c) In order to receive a grant under paragraph (b), a community must show
28.30 involvement of at least three sectors of their community and the active leadership of both
28.31 youth and adults. Sectors may include, but are not limited to, local government, schools,
28.32 community action agencies, faith communities, businesses, higher education institutions,
28.33 and the medical community. In addition, communities must agree to: (1) attend training
28.34 on community mobilization processes and strength-based approaches; (2) apply the assets
28.35 getting to outcomes process in their initiative; (3) meet at least two times during the

29.1 grant period to share successes and challenges with other grantees; (4) participate on an
29.2 electronic listserv to share information throughout the period on their work; and (5) all
29.3 communication requirements and reporting processes.

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

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

29.11 Sec. 30. **CIRCLES OF SUPPORT GRANTS.**

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

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

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

29.24 Sec. 31. **HOMELESS SHELTERS; SCHOOL DISTRICTS.**

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

29.27 Sec. 32. **REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES,**
29.28 **GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.**

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

Sec. 33. **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 Statutes, chapter 256D, and programs under Minnesota Statutes, chapter 256J, using EBT cards. The task force will consider cost to the state, feasibility of execution at retail, and ease of use and privacy for EBT cardholders.

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

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

Sec. 34. **STREAMLINING CHILDREN AND COMMUNITY SERVICES ACT REPORTING REQUIREMENTS.**

The commissioner of human services and county human services representatives, in consultation with other interested parties, shall develop a streamlined alternative to current reporting requirements related to the Children and Community Services Act service plan. The commissioner shall submit recommendations and draft legislation to the chairs and ranking minority members of the committees having jurisdiction over human services no later than November 15, 2012.

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10; 256.9791; 256.9862, subdivision 2; and 256D.46, subdivisions 2 and 3, are repealed.

(b) Minnesota Rules, parts 3400.0130, subpart 8; and 9500.1261, subparts 3, items D and E, 4, and 5, are repealed effective September 3, 2012.

ARTICLE 2

DEPARTMENT OF HEALTH

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

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

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

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

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

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

32.1 local level. The commissioner may adopt rules requiring the use of the Uniform Bill
32.2 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic
32.3 version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized
32.4 forms or procedures;

32.5 (5) undertake health planning responsibilities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33.17 Subd. 6. **Additional standards for electronic prescribing.** By January 1, 2012,
33.18 the commissioner of health, in consultation with the Minnesota e-Health Advisory
33.19 Committee, must develop a method for incorporation of the following transactions into the
33.20 requirements and standards for electronic prescribing provided in subdivisions 2 and 3:
33.21 (1) submission of requests for a formulary exception based on information required
33.22 on the form developed according to subdivision 4; and
33.23 (2) submission of prior authorization requests based on information required on the
33.24 form developed according to subdivision 5.

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

33.26 **62J.692 MEDICAL EDUCATION.**

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

33.29 (a) "Accredited clinical training" means the clinical training provided by a
33.30 medical education program that is accredited through an organization recognized by the
33.31 Department of Education, the Centers for Medicare and Medicaid Services, or another
33.32 national body who reviews the accrediting organizations for multiple disciplines and

34.1 whose standards for recognizing accrediting organizations are reviewed and approved by
34.2 the commissioner of health in consultation with the Medical Education and Research
34.3 Advisory Committee.

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

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

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

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

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

34.18 (g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
34.19 equivalent counts, that are at training sites located in Minnesota with currently active
34.20 medical assistance enrollment status and a National Provider Identification (NPI) number
34.21 where training occurs in either an inpatient or ambulatory patient care setting and where
34.22 the training is funded, in part, by patient care revenues. ~~Training that occurs in nursing
34.23 facility settings is not eligible for funding under this section.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.35 (e) An applicant that does not provide information requested by the commissioner
35.36 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

37.1 (3) \$500,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 shall
37.2 be distributed to the community health centers development grants program according
37.3 to section 145.987;

37.4 (4) \$500,000 in fiscal year 2012 and \$200,000 beginning in fiscal year 2013 shall be
37.5 distributed to the community mental health centers grant program according to section
37.6 145.9272;

37.7 (5) \$1,000,000 in fiscal year 2012 and \$444,000 beginning in fiscal year 2013 shall
37.8 be distributed to the health careers opportunities grant program according to section
37.9 144.1499; and

37.10 ~~(3)~~ (6) \$1,800,000 to the Academic Health Center. \$150,000 of the funds distributed
37.11 to the Academic Health Center under this paragraph shall be used for a program to assist
37.12 internationally trained physicians who are legal residents and who commit to serving
37.13 underserved Minnesota communities in a health professional shortage area to successfully
37.14 compete for family medicine residency programs at the University of Minnesota.

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

37.17 (d) Funds shall be distributed to the sponsoring institutions indicating the amount
37.18 to be distributed to each of the sponsor's clinical medical education programs based on
37.19 the criteria in this subdivision and in accordance with the commissioner's approval letter.
37.20 Each clinical medical education program must distribute funds allocated under paragraph
37.21 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
37.22 institutions, which are accredited through an organization recognized by the Department
37.23 of Education or the Centers for Medicare and Medicaid Services, may contract directly
37.24 with training sites to provide clinical training. To ensure the quality of clinical training,
37.25 those accredited sponsoring institutions must:

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

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

37.31 (e) Any funds not distributed in accordance with the commissioner's approval letter
37.32 must be returned to the medical education and research fund within 30 days of receiving
37.33 notice from the commissioner. The commissioner shall distribute returned funds to the
37.34 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:

- 39.1 (1) \$2,157,000 shall be distributed by the commissioner to the University of
39.2 Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;
- 39.3 (2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County
39.4 Medical Center for clinical medical education;
- 39.5 (3) \$17,400,000 shall be distributed by the commissioner to the University of
39.6 Minnesota Board of Regents for purposes of medical education;
- 39.7 (4) ~~\$1,121,640~~ \$1,021,640 shall be distributed by the commissioner to clinical
39.8 medical education dental innovation grants in accordance with subdivision 7a; ~~and~~
- 39.9 (5) \$100,000 shall be distributed to the health careers opportunities grant program
39.10 according to section 144.1499; and
- 39.11 (6) the remainder of the amount transferred according to section 256B.69,
39.12 subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to
39.13 clinical medical education programs that meet the qualifications of subdivision 3 based on
39.14 the formula in subdivision 4, paragraph (a), or subdivision 11, as appropriate.

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

- 39.22 (1) potential to successfully increase access to an underserved population;
- 39.23 (2) ~~the long-term viability of the project to improve access beyond the period~~
39.24 ~~of initial funding;~~
- 39.25 ~~(3)~~ evidence of collaboration between the applicant and local communities; and
- 39.26 ~~(4) the efficiency in the use of the funding; and~~
- 39.27 ~~(5) (3) the priority level of the project in relation to state clinical education, access,~~
39.28 ~~and health disparity~~ workforce goals.

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

39.32 Subd. 8. **Federal financial participation.** The commissioner of human services
39.33 shall seek to maximize federal financial participation in payments for medical education
39.34 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

41.1 urban area according to the RUCA system shall be weighted at the weight in item (i)
41.2 multiplied by 1.0;

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

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

41.20 (b) Public program revenue for the distribution formula includes revenue for the
41.21 relevant MERC reporting period from medical assistance, prepaid medical assistance,
41.22 general assistance medical care, MinnesotaCare, and prepaid general assistance medical
41.23 care, as reported to the Department of Health pursuant to sections 144.562, 144.564,
41.24 and 144.695 to 144.703 and Minnesota Rules, chapter 4650, by December 31 of the
41.25 year in which the MERC application is submitted. Training sites that receive no public
41.26 program revenue are ineligible for funds available under this subdivision. For purposes
41.27 of determining training-site level grants to be distributed under paragraph (a), clause
41.28 (2), total statewide average costs per trainee for medical residents is based on audited
41.29 clinical training costs per trainee in primary care clinical medical education programs for
41.30 medical residents. Total statewide average costs per trainee for dental residents is based
41.31 on audited clinical training costs per trainee in clinical medical education programs for
41.32 dental students. Total statewide average costs per trainee for pharmacy residents is based
41.33 on audited clinical training costs per trainee in clinical medical education programs for
41.34 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

45.1 professions education programs and other activities to improve retention of these students
45.2 in health professions education programs; or

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

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

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

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

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

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

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

45.19 (6) a timeline for completion of the project;

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

45.22 (8) a plan to evaluate project outcomes; and

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

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

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

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

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

45.36 (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

49.1 American Indian or other populations of color, such as federally recognized American
49.2 Indian reservations.

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

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

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

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

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

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

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

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

49.23 (2) a Minnesota resident; and

49.24 (3) an individual from a racial, ethnic, or cultural population experiencing health
49.25 disparities in the state.

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

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

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

(1) a change in name or address;

(2) a decision not to fulfill a service obligation; or

(3) cessation of obligated practice.

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

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

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

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

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

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

51.17 (e) The accreditation of any laboratory that fails to submit a renewal application
51.18 and fees to the commissioner expires automatically on December 31 without notice or
51.19 further proceeding. Any person who operates a laboratory as accredited after expiration of
51.20 accreditation or without having submitted an application and paid the fees is in violation
51.21 of the provisions of this section and is subject to enforcement action under sections
51.22 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired
51.23 accreditation may reapply under subdivision 6.

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

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

51.32 (1) complies with the methodology and quality control requirements, where
51.33 available, in the most recent, approved edition of the Standard Methods for the
51.34 Examination of Water and Wastewater as published by the Water Environment Federation;
51.35 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:

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

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

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

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

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

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

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

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

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

53.22 **144E.123 PREHOSPITAL CARE DATA.**

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

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

53.31 Subd. 3. **Review.** Prehospital care data may be reviewed by the board or its
53.32 designees. The data shall be classified as private data on individuals under chapter 13, the
53.33 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.

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

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

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

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

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

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

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

The commissioner of health shall survey the diversity of the work force for health-related professions and compare proportions in the allied health professions among populations experiencing health disparities, including cultural, racial, ethnic, and geographic factors, compared to the population of the state. Based on this survey, the commissioner shall determine on an annual basis the ratio of training and residency positions needed versus those available based on funding capacity.

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

Subd. 7. **Consultation and engagement of consumers and communities with poorer health and outcomes.** Communities who receive state and federal health grants must demonstrate to the commissioner that the applicant or grantee consulted with and engaged local consumers, community organizations, and leaders representing the subgroups of the community that experience the greatest health disparities in the development of the local plan and that the plan incorporates components and activities that reflect the needs and preferences of these communities. The plan must also include

56.1 a process for ongoing consultation and engagement of these consumers, community
56.2 organizations, and leaders in the implementation of the plan and activities funded by
56.3 state grants.

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

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

56.11 Sec. 28. **[145.987] COMMUNITY HEALTH CENTERS DEVELOPMENT**
56.12 **GRANTS FOR UNDERSERVED COMMUNITIES.**

56.13 (a) The commissioner of health shall award grants from money appropriated for this
56.14 purpose to expand community health centers, as defined in section 145.9269, subdivision
56.15 1, in the state through the establishment of new community health centers or sites in
56.16 areas defined as small rural areas or isolated rural areas according to the four category
56.17 classification of the Rural Urban Commuting Area system developed for the United States
56.18 Health Resources and Services Administration or serving underserved patient populations
56.19 who experience the greatest disparities in health outcomes.

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

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

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

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

56.28 Funds may not be used for operating costs.

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

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

56.34 (1) the unmet need in the underserved community;

57.1 (2) the degree of disparities in health outcomes in the underserved community; and
57.2 (3) the extent to which people from the underserved community participated in
57.3 the development of the proposal.

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

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

57.10 (1) a description of outreach strategies to families prenatally or at birth;
57.11 (2) provisions for the seamless delivery of health, safety, and early learning services;
57.12 (3) methods to promote continuity of services when families move within the state;
57.13 (4) a description of the community demographics;
57.14 (5) a plan for meeting outcome measures; and
57.15 (6) a proposed work plan that includes:
57.16 (i) coordination to ensure nonduplication of services for children and families;
57.17 (ii) a description of the strategies to ensure that children and families at greatest risk
57.18 receive appropriate services; and
57.19 (iii) collaboration with multidisciplinary partners including public health,
57.20 ECFE, Head Start, community health workers, social workers, community home
57.21 visiting programs, school districts, and other relevant partners. Letters of intent from
57.22 multidisciplinary partners must be submitted with the plan.

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

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

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

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

57.33 (4) provide information on and referrals to health care services, if needed, including
57.34 information on and assistance in applying for health care coverage for which the child or

58.1 family may be eligible; and provide information on preventive services, developmental
58.2 assessments, and the availability of public assistance programs as appropriate;

58.3 (5) provide youth development programs when appropriate;

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

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

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

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

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

58.17 (c) When available, programs that receive funds under this section must offer or
58.18 provide the family with a referral to center-based or group meetings that meet at least
58.19 once per month for those families identified with additional needs. The meetings must
58.20 focus on further enhancing the information, activities, and skill-building addressed during
58.21 home visitation; offering opportunities for parents to meet with and support each other;
58.22 and offering infants and toddlers a safe, nurturing, and stimulating environment for
58.23 socialization and supervised play with qualified teachers.

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

58.28 (e) Data collected on individuals served by the home visiting programs must remain
58.29 confidential and must not be disclosed by providers of home visiting services without a
58.30 specific informed written consent that identifies disclosures to be made. Upon request,
58.31 agencies providing home visiting services must provide recipients with information on
58.32 disclosures, including the names of entities and individuals receiving the information and
58.33 the general purpose of the disclosure. Prospective and current recipients of home visiting
58.34 services must be told and informed in writing that written consent for disclosure of data is
58.35 not required for access to home visiting services.

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

59.8 Sec. 30. Minnesota Statutes 2010, section 152.027, is amended by adding a subdivision
59.9 to read:

59.10 Subd. 6. **Sale or possession of synthetic cannabinoids.** (a) A person who
59.11 unlawfully sells any amount of a synthetic cannabinoid is guilty of a gross misdemeanor.

59.12 (b) A person who unlawfully possesses any amount of a synthetic cannabinoid is
59.13 guilty of a misdemeanor.

59.14 (c) For purposes of this subdivision, "synthetic cannabinoid" includes, unless
59.15 specifically excepted or unless listed in another schedule, any natural or synthetic material,
59.16 compound, mixture, or preparation that contains any quantity of a substance that is a
59.17 cannabinoid receptor agonist, including, but not limited to, the following substances and
59.18 their analogs, including homologues; isomers, whether optical, positional, or geometric;
59.19 esters; ethers; salts; and salts of isomers, esters, and ethers, whenever the existence of the
59.20 isomers, esters, ethers, or salts is possible within the specific chemical designation:

59.21 1-pentyl-2-methyl-3-(1-naphthoyl)indole (JWH-007),
59.22 (2-Methyl-1-propyl-1H-indol-3-yl)-1-naphthalenylmethanone (JWH-015),
59.23 1-Pentyl-3-(1-naphthoyl)indole (JWH-018), 1-hexyl-3-(naphthalen-1-oyl)indole
59.24 (JWH-019), 1-Butyl-3-(1-naphthoyl)indole (JWH-073),
59.25 4-methoxynaphthalen-1-yl-(1-pentylindol-3-yl)methanone (JWH-081),
59.26 4-methoxynaphthalen-1-yl-(1-pentyl-2-methylindol-3-yl)methanone
59.27 (JWH-098), (1-(2-morpholin-4-ylethyl)indol-3-yl)-naphthalen-1-ylmethanone
59.28 (JWH-200), 7-methoxynaphthalen-1-yl-(1-pentylindol-3-yl)methanone
59.29 (JWH-164), 2-(2-chlorophenyl)-1-(1-pentylindol-3-yl)ethanone (JWH-203),
59.30 4-ethylnaphthalen-1-yl-(1-pentylindol-3-yl)methanone (JWH-210),
59.31 2-(2-methoxyphenyl)-1-(1-pentylindol-3-yl)ethanone (JWH-250),
59.32 1-pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398), (6aR,10aR)-
59.33 9-(Hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-
59.34 tetrahydrobenzo[c]chromen-1-ol (HU-210), (dexanabinol, (6aS,10aS)-9-
59.35 (hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-

60.1 tetrahydrobenzo[c]chromen-1-ol) (HU-211), (R)-(+)-[2,3-Dihydro-5-methyl-3-
60.2 (4-morpholinylmethyl)pyrrolo[1,2,3-de)-1,4-benzoxazin-6-yl]-1-napthalenylmethanone
60.3 (WIN-55/212-2), 2-[(1R,3S)-3-hydroxycyclohexyl]- 5-(2-methyloctan-2-yl)phenol
60.4 (CP47,497), dimethylheptylpyran.

60.5 **EFFECTIVE DATE.** This section is effective August 1, 2011, and applies to crimes
60.6 committed on or after that date.

60.7 Sec. 31. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision
60.8 to read:

60.9 Subd. 7a. **Limited food establishment.** "Limited food establishment" means a food
60.10 and beverage service establishment that primarily provides beverages that consist of
60.11 combining dry mixes and water or ice for immediate service to the consumer. Limited
60.12 food establishments must use equipment and utensils that are nontoxic, durable, and retain
60.13 their characteristic qualities under normal use conditions and may request a variance for
60.14 plumbing requirements from the commissioner.

60.15 Sec. 32. Minnesota Statutes 2010, section 157.20, is amended by adding a subdivision
60.16 to read:

60.17 Subd. 5. **Waivers during inspection.** Notwithstanding any provision of this
60.18 chapter or Minnesota Rules, chapter 4626, any plumbing or other facility requirement,
60.19 including sewage access charge and related local fees, may be waived by the inspector if
60.20 the inspector deems a waiver appropriate and reasonable and determines that no significant
60.21 adverse effects on public health, safety, or the environment would result from such waiver.

60.22 Sec. 33. Minnesota Statutes 2010, section 169A.20, subdivision 1, is amended to read:

60.23 Subdivision 1. **Driving while impaired crime; motor vehicle.** It is a crime for
60.24 any person to drive, operate, or be in physical control of any motor vehicle, as defined
60.25 in section 169A.03, subdivision 15, except for motorboats in operation and off-road
60.26 recreational vehicles, within this state or on any boundary water of this state when:

60.27 (1) the person is under the influence of alcohol;

60.28 (2) the person is under the influence of a controlled substance or a substance listed in
60.29 section 152.027, subdivision 6;

60.30 (3) the person is knowingly under the influence of a hazardous substance that
60.31 affects the nervous system, brain, or muscles of the person so as to substantially impair
60.32 the person's ability to drive or operate the motor vehicle;

61.1 (4) the person is under the influence of a combination of any two or more of the
61.2 elements named in clauses (1) to (3);

61.3 (5) the person's alcohol concentration at the time, or as measured within two hours
61.4 of the time, of driving, operating, or being in physical control of the motor vehicle is
61.5 0.08 or more;

61.6 (6) the vehicle is a commercial motor vehicle and the person's alcohol concentration
61.7 at the time, or as measured within two hours of the time, of driving, operating, or being in
61.8 physical control of the commercial motor vehicle is 0.04 or more; or

61.9 (7) the person's body contains any amount of a controlled substance listed in
61.10 Schedule I or II, or its metabolite, other than marijuana or tetrahydrocannabinols.

61.11 **EFFECTIVE DATE.** This section is effective August 1, 2011, and applies to crimes
61.12 committed on or after that date.

61.13 Sec. 34. Minnesota Statutes 2010, section 169A.20, subdivision 1a, is amended to read:

61.14 Subd. 1a. **Driving while impaired crime; motorboat in operation.** It is a crime
61.15 for any person to operate or be in physical control of a motorboat in operation on any
61.16 waters or boundary water of this state when:

61.17 (1) the person is under the influence of alcohol;

61.18 (2) the person is under the influence of a controlled substance or a substance listed in
61.19 section 152.027, subdivision 6;

61.20 (3) the person is knowingly under the influence of a hazardous substance that affects
61.21 the nervous system, brain, or muscles of the person so as to substantially impair the
61.22 person's ability to drive or operate the motorboat;

61.23 (4) the person is under the influence of a combination of any two or more of the
61.24 elements named in clauses (1) to (3);

61.25 (5) the person's alcohol concentration at the time, or as measured within two hours
61.26 of the time, of driving, operating, or being in physical control of the motorboat is 0.08 or
61.27 more; or

61.28 (6) the person's body contains any amount of a controlled substance listed in
61.29 Schedule I or II, or its metabolite, other than marijuana or tetrahydrocannabinols.

61.30 **EFFECTIVE DATE.** This section is effective August 1, 2011, and applies to crimes
61.31 committed on or after that date.

61.32 Sec. 35. Minnesota Statutes 2010, section 169A.20, subdivision 1b, is amended to read:

62.1 Subd. 1b. **Driving while impaired crime; snowmobile and all-terrain vehicle.** It
62.2 is a crime for any person to operate or be in physical control of a snowmobile as defined in
62.3 section 84.81, subdivision 3, or all-terrain vehicle as defined in section 84.92, subdivision
62.4 8, anywhere in this state or on the ice of any boundary water of this state when:

62.5 (1) the person is under the influence of alcohol;

62.6 (2) the person is under the influence of a controlled substance or a substance listed in
62.7 section 152.027, subdivision 6;

62.8 (3) the person is knowingly under the influence of a hazardous substance that affects
62.9 the nervous system, brain, or muscles of the person so as to substantially impair the
62.10 person's ability to drive or operate the snowmobile or all-terrain vehicle;

62.11 (4) the person is under the influence of a combination of any two or more of the
62.12 elements named in clauses (1) to (3);

62.13 (5) the person's alcohol concentration at the time, or as measured within two hours
62.14 of the time, of driving, operating, or being in physical control of the snowmobile or
62.15 all-terrain vehicle is 0.08 or more; or

62.16 (6) the person's body contains any amount of a controlled substance listed in
62.17 Schedule I or II, or its metabolite, other than marijuana or tetrahydrocannabinols.

62.18 **EFFECTIVE DATE.** This section is effective August 1, 2011, and applies to crimes
62.19 committed on or after that date.

62.20 Sec. 36. Minnesota Statutes 2010, section 169A.20, subdivision 1c, is amended to read:

62.21 Subd. 1c. **Driving while impaired crime; off-highway motorcycle and off-road**
62.22 **vehicle.** It is a crime for any person to operate or be in physical control of any off-highway
62.23 motorcycle as defined in section 84.787, subdivision 7, or any off-road vehicle as defined
62.24 in section 84.797, subdivision 7, anywhere in this state or on the ice of any boundary
62.25 water of this state when:

62.26 (1) the person is under the influence of alcohol;

62.27 (2) the person is under the influence of a controlled substance or a substance listed in
62.28 section 152.027, subdivision 6;

62.29 (3) the person is knowingly under the influence of a hazardous substance that affects
62.30 the nervous system, brain, or muscles of the person so as to substantially impair the
62.31 person's ability to drive or operate the off-highway motorcycle or off-road vehicle;

62.32 (4) the person is under the influence of a combination of any two or more of the
62.33 elements named in clauses (1) to (3);

(5) the person's alcohol concentration at the time, or as measured within two hours of the time, of driving, operating, or being in physical control of the off-highway motorcycle or off-road vehicle is 0.08 or more; or

(6) the person's body contains any amount of a controlled substance listed in Schedule I or II, or its metabolite, other than marijuana or tetrahydrocannabinols.

EFFECTIVE DATE. This section is effective August 1, 2011, and applies to crimes committed on or after that date.

Sec. 37. Minnesota Statutes 2010, section 297F.10, subdivision 1, is amended to read:

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

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

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

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

Sec. 38. **TRANSFER OF HEALTH QUALITY DATA COLLECTION.**

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

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

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

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

Subd. 5. **Commissioner of human services.** (a) During the 2012 legislative session, the commissioner of human services, 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.

(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. 39. **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. 40. **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. 41. **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. 42. **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 not-for-profit health maintenance organizations operating in Minnesota and other states. The study findings must address whether the state of Minnesota could: (1) reduce medical assistance and MinnesotaCare costs and costs of providing coverage to state employees; and (2) maintain or improve the quality of care provided to state health care program enrollees and state employees if for-profit health maintenance organizations were allowed to operate in the state. The commissioner shall require the entity under contract to report study findings to the commissioner and the legislature by January 15, 2012.

Sec. 43. **MINNESOTA TASK FORCE ON PREMATUREITY.**

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

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

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

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

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

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

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

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

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

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

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

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

(2) coordination of information among appropriate professional and advocacy 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. 44. **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. 45. **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; and 144.1464, 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

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 and added to fiscal notes 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 private insurance premiums and 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;

69.1 (d) the license holder is a community collaborative child care provider. For
69.2 purposes of this subdivision, a community collaborative child care provider is a provider
69.3 participating in a cooperative agreement with a community action agency as defined in
69.4 section 256E.31; ~~or~~

69.5 (e) the license holder is a not-for-profit agency that provides child care in a dwelling
69.6 located on a residential lot and the license holder maintains two or more contracts with
69.7 community employers or other community organizations to provide child care services.
69.8 The county licensing agency may grant a capacity variance to a license holder licensed
69.9 under this paragraph to exceed the licensed capacity of 14 children by no more than five
69.10 children during transition periods related to the work schedules of parents, if the license
69.11 holder meets the following requirements:

69.12 (1) the program does not exceed a capacity of 14 children more than a cumulative
69.13 total of four hours per day;

69.14 (2) the program meets a one to seven staff-to-child ratio during the variance period;

69.15 (3) all employees receive at least an extra four hours of training per year than
69.16 required in the rules governing family child care each year;

69.17 (4) the facility has square footage required per child under Minnesota Rules, part
69.18 9502.0425;

69.19 (5) the program is in compliance with local zoning regulations;

69.20 (6) the program is in compliance with the applicable fire code as follows:

69.21 (i) if the program serves more than five children older than 2-1/2 years of age,
69.22 but no more than five children 2-1/2 years of age or less, the applicable fire code is
69.23 educational occupancy, as provided in Group E Occupancy under the Minnesota State
69.24 Fire Code 2003, Section 202; or

69.25 (ii) if the program serves more than five children 2-1/2 years of age or less, the
69.26 applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire
69.27 Code 2003, Section 202; and

69.28 (7) any age and capacity limitations required by the fire code inspection and square
69.29 footage determinations shall be printed on the license; or

69.30 (f) the license holder is the primary provider of care and has located the licensed
69.31 child care program in a commercial space, if the license holder meets the following
69.32 requirements:

69.33 (1) the program is in compliance with local zoning regulations;

69.34 (2) the program is in compliance with the applicable fire code as follows:

69.35 (i) if the program serves more than five children older than 2-1/2 years of age,
69.36 but no more than five children 2-1/2 years of age or less, the applicable fire code is

70.1 educational occupancy, as provided in Group E Occupancy under the Minnesota State
70.2 Fire Code 2003, Section 202; or
70.3 (ii) if the program serves more than five children 2-1/2 years of age or less, the
70.4 applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire
70.5 Code 2003, Section 202;
70.6 (3) any age and capacity limitations required by the fire code inspection and square
70.7 footage determinations are printed on the license; and
70.8 (4) the license holder prominently displays the license issued by the commissioner
70.9 which contains the statement "This special family child care provider is not licensed as a
70.10 child care center."

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

70.13 Subd. 33. **Combined application form; referral of veterans.** The commissioner
70.14 shall modify the combined application form to add a question asking applicants: "Are
70.15 you a United States military veteran?" The commissioner shall ensure that all applicants
70.16 who identify themselves as veterans are referred to a county veterans service officer for
70.17 assistance in applying to the United States Department of Veterans Affairs for any benefits
70.18 for which they may be eligible.

70.19 Sec. 4. Minnesota Statutes 2010, section 256B.04, subdivision 14a, is amended to read:

70.20 Subd. 14a. **Level of need determination.** Nonemergency medical transportation
70.21 level of need determinations must be performed by a physician, a registered nurse working
70.22 under direct supervision of a physician, a physician's assistant, a nurse practitioner, a
70.23 licensed practical nurse, or a discharge planner.

70.24 Nonemergency medical transportation level of need determinations must not be
70.25 performed more than annually on any individual, unless the individual's circumstances
70.26 have sufficiently changed so as to require a new level of need determination. No entity
70.27 shall charge, and the commissioner shall pay, no more than \$25 for performing a level of
70.28 need determination regarding any person receiving nonemergency medical transportation,
70.29 including special transportation.

70.30 Special transportation services to eligible persons who need a stretcher-accessible
70.31 vehicle from a hospital are exempt from a level of need determination if the special
70.32 transportation services have been ordered by the eligible person's physician, registered
70.33 nurse working under direct supervision of a physician, physician's assistant, nurse
70.34 practitioner, licensed practical nurse, or discharge planner pursuant to Medicare guidelines.

71.1 Individuals transported to or residing in licensed nursing facilities are exempt from a
71.2 level of need determination and are eligible for special transportation services until the
71.3 individual no longer resides in a licensed nursing facility. If a person authorized by this
71.4 subdivision to perform a level of need determination determines that an individual requires
71.5 stretcher transportation, the individual is presumed to maintain that level of need until
71.6 otherwise determined by a person authorized to perform a level of need determination, or
71.7 for six months, whichever is sooner.

71.8 Sec. 5. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to
71.9 read:

71.10 Subd. 17. **Transportation costs.** (a) Medical assistance covers medical
71.11 transportation costs incurred solely for obtaining emergency medical care or transportation
71.12 costs incurred by eligible persons in obtaining emergency or nonemergency medical
71.13 care when paid directly to an ambulance company, common carrier, or other recognized
71.14 providers of transportation services. Medical transportation must be provided by:

71.15 (1) an ambulance, as defined in section 144E.001, subdivision 2;

71.16 (2) special transportation; or

71.17 (3) common carrier including, but not limited to, bus, taxicab, other commercial
71.18 carrier, or private automobile.

71.19 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,
71.20 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that
71.21 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial
71.22 transportation, or private automobile.

71.23 The commissioner may use an order by the recipient's attending physician to certify that
71.24 the recipient requires special transportation services. Special transportation providers
71.25 shall perform driver-assisted services for eligible individuals. Driver-assisted service
71.26 includes passenger pickup at and return to the individual's residence or place of business,
71.27 assistance with admittance of the individual to the medical facility, and assistance in
71.28 passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special
71.29 transportation providers must obtain written documentation from the health care service
71.30 provider who is serving the recipient being transported, identifying the time that the
71.31 recipient arrived. Special transportation providers may not bill for separate base rates for
71.32 the continuation of a trip beyond the original destination. Special transportation providers
71.33 must take recipients to the nearest appropriate health care provider, using the most direct
71.34 route as determined by a commercially available mileage software program approved by

72.1 the commissioner. The minimum medical assistance reimbursement rates for special
72.2 transportation services are:

72.3 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to
72.4 eligible persons who need a wheelchair-accessible van;

72.5 (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to
72.6 eligible persons who do not need a wheelchair-accessible van; and

72.7 (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
72.8 special transportation services to eligible persons who need a stretcher-accessible vehicle;

72.9 (2) the base rates for special transportation services in areas defined under RUCA
72.10 to be super rural shall be equal to the reimbursement rate established in clause (1) plus
72.11 11.3 percent; and

72.12 (3) for special transportation services in areas defined under RUCA to be rural
72.13 or super rural areas:

72.14 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
72.15 percent of the respective mileage rate in clause (1); and

72.16 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
72.17 112.5 percent of the respective mileage rate in clause (1).

72.18 (c) For purposes of reimbursement rates for special transportation services under
72.19 paragraph (b), the zip code of the recipient's place of residence shall determine whether
72.20 the urban, rural, or super rural reimbursement rate applies.

72.21 (d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"
72.22 means a census-tract based classification system under which a geographical area is
72.23 determined to be urban, rural, or super rural.

72.24 Sec. 6. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision
72.25 to read:

72.26 Subd. 3a. **Spousal contribution.** (a) For purposes of this subdivision, the following
72.27 terms have the meanings given:

72.28 (1) "commissioner" means the commissioner of human services;

72.29 (2) "community spouse" means the spouse, who lives in the community, of an
72.30 individual receiving long-term care services in a long-term care facility or home care
72.31 services pursuant to the Medicaid waiver for elderly services under section 256B.0915
72.32 or the alternative care program under section 256B.0913. A community spouse does not
72.33 include a spouse living in the community who receives a monthly income allowance
72.34 under section 256B.058, subdivision 2, or who receives home care services or home

73.1 and community-based services under section 256B.0915, 256B.092, or 256B.49, or the
73.2 alternative care program under section 256B.0913;

73.3 (3) "cost of care" means the actual fee-for-service costs or capitated payments for
73.4 the long-term care spouse;

73.5 (4) "department" means the Department of Human Services;

73.6 (5) "disabled child" means a blind or permanently and totally disabled son or
73.7 daughter of any age as defined in the Supplemental Security Income program or the state
73.8 medical review team;

73.9 (6) "income" means earned and unearned income, attributable to the community
73.10 spouse, used to calculate the adjusted gross income on the prior year's income tax return.
73.11 Evidence of income includes, but is not limited to, W-2 and 1099 forms; and

73.12 (7) "long-term care spouse" means the spouse who is receiving long-term care
73.13 services in a long-term care facility or home care services pursuant to the Medicaid
73.14 waiver for elderly services under section 256B.0915 or the alternative care program under
73.15 section 256B.0913.

73.16 (b) The community spouse of a long-term care spouse who receives medical
73.17 assistance or alternative care services has an obligation to contribute to the cost of care.
73.18 The community spouse must pay a monthly fee on a sliding fee scale based on the
73.19 community spouse's income. If a minor or disabled child resides with and receives care
73.20 from the community spouse, then no fee shall be assessed.

73.21 (c) For a community spouse with an income equal to or greater than 250 percent of
73.22 the federal poverty guidelines for a family of two and less than 545 percent of the federal
73.23 poverty guidelines for a family of two, the spousal contribution shall be determined using
73.24 a sliding fee scale established by the commissioner that begins at 7.5 percent of the
73.25 community spouse's income and increases to 15 percent for those with an income of up to
73.26 545 percent of the federal poverty guidelines for a family of two.

73.27 (d) For a community spouse with an income equal to or greater than 545 percent of
73.28 the federal poverty guidelines for a family of two and less than 750 percent of the federal
73.29 poverty guidelines for a family of two, the spousal contribution shall be determined using
73.30 a sliding fee scale established by the commissioner that begins at 15 percent of the
73.31 community spouse's income and increases to 25 percent for those with an income of up to
73.32 750 percent of the federal poverty guidelines for a family of two.

73.33 (e) For a community spouse with an income equal to or greater than 750 percent of
73.34 the federal poverty guidelines for a family of two and less than 975 percent of the federal
73.35 poverty guidelines for a family of two, the spousal contribution shall be determined using
73.36 a sliding fee scale established by the commissioner that begins at 25 percent of the

74.1 community spouse's income and increases to 33 percent for those with an income of up to
74.2 975 percent of the federal poverty guidelines for a family of two.

74.3 (f) For a community spouse with an income equal to or greater than 975 percent of
74.4 the federal poverty guidelines for a family of two, the spousal contribution shall be 33
74.5 percent of the community spouse's income.

74.6 (g) The spousal contribution shall be explained in writing at the time eligibility
74.7 for medical assistance or alternative care is being determined. In addition to explaining
74.8 the formula used to determine the fee, the county or tribal agency shall provide written
74.9 information describing how to request a variance for undue hardship, how a contribution
74.10 may be reviewed or redetermined, the right to appeal a contribution determination, and
74.11 that the consequences for not complying with a request to provide information shall be
74.12 an assessment against the community spouse for the full cost of care for the long-term
74.13 care spouse.

74.14 (h) The contribution shall be assessed for each month the long-term care spouse
74.15 has a community spouse and is eligible for medical assistance payment of long-term
74.16 care services or alternative care.

74.17 (i) The spousal contribution shall be reviewed at least once every 12 months and
74.18 when there is a loss or gain in income in excess of ten percent. Thirty days prior to a
74.19 review or redetermination, written notice must be provided to the community spouse
74.20 and must contain the amount the spouse is required to contribute, notice of the right to
74.21 redetermination and appeal, and the telephone number of the division at the agency that is
74.22 responsible for redetermination and review. If, after review, the contribution amount is to
74.23 be adjusted, the county or tribal agency shall mail a written notice to the community spouse
74.24 30 days in advance of the effective date of the change in the amount of the contribution.

74.25 (1) The spouse shall notify the county or tribal agency within 30 days of a gain or
74.26 loss in income in excess of ten percent and provide the agency supporting documentation
74.27 to verify the need for redetermination of the fee.

74.28 (2) When a spouse requests a review or redetermination of the contribution amount,
74.29 a request for information shall be sent to the spouse within ten calendar days after the
74.30 county or tribal agency receives the request for review.

74.31 (3) No action shall be taken on a review or redetermination until the required
74.32 information is received by the county or tribal agency.

74.33 (4) The review of the spousal contribution shall be completed within ten days after
74.34 the county or tribal agency receives completed information that verifies a loss or gain in
74.35 income in excess of ten percent.

75.1 (5) An increase in the contribution amount is effective in the month in which the
75.2 increase in spousal income occurs.

75.3 (6) A decrease in the contribution amount is effective in the month the spouse
75.4 verifies the reduction in income, retroactive to no longer than six months.

75.5 (j) In no case shall the spousal contribution exceed the amount of medical assistance
75.6 expended or the cost of alternative care services for the care of the long-term care spouse.
75.7 Annually, upon redetermination, or at termination of eligibility, the total amount of
75.8 medical assistance paid or costs of alternative care for the care of the long-term care spouse
75.9 and the total amount of the spousal contribution shall be compared. If the total amount
75.10 of the spousal contribution exceeds the total amount of medical assistance expended or
75.11 cost of alternative care, then the agency shall reimburse the community spouse the excess
75.12 amount if the long-term care spouse is no longer receiving services, or apply the excess
75.13 amount to the spousal contribution due until the excess amount is exhausted.

75.14 (k) A community spouse may request a variance by submitting a written request
75.15 and supporting documentation that payment of the calculated contribution would cause
75.16 an undue hardship. An undue hardship is defined as the inability to pay the calculated
75.17 contribution due to medical expenses incurred by the community spouse. Documentation
75.18 must include proof of medical expenses incurred by the community spouse since the last
75.19 annual redetermination of the contribution amount that are not reimbursable by any public
75.20 or private source, and are a type, regardless of amount, that would be allowable as a
75.21 federal tax deduction under the Internal Revenue Code.

75.22 (1) A spouse who requests a variance from a notice of an increase in the amount
75.23 of spousal contribution shall continue to make monthly payments at the lower amount
75.24 pending determination of the variance request. A spouse who requests a variance from
75.25 the initial determination shall not be required to make a payment pending determination
75.26 of the variance request. Payments made pending outcome of the variance request that
75.27 result in overpayment must be returned to the spouse, if the community spouse is no
75.28 longer receiving services, or applied to the spousal contribution in the current year. If the
75.29 variance is denied, the spouse shall pay the additional amount due from the effective date
75.30 of the increase or the total amount due from the effective date of the original notice of
75.31 determination of the spousal contribution.

75.32 (2) A spouse who is granted a variance shall sign a written agreement in which the
75.33 spouse agrees to report to the county or tribal agency any changes in circumstances that
75.34 gave rise to the undue hardship variance.

75.35 (3) When the county or tribal agency receives a request for a variance, written notice
75.36 of a grant or denial of the variance shall be mailed to the spouse within 30 calendar days

76.1 after the county or tribal agency receives the financial information required in this clause.
76.2 The granting of a variance will necessitate a written agreement between the spouse and the
76.3 county or tribal agency with regard to the specific terms of the variance. The variance
76.4 will not become effective until the written agreement is signed by the spouse. If the
76.5 county or tribal agency denies in whole or in part the request for a variance, the denial
76.6 notice shall set forth in writing the reasons for the denial that address the specific hardship
76.7 and right to appeal.

76.8 (4) If a variance is granted, the term of the variance shall not exceed 12 months
76.9 unless otherwise determined by the county or tribal agency.

76.10 (5) Undue hardship does not include action taken by a spouse which divested or
76.11 diverted income in order to avoid being assessed a spousal contribution.

76.12 (l) A spouse aggrieved by an action under this subdivision has the right to appeal
76.13 under subdivision 4. If the spouse appeals on or before the effective date of an increase
76.14 in the spousal fee, the spouse shall continue to make payments to the county or tribal
76.15 agency in the lower amount while the appeal is pending. A spouse appealing an initial
76.16 determination of a spousal contribution shall not be required to make monthly payments
76.17 pending an appeal decision. Payments made that result in an overpayment shall be
76.18 reimbursed to the spouse if the long-term care spouse is no longer receiving services, or
76.19 applied to the spousal contribution remaining in the current year. If the commissioner's
76.20 determination is affirmed, the community spouse shall pay within 90 calendar days of the
76.21 order the total amount due from the effective date of the original notice of determination
76.22 of the spousal contribution. The commissioner's order is binding on the spouse and the
76.23 agency and shall be implemented subject to section 256.045, subdivision 7. No additional
76.24 notice is required to enforce the commissioner's order.

76.25 (m) If the county or tribal agency finds that notice of the payment obligation was
76.26 given to the community spouse and the spouse was determined to be able to pay, but that
76.27 the spouse failed or refused to pay, a cause of action exists against the community spouse
76.28 for that portion of medical assistance payment of long-term care services or alternative
76.29 care services granted after notice was given to the community spouse. The action may be
76.30 brought by the county or tribal agency in the county where assistance was granted for the
76.31 assistance together with the costs of disbursements incurred due to the action. In addition
76.32 to granting the county or tribal agency a money judgment, the court may, upon a motion or
76.33 order to show cause, order continuing contributions by a community spouse found able to
76.34 repay the county or tribal agency. The order shall be effective only for the period of time
76.35 during which a contribution shall be assessed.

77.1 (n) Counties and tribes are entitled to one-half of the nonfederal share of
77.2 contributions made under this section for long-term care spouses on medical assistance
77.3 that are directly attributed to county or tribal efforts. Counties and tribes are entitled to
77.4 25 percent of the contributions made under this section for long-term care spouses on
77.5 alternative care directly attributed to county or tribal efforts.

77.6 Sec. 7. Minnesota Statutes 2010, section 326B.175, is amended to read:

77.7 **326B.175 ELEVATORS, ENTRANCES SEALED.**

77.8 Except as provided in section 326B.188, it shall be the duty of the department and
77.9 the licensing authority of any municipality which adopts any such ordinance whenever
77.10 it finds any such elevator under its jurisdiction in use in violation of any provision of
77.11 sections 326B.163 to 326B.178 to seal the entrances of such elevator and attach a notice
77.12 forbidding the use of such elevator until the provisions thereof are complied with.

77.13 Sec. 8. **[326B.188] COMPLIANCE WITH ELEVATOR CODE CHANGES.**

77.14 (a) This section applies to code requirements for existing elevators and related
77.15 devices under Minnesota Rules, chapter 1307, where the deadline set by law for meeting
77.16 the code requirements is January 29, 2012, or later.

77.17 (b) If the department or municipality conducting elevator inspections within its
77.18 jurisdiction notifies the owner of an existing elevator or related device of the code
77.19 requirements before the effective date of this section, the owner may submit a compliance
77.20 plan by December 30, 2011. If the department or municipality does not notify the owner
77.21 of an existing elevator or related device of the code requirements before the effective
77.22 date of this section, the department or municipality shall notify the owner of the code
77.23 requirements and permit the owner to submit a compliance plan by December 30, 2011, or
77.24 within 60 days after the date of notification, whichever is later.

77.25 (c) Any compliance plan submitted under this section must result in compliance with
77.26 the code requirements by the later of January 29, 2012, or three years after submission of
77.27 the compliance plan. Elevators and related devices that are not in compliance with the
77.28 code requirements by the later of January 29, 2012, or three years after the submission of
77.29 the compliance plan may be taken out of service as provided in section 326B.175.

77.30 Sec. 9. **DEVELOPMENTAL DISABILITY WAIVERED SERVICES.**

77.31 Subdivision 1. **Purpose.** All individuals in the state of Minnesota who are eligible
77.32 for developmental disability waived services are entitled to receive adequate services,

within the limits of available funding, to ensure their basic needs for housing, food, health, and safety are met.

Subd. 2. **Instructions to commissioner.** (a) No later than November 1, 2011, the commissioner of human services shall convene a workgroup to define the essential services required to adequately meet the needs of individuals who receive developmental disability waived services. The commissioner shall identify the essential services in each of the following tiers:

(1) tier 1, services and costs associated with safety, food, housing, and health care;

(2) tier 2, services and costs associated with enhancements toward self-sufficiency; and

(3) tier 3, services and costs associated with quality of life improvements.

(b) The commissioner, or designee, and a representative designated by the counties shall cochair the workgroup. The workgroup shall consider Tier 1 services to be the most important and of highest priority for available funds, and may choose to implement a policy that all waiver-eligible individuals receive Tier 1 services within the limits of available funding before services from Tier 2 or 3 are offered to waiver-eligible individuals.

Sec. 10. ANALYSIS OF PROGRAMS AND THEIR EFFECT ON MARRIAGES; REPORT.

(a) The commissioner of human services shall conduct an analysis of how current human services programs affect the motivation and capacity of individuals to form and sustain marriages in which to raise children. Programs to be examined in this marriage impact analysis may include, but are not limited to, medical assistance, MinnesotaCare, Minnesota family investment program, child protection, child support enforcement, and child welfare services.

(b) Before January 1, 2012, the commissioner shall submit a report to the legislature describing the results of this analysis and outline proposals to improve the ability of human services programs to help people who are interested in marriage to form and sustain marriages in which to raise children. The commissioner shall ensure that experts on marriage are consulted on the process of conducting the analysis and writing the report.

Sec. 11. LEGISLATIVE APPROVAL FOR FEDERAL FUNDS.

In addition to the requirements of Minnesota Statutes, section 3.3005, the commissioners of human services and health shall not expend any funding received through federal grants or subsequent renewal of federal grants without the approval of

79.1 three of the four chairs and ranking minority members of the legislative committees with
79.2 jurisdiction over health and human services finance.

79.3 Sec. 12. **NONEMERGENCY MEDICAL TRANSPORTATION SINGLE**
79.4 **ADMINISTRATIVE STRUCTURE PROPOSAL.**

79.5 (a) The commissioner of human services shall develop a proposal to create a single
79.6 administrative structure for providing nonemergency medical transportation services to
79.7 fee-for-service medical assistance recipients. This proposal must consolidate access and
79.8 special transportation into one administrative structure with the goal of standardizing
79.9 eligibility determination processes, scheduling arrangements, billing procedures, data
79.10 collection, and oversight mechanisms in order to enhance coordination, improve
79.11 accountability, and lessen confusion.

79.12 (b) In developing the proposal, the commissioner shall:

79.13 (1) examine the current responsibilities performed by the counties and the
79.14 Department of Human Services and consider the shift in costs if these responsibilities are
79.15 changed;

79.16 (2) identify key performance measures to assess the cost effectiveness of
79.17 nonemergency medical transportation statewide, including a process to collect, audit,
79.18 and report data;

79.19 (3) develop a statewide complaint system for medical assistance recipients using
79.20 special transportation;

79.21 (4) establish a standardized billing process;

79.22 (5) establish a process that provides public input from interested parties before
79.23 special transportation eligibility policies are implemented or significantly changed;

79.24 (6) establish specific eligibility criteria that include the frequency of eligibility
79.25 assessments and the length of time a recipient remains eligible for special transportation;

79.26 (7) develop a reimbursement method to compensate volunteers for no-load miles
79.27 when transporting recipients to or from health-related appointments; and

79.28 (8) establish specific eligibility criteria to maximize the use of public transportation
79.29 by recipients who are without a physical, mental, or other impairment that would prohibit
79.30 safely accessing and using public transportation.

79.31 (c) In developing the proposal, the commissioner shall consult with the
79.32 nonemergency medical transportation advisory council established under paragraph (d).

79.33 (d) The commissioner shall establish the nonemergency medical transportation
79.34 advisory council to assist the commissioner in developing a single administrative structure

80.1 for providing nonemergency medical transportation services. The council shall be
80.2 comprised of:

80.3 (1) one representative each from the departments of human services and
80.4 transportation;

80.5 (2) one representative each from the following organizations: the Minnesota State
80.6 Council on Disability, the Minnesota Consortium for Citizens with Disabilities, ARC of
80.7 Minnesota, the Association of Minnesota Counties, the R-80 Medical Transportation
80.8 Coalition, the Minnesota Para Transit Association, Legal Aid, the Minnesota Ambulance
80.9 Association, the National Alliance on Mental Illness, the Minnesota Transportation
80.10 Providers Alliance, and the Minnesota Inter-County Association; and

80.11 (3) four members from the house of representatives, two from the majority party
80.12 and two from the minority party, appointed by the speaker, and four members from the
80.13 senate, two from the majority party and two from the minority party, appointed by the
80.14 Subcommittee on Committees of the Committee on Rules and Administration.

80.15 The council is governed by Minnesota Statutes, section 15.509, except that members
80.16 shall not receive per diems. The commissioner of human services shall fund all costs
80.17 related to the council from existing resources.

80.18 (e) The commissioner shall submit the proposal and draft legislation necessary for
80.19 implementation to the chairs and ranking minority members of the senate and house of
80.20 representatives committees or divisions with jurisdiction over health care policy and
80.21 finance by January 15, 2012.

80.22 Sec. 13. **RECOVERY FROM BROKER.**

80.23 (a) If deemed appropriate after a review by the Attorney General's office, the
80.24 commissioner of human services, in cooperation with the commissioner of management
80.25 and budget, shall recover from any broker of nonemergency medical transportation
80.26 services all administrative amounts paid in excess of the original agreed upon amount as
80.27 stated in any contract or compensation agreement that provided for the total compensation
80.28 for administrative services in each state fiscal year to not exceed a specific agreed amount
80.29 for fiscal years 2005, 2006, 2007, 2008, 2009, and 2010.

80.30 (b) Recoveries under this section shall be based on the findings of the Office of
80.31 Legislative Auditor's report on medical nonemergency transportation released in February
80.32 2011.

ARTICLE 4

HEALTH LICENSING FEES

Section 1. Minnesota Statutes 2010, section 148.07, subdivision 1, is amended to read:

Subdivision 1. **Renewal fees.** All persons practicing chiropractic within this state, or licensed so to do, shall pay, on or before the date of expiration of their licenses, to the Board of Chiropractic Examiners a renewal fee set ~~by the board~~ in accordance with section 16A.1283, with a penalty ~~set by the board~~ for each month or portion thereof for which a license fee is in arrears and upon payment of the renewal and upon compliance with all the rules of the board, shall be entitled to renewal of their license.

Sec. 2. Minnesota Statutes 2010, section 148.108, is amended by adding a subdivision to read:

- Subd. 4. **Animal chiropractic.** (a) Animal chiropractic registration fee is \$125.
(b) Animal chiropractic registration renewal fee is \$75.
(c) Animal chiropractic inactive renewal fee is \$25.

Sec. 3. Minnesota Statutes 2010, section 148.191, subdivision 2, is amended to read:

Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine, license, and renew the license of duly qualified applicants. It shall hold examinations at least once in each year at such time and place as it may determine. It shall by rule 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~~

82.1 ~~health nurses.~~ It shall have power to issue subpoenas, and to compel the attendance of
82.2 witnesses and the production of all necessary documents and other evidentiary material.
82.3 Any board member may administer oaths to witnesses, or take their affirmation. It shall
82.4 keep a record of all its proceedings.

82.5 (b) The board shall have access to hospital, nursing home, and other medical records
82.6 of a patient cared for by a nurse under review. If the board does not have a written consent
82.7 from a patient permitting access to the patient's records, the nurse or facility shall delete
82.8 any data in the record that identifies the patient before providing it to the board. The board
82.9 shall have access to such other records as reasonably requested by the board to assist the
82.10 board in its investigation. Nothing herein may be construed to allow access to any records
82.11 protected by section 145.64. The board shall maintain any records obtained pursuant to
82.12 this paragraph as investigative data under chapter 13.

82.13 (c) The board may accept and expend grants or gifts of money or in-kind services
82.14 from a person, a public or private entity, or any other source for purposes consistent with
82.15 the board's role and within the scope of its statutory authority.

82.16 (d) The board may accept registration fees for meetings and conferences conducted
82.17 for the purposes of board activities that are within the scope of its authority.

82.18 Sec. 4. Minnesota Statutes 2010, section 148.212, subdivision 1, is amended to read:

82.19 Subdivision 1. **Issuance.** Upon receipt of the applicable licensure or reregistration
82.20 fee and permit fee, and in accordance with rules of the board, the board may issue
82.21 a nonrenewable temporary permit to practice professional or practical nursing to an
82.22 applicant for licensure or reregistration who is not the subject of a pending investigation
82.23 or disciplinary action, nor disqualified for any other reason, under the following
82.24 circumstances:

82.25 (a) ~~The applicant for licensure by examination under section 148.211, subdivision~~
82.26 ~~1, has graduated from an approved nursing program within the 60 days preceding board~~
82.27 ~~receipt of an affidavit of graduation or transcript and has been authorized by the board to~~
82.28 ~~write the licensure examination for the first time in the United States. The permit holder~~
82.29 ~~must practice professional or practical nursing under the direct supervision of a registered~~
82.30 ~~nurse. The permit is valid from the date of issue until the date the board takes action on~~
82.31 ~~the application or for 60 days whichever occurs first.~~

82.32 (b) The applicant for licensure by endorsement under section 148.211, subdivision 2,
82.33 is currently licensed to practice professional or practical nursing in another state, territory,
82.34 or Canadian province. The permit is valid ~~from submission of a proper request~~ until the
82.35 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~~

84.1 registration ~~certificate~~ shall be issued to the person who shall immediately be placed on
84.2 the practicing list as a registered nurse or licensed practical nurse.

84.3 Subd. 6. **Verification.** A person licensed under the provisions of sections 148.171 to
84.4 148.285 who requests the board to verify a Minnesota license to another state, territory,
84.5 or country or to an agency, facility, school, or institution shall pay a fee ~~to the board~~
84.6 for each verification.

84.7 Sec. 6. **[148.242] FEES.**

84.8 The fees specified in section 148.243 are nonrefundable and must be deposited in
84.9 the state government special revenue fund.

84.10 Sec. 7. **[148.243] FEE AMOUNTS.**

84.11 Subdivision 1. **Licensure by examination.** The fee for licensure by examination is
84.12 \$105.

84.13 Subd. 2. **Reexamination fee.** The reexamination fee is \$60.

84.14 Subd. 3. **Licensure by endorsement.** The fee for licensure by endorsement is \$105.

84.15 Subd. 4. **Registration renewal.** The fee for registration renewal is \$85.

84.16 Subd. 5. **Reregistration.** The fee for reregistration is \$105.

84.17 Subd. 6. **Replacement license.** The fee for a replacement license is \$20.

84.18 Subd. 7. **Public health nurse certification.** The fee for public health nurse
84.19 certification is \$30.

84.20 Subd. 8. **Drug Enforcement Administration verification for Advanced Practice**
84.21 **Registered Nurse (APRN).** The Drug Enforcement Administration verification for
84.22 APRN is \$50.

84.23 Subd. 9. **Licensure verification other than through Nursys.** The fee for
84.24 verification of licensure status other than through Nursys verification is \$20.

84.25 Subd. 10. **Verification of examination scores.** The fee for verification of
84.26 examination scores is \$20.

84.27 Subd. 11. **Microfilmed licensure application materials.** The fee for a copy of
84.28 microfilmed licensure application materials is \$20.

84.29 Subd. 12. **Nursing business registration; initial application.** The fee for the initial
84.30 application for nursing business registration is \$100.

84.31 Subd. 13. **Nursing business registration; annual application.** The fee for the
84.32 annual application for nursing business registration is \$25.

84.33 Subd. 14. **Practicing without current registration.** The fee for practicing without
84.34 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;

(6) application fee for LMFT licensure by reciprocity is \$340;

(7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license is \$75;

(8) annual renewal fee for LAMFT license is \$75;

(9) late fee for LAMFT renewal is \$50;

(10) fee for reinstatement of license is \$150; and

(11) fee for emeritus status is \$125.

Subd. 3. **Other fees.** Other fees charged by the board are as follows:

- 86.1 (1) sponsor application fee for approval of a continuing education course is \$60;
86.2 (2) fee for license verification by mail is \$10;
86.3 (3) duplicate license fee is \$25;
86.4 (4) duplicate renewal card fee is \$10;
86.5 (5) fee for licensee mailing list is \$60;
86.6 (6) fee for a rule book is \$10; and
86.7 (7) fees as authorized by section 148B.175, subdivision 6, clause (7).

86.8 Sec. 9. Minnesota Statutes 2010, section 148B.33, subdivision 2, is amended to read:

86.9 Subd. 2. **Fee.** Each applicant shall pay a nonrefundable application fee ~~set by~~
86.10 ~~the board~~ under section 148B.17.

86.11 Sec. 10. Minnesota Statutes 2010, section 148B.52, is amended to read:

86.12 **148B.52 DUTIES OF THE BOARD.**

86.13 (a) The Board of Behavioral Health and Therapy shall:

86.14 (1) establish by rule appropriate techniques, including examinations and other
86.15 methods, for determining whether applicants and licensees are qualified under sections
86.16 148B.50 to 148B.593;

86.17 (2) establish by rule standards for professional conduct, including adoption of a
86.18 Code of Professional Ethics and requirements for continuing education and supervision;

86.19 (3) issue licenses to individuals qualified under sections 148B.50 to 148B.593;

86.20 (4) establish by rule standards for initial education including coursework for
86.21 licensure and content of professional education;

86.22 (5) establish, maintain, and publish annually a register of current licensees and
86.23 approved supervisors;

86.24 (6) establish initial and renewal application and examination fees sufficient to cover
86.25 operating expenses of the board and its agents in accordance with section 16A.1283;

86.26 (7) educate the public about the existence and content of the laws and rules for
86.27 licensed professional counselors to enable consumers to file complaints against licensees
86.28 who may have violated the rules; and

86.29 (8) periodically evaluate its rules in order to refine the standards for licensing
86.30 professional counselors and to improve the methods used to enforce the board's standards.

86.31 (b) The board may appoint a professional discipline committee for each occupational
86.32 licensure regulated by the board, and may appoint a board member as chair. The
86.33 professional discipline committee shall consist of five members representative of the

87.1 licensed occupation and shall provide recommendations to the board with regard to rule
87.2 techniques, standards, procedures, and related issues specific to the licensed occupation.

87.3 Sec. 11. Minnesota Statutes 2010, section 150A.091, subdivision 2, is amended to read:

87.4 Subd. 2. **Application fees.** Each applicant shall submit with a license, advanced
87.5 dental therapist certificate, or permit application a nonrefundable fee in the following
87.6 amounts in order to administratively process an application:

- 87.7 (1) dentist, \$140;
87.8 (2) full faculty dentist, \$140;
87.9 ~~(2)~~ (3) limited faculty dentist, \$140;
87.10 ~~(3)~~ (4) resident dentist or dental provider, \$55;
87.11 (5) advanced dental therapist, \$100;
87.12 ~~(4)~~ (6) dental therapist, \$100;
87.13 ~~(5)~~ (7) dental hygienist, \$55;
87.14 ~~(6)~~ (8) licensed dental assistant, \$55; and
87.15 ~~(7)~~ (9) dental assistant with a permit as described in Minnesota Rules, part
87.16 3100.8500, subpart 3, \$15.

87.17 Sec. 12. Minnesota Statutes 2010, section 150A.091, subdivision 3, is amended to read:

87.18 Subd. 3. **Initial license or permit fees.** Along with the application fee, each of the
87.19 following applicants shall submit a separate prorated initial license or permit fee. The
87.20 prorated initial fee shall be established by the board based on the number of months of the
87.21 applicant's initial term as described in Minnesota Rules, part 3100.1700, subpart 1a, not to
87.22 exceed the following monthly fee amounts:

- 87.23 (1) dentist or full faculty dentist, \$14 times the number of months of the initial term;
87.24 (2) dental therapist, \$10 times the number of months of the initial term;
87.25 (3) dental hygienist, \$5 times the number of months of the initial term;
87.26 (4) licensed dental assistant, \$3 times the number of months of the initial term; and
87.27 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,
87.28 subpart 3, \$1 times the number of months of the initial term.

87.29 Sec. 13. Minnesota Statutes 2010, section 150A.091, subdivision 4, is amended to read:

87.30 Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit
87.31 with an annual license renewal application a fee established by the board not to exceed
87.32 the following amounts:

- 87.33 (1) limited faculty dentist, \$168; and

88.1 (2) resident dentist or dental provider, \$59.

88.2 Sec. 14. Minnesota Statutes 2010, section 150A.091, subdivision 5, is amended to read:

88.3 Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall
88.4 submit with a biennial license or permit renewal application a fee as established by the
88.5 board, not to exceed the following amounts:

88.6 (1) dentist or full faculty dentist, \$336;

88.7 (2) dental therapist, \$180;

88.8 (3) dental hygienist, \$118;

88.9 (4) licensed dental assistant, \$80; and

88.10 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,
88.11 subpart 3, \$24.

88.12 Sec. 15. Minnesota Statutes 2010, section 150A.091, subdivision 8, is amended to read:

88.13 Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with
88.14 a request for issuance of a duplicate of the original license, or of an annual or biennial
88.15 renewal certificate for a license or permit, a fee in the following amounts:

88.16 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental
88.17 assistant license, \$35; and

88.18 (2) annual or biennial renewal certificates, \$10.

88.19 Sec. 16. Minnesota Statutes 2010, section 150A.091, is amended by adding a
88.20 subdivision to read:

88.21 Subd. 16. **Failure of professional development portfolio audit.** A licensee shall
88.22 submit a fee as established by the board not to exceed the amount of \$250 after failing
88.23 two consecutive professional development portfolio audits and, thereafter, for each failed
88.24 professional development portfolio audit under Minnesota Rules, part 3100.5300.

88.25 Sec. 17. **[151.065] FEE AMOUNTS.**

88.26 Subdivision 1. **Application fees.** Application fees for licensure and registration
88.27 are as follows:

88.28 (1) pharmacist licensed by examination, \$130;

88.29 (2) pharmacist licensed by reciprocity, \$225;

88.30 (3) pharmacy intern, \$30;

88.31 (4) pharmacy technician, \$30;

88.32 (5) pharmacy, \$190;

- 89.1 (6) drug wholesaler, legend drugs only, \$200;
- 89.2 (7) drug wholesaler, legend and nonlegend drugs, \$200;
- 89.3 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;
- 89.4 (9) drug wholesaler, medical gases, \$150;
- 89.5 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;
- 89.6 (11) drug manufacturer, legend drugs only, \$200;
- 89.7 (12) drug manufacturer, legend and nonlegend drugs, \$200;
- 89.8 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$175;
- 89.9 (14) drug manufacturer, medical gases, \$150;
- 89.10 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;
- 89.11 (16) medical gas distributor, \$75;
- 89.12 (17) controlled substance researcher, \$50; and
- 89.13 (18) pharmacy professional corporation, \$100.
- 89.14 Subd. 2. **Original license fee.** The pharmacist original licensure fee, \$130.
- 89.15 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees
- 89.16 are as follows:
- 89.17 (1) pharmacist, \$130;
- 89.18 (2) pharmacy technician, \$30;
- 89.19 (3) pharmacy, \$190;
- 89.20 (4) drug wholesaler, legend drugs only, \$200;
- 89.21 (5) drug wholesaler, legend and nonlegend drugs, \$200;
- 89.22 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;
- 89.23 (7) drug wholesaler, medical gases, \$150;
- 89.24 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;
- 89.25 (9) drug manufacturer, legend drugs only, \$200;
- 89.26 (10) drug manufacturer, legend and nonlegend drugs, \$200;
- 89.27 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$175;
- 89.28 (12) drug manufacturer, medical gases, \$150;
- 89.29 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;
- 89.30 (14) medical gas distributor, \$75;
- 89.31 (15) controlled substance researcher, \$50; and
- 89.32 (16) pharmacy professional corporation, \$45.
- 89.33 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses
- 89.34 and certificates are as follows:
- 89.35 (1) intern affidavit, \$15;
- 89.36 (2) duplicate small license, \$15; and

90.1 (3) duplicate large certificate, \$25.

90.2 Subd. 5. **Late fees.** All annual renewal fees are subject to a 50 percent late fee if
90.3 the renewal fee and application are not received by the board prior to the date specified
90.4 by the board.

90.5 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's
90.6 license to lapse may reinstate the license with board approval and upon payment of any
90.7 fees and late fees in arrears, up to a maximum of \$1,000.

90.8 (b) A pharmacy technician who has allowed the technician's registration to lapse
90.9 may reinstate the registration with board approval and upon payment of any fees and late
90.10 fees in arrears, up to a maximum of \$90.

90.11 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical
90.12 gas distributor who has allowed the license of the establishment to lapse may reinstate the
90.13 license with board approval and upon payment of any fees and late fees in arrears.

90.14 (d) A controlled substance researcher who has allowed the researcher's registration
90.15 to lapse may reinstate the registration with board approval and upon payment of any fees
90.16 and late fees in arrears.

90.17 (e) A pharmacist owner of a professional corporation who has allowed the
90.18 corporation's registration to lapse may reinstate the registration with board approval and
90.19 upon payment of any fees and late fees in arrears.

90.20 Sec. 18. Minnesota Statutes 2010, section 151.07, is amended to read:

90.21 **151.07 MEETINGS; EXAMINATION FEE.**

90.22 The board shall meet at times as may be necessary and as it may determine to
90.23 examine applicants for licensure and to transact its other business, giving reasonable
90.24 notice of all examinations by mail to known applicants therefor. The secretary shall record
90.25 the names of all persons licensed by the board, together with the grounds upon which
90.26 the right of each to licensure was claimed. The fee for examination shall be in ~~such the~~
90.27 ~~amount as the board may determine~~ specified in section 151.065, which fee may in the
90.28 discretion of the board be returned to applicants not taking the examination.

90.29 Sec. 19. Minnesota Statutes 2010, section 151.101, is amended to read:

90.30 **151.101 INTERNSHIP.**

90.31 Upon payment of the fee specified in section 151.065, the board may ~~license~~ register
90.32 as an intern any natural persons who have satisfied the board that they are of good moral
90.33 character, not physically or mentally unfit, and who have successfully completed the
90.34 educational requirements for intern ~~licensure~~ registration prescribed by the board. The

91.1 board shall prescribe standards and requirements for interns, pharmacist-preceptors, and
91.2 internship training but may not require more than one year of such training.

91.3 The board in its discretion may accept internship experience obtained in another
91.4 state provided the internship requirements in such other state are in the opinion of the
91.5 board equivalent to those herein provided.

91.6 Sec. 20. Minnesota Statutes 2010, section 151.102, is amended by adding a subdivision
91.7 to read:

91.8 Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy
91.9 technician unless all applicable fees specified in section 151.065 have been paid.

91.10 Sec. 21. Minnesota Statutes 2010, section 151.12, is amended to read:

91.11 **151.12 RECIPROCITY; LICENSURE.**

91.12 The board may in its discretion grant licensure without examination to any
91.13 pharmacist licensed by the Board of Pharmacy or a similar board of another state which
91.14 accords similar recognition to licensees of this state; provided, the requirements for
91.15 licensure in such other state are in the opinion of the board equivalent to those herein
91.16 provided. The fee for licensure shall be in ~~such the amount as the board may determine by~~
91.17 rule specified in section 151.065.

91.18 Sec. 22. Minnesota Statutes 2010, section 151.13, subdivision 1, is amended to read:

91.19 Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist
91.20 shall pay to the board a the annual renewal fee to be fixed by it specified in section
91.21 151.065. The board may promulgate by rule a charge to be assessed for the delinquent
91.22 payment of a fee; the late fee specified in section 151.065 if the renewal fee and
91.23 application are not received by the board prior to the date specified by the board. It shall
91.24 be unlawful for any person licensed as a pharmacist who refuses or fails to pay ~~such any~~
91.25 applicable renewal or late fee to practice pharmacy in this state. Every certificate and
91.26 license shall expire at the time therein prescribed.

91.27 Sec. 23. Minnesota Statutes 2010, section 151.19, is amended to read:

91.28 **151.19 REGISTRATION; FEES.**

91.29 Subdivision 1. **Pharmacy registration.** The board shall require and provide for the
91.30 annual registration of every pharmacy now or hereafter doing business within this state.
91.31 Upon the payment of ~~a any applicable fee to be set by the board~~ specified in section
91.32 151.065, the board shall issue a registration certificate in such form as it may prescribe to

92.1 such persons as may be qualified by law to conduct a pharmacy. Such certificate shall be
92.2 displayed in a conspicuous place in the pharmacy for which it is issued and expire on the
92.3 30th day of June following the date of issue. It shall be unlawful for any person to conduct
92.4 a pharmacy unless such certificate has been issued to the person by the board.

92.5 Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an
92.6 annual nonresident special pharmacy registration for all pharmacies located outside of this
92.7 state that regularly dispense medications for Minnesota residents and mail, ship, or deliver
92.8 prescription medications into this state. Nonresident special pharmacy registration shall
92.9 be granted by the board upon payment of any applicable fee specified in section 151.065
92.10 and the disclosure and certification by a pharmacy:

92.11 (1) that it is licensed in the state in which the dispensing facility is located and from
92.12 which the drugs are dispensed;

92.13 (2) the location, names, and titles of all principal corporate officers and all
92.14 pharmacists who are dispensing drugs to residents of this state;

92.15 (3) that it complies with all lawful directions and requests for information from
92.16 the Board of Pharmacy of all states in which it is licensed or registered, except that it
92.17 shall respond directly to all communications from the board concerning emergency
92.18 circumstances arising from the dispensing of drugs to residents of this state;

92.19 (4) that it maintains its records of drugs dispensed to residents of this state so that the
92.20 records are readily retrievable from the records of other drugs dispensed;

92.21 (5) that it cooperates with the board in providing information to the Board of
92.22 Pharmacy of the state in which it is licensed concerning matters related to the dispensing
92.23 of drugs to residents of this state;

92.24 (6) that during its regular hours of operation, but not less than six days per week, for
92.25 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
92.26 communication between patients in this state and a pharmacist at the pharmacy who has
92.27 access to the patients' records; the toll-free number must be disclosed on the label affixed
92.28 to each container of drugs dispensed to residents of this state; and

92.29 (7) that, upon request of a resident of a long-term care facility located within the
92.30 state of Minnesota, the resident's authorized representative, or a contract pharmacy or
92.31 licensed health care facility acting on behalf of the resident, the pharmacy will dispense
92.32 medications prescribed for the resident in unit-dose packaging or, alternatively, comply
92.33 with the provisions of section 151.415, subdivision 5.

92.34 Subd. 3. **Sale of federally restricted medical gases.** The board shall require and
92.35 provide for the annual registration of every person or establishment not licensed as a
92.36 pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted

93.1 medical gases. Upon the payment of ~~a~~ any applicable fee to be set by the board specified
93.2 in section 151.065, the board shall issue a registration certificate in such form as it may
93.3 prescribe to those persons or places that may be qualified to sell or distribute federally
93.4 restricted medical gases. The certificate shall be displayed in a conspicuous place in the
93.5 business for which it is issued and expire on the date set by the board. It is unlawful for
93.6 a person to sell or distribute federally restricted medical gases unless a certificate has
93.7 been issued to that person by the board.

93.8 Sec. 24. Minnesota Statutes 2010, section 151.25, is amended to read:

93.9 **151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.**

93.10 The board shall require and provide for the annual registration of every person
93.11 engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes,
93.12 now or hereafter doing business with accounts in this state. Upon a payment of ~~a~~ any
93.13 applicable fee as set by the board specified in section 151.065, the board shall issue a
93.14 registration certificate in such form as it may prescribe to such manufacturer. Such
93.15 registration certificate shall be displayed in a conspicuous place in such manufacturer's
93.16 or wholesaler's place of business for which it is issued and expire on the date set by the
93.17 board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals,
93.18 or poisons for medicinal purposes unless such a certificate has been issued to the person
93.19 by the board. It shall be unlawful for any person engaged in the manufacture of drugs,
93.20 medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell
93.21 legend drugs to other than a pharmacy, except as provided in this chapter.

93.22 Sec. 25. Minnesota Statutes 2010, section 151.47, subdivision 1, is amended to read:

93.23 Subdivision 1. **Requirements.** All wholesale drug distributors are subject to the
93.24 requirements in paragraphs (a) to (f).

93.25 (a) No person or distribution outlet shall act as a wholesale drug distributor without
93.26 first obtaining a license from the board and paying ~~the required~~ any applicable fee
93.27 specified in section 151.065.

93.28 (b) No license shall be issued or renewed for a wholesale drug distributor to operate
93.29 unless the applicant agrees to operate in a manner prescribed by federal and state law and
93.30 according to the rules adopted by the board.

93.31 (c) The board may require a separate license for each facility directly or indirectly
93.32 owned or operated by the same business entity within the state, or for a parent entity
93.33 with divisions, subsidiaries, or affiliate companies within the state, when operations

94.1 are conducted at more than one location and joint ownership and control exists among
94.2 all the entities.

94.3 (d) As a condition for receiving and retaining a wholesale drug distributor license
94.4 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has
94.5 and will continuously maintain:

94.6 (1) adequate storage conditions and facilities;

94.7 (2) minimum liability and other insurance as may be required under any applicable
94.8 federal or state law;

94.9 (3) a viable security system that includes an after hours central alarm, or comparable
94.10 entry detection capability; restricted access to the premises; comprehensive employment
94.11 applicant screening; and safeguards against all forms of employee theft;

94.12 (4) a system of records describing all wholesale drug distributor activities set forth
94.13 in section 151.44 for at least the most recent two-year period, which shall be reasonably
94.14 accessible as defined by board regulations in any inspection authorized by the board;

94.15 (5) principals and persons, including officers, directors, primary shareholders,
94.16 and key management executives, who must at all times demonstrate and maintain their
94.17 capability of conducting business in conformity with sound financial practices as well
94.18 as state and federal law;

94.19 (6) complete, updated information, to be provided to the board as a condition for
94.20 obtaining and retaining a license, about each wholesale drug distributor to be licensed,
94.21 including all pertinent corporate licensee information, if applicable, or other ownership,
94.22 principal, key personnel, and facilities information found to be necessary by the board;

94.23 (7) written policies and procedures that assure reasonable wholesale drug distributor
94.24 preparation for, protection against, and handling of any facility security or operation
94.25 problems, including, but not limited to, those caused by natural disaster or government
94.26 emergency, inventory inaccuracies or product shipping and receiving, outdated product
94.27 or other unauthorized product control, appropriate disposition of returned goods, and
94.28 product recalls;

94.29 (8) sufficient inspection procedures for all incoming and outgoing product
94.30 shipments; and

94.31 (9) operations in compliance with all federal requirements applicable to wholesale
94.32 drug distribution.

94.33 (e) An agent or employee of any licensed wholesale drug distributor need not seek
94.34 licensure under this section.

94.35 (f) A wholesale drug distributor shall file with the board an annual report, in a
94.36 form and on the date prescribed by the board, identifying all payments, honoraria,

95.1 reimbursement or other compensation authorized under section 151.461, clauses (3) to
95.2 (5), paid to practitioners in Minnesota during the preceding calendar year. The report
95.3 shall identify the nature and value of any payments totaling \$100 or more, to a particular
95.4 practitioner during the year, and shall identify the practitioner. Reports filed under this
95.5 provision are public data.

95.6 Sec. 26. Minnesota Statutes 2010, section 151.48, is amended to read:

95.7 **151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.**

95.8 (a) It is unlawful for an out-of-state wholesale drug distributor to conduct business
95.9 in the state without first obtaining a license from the board and paying ~~the required~~ any
95.10 applicable fee specified in section 151.065.

95.11 (b) Application for an out-of-state wholesale drug distributor license under this
95.12 section shall be made on a form furnished by the board.

95.13 (c) No person acting as principal or agent for any out-of-state wholesale drug
95.14 distributor may sell or distribute drugs in the state unless the distributor has obtained
95.15 a license.

95.16 (d) The board may adopt regulations that permit out-of-state wholesale drug
95.17 distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state
95.18 wholesale drug distributor:

95.19 (1) possesses a valid license granted by another state under legal standards
95.20 comparable to those that must be met by a wholesale drug distributor of this state as
95.21 prerequisites for obtaining a license under the laws of this state; and

95.22 (2) can show that the other state would extend reciprocal treatment under its own
95.23 laws to a wholesale drug distributor of this state.

95.24 Sec. 27. Minnesota Statutes 2010, section 152.12, subdivision 3, is amended to read:

95.25 Subd. 3. **Research project use of controlled substances.** Any qualified person
95.26 may use controlled substances in the course of a bona fide research project but cannot
95.27 administer or dispense such drugs to human beings unless such drugs are prescribed,
95.28 dispensed and administered by a person lawfully authorized to do so. Every person
95.29 who engages in research involving the use of such substances shall apply annually for
95.30 registration by the state Board of Pharmacy and shall pay any applicable fee specified in
95.31 section 151.065, provided that such registration shall not be required if the person is
95.32 covered by and has complied with federal laws covering such research projects.

ARTICLE 5

HEALTH CARE

Section 1. [1.06] FREEDOM OF CHOICE IN HEALTH CARE ACT.

Subdivision 1. Citation. This section shall be known as and may be cited as the "Freedom of Choice in Health Care Act."

Subd. 2. Definitions. (a) For purposes of this section, the following terms have the meanings given them.

(b) "Health care service" means any service, treatment, or provision of a product for the care of a physical or mental disease, illness, injury, defect, or condition, or to otherwise maintain or improve physical or mental health, subject to all laws and rules regulating health service providers and products within the state of Minnesota.

(c) "Mode of securing" means to purchase directly or on credit or by trade, or to contract for third-party payment by insurance or other legal means as authorized by the state of Minnesota, or to apply for or accept employer-sponsored or government-sponsored health care benefits under such conditions as may legally be required as a condition of such benefits, or any combination of the same.

(d) "Penalty" means any civil or criminal fine, tax, salary or wage withholding, surcharge, fee, or any other imposed consequence established by law or rule of a government or its subdivision or agency that is used to punish or discourage the exercise of rights protected under this section.

Subd. 3. Statement of public policy. (a) The power to require or regulate a person's choice in the mode of securing health care services, or to impose a penalty related to that choice, is not found in the Constitution of the United States of America, and is therefore a power reserved to the people pursuant to the Ninth Amendment, and to the several states pursuant to the Tenth Amendment. The state of Minnesota hereby exercises its sovereign power to declare the public policy of the state of Minnesota regarding the right of all persons residing in the state in choosing the mode of securing health care services.

(b) It is hereby declared that the public policy of the state of Minnesota, consistent with our constitutionally recognized and inalienable rights of liberty, is that every person within the state of Minnesota is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty.

(c) The policy stated under this section shall not be applied to impair any right of contract related to the provision of health care services to any person or group.

Subd. 4. Enforcement. Upon penalty of suspension or revocation of any applicable license, no public official, employee, officer of the court, or agent of the state of

97.1 Minnesota, or any branch or political subdivision thereof, shall act to impose, collect,
97.2 enforce, or effectuate any penalty in the state of Minnesota that violates the public policy
97.3 set forth in this section.

97.4 Sec. 2. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:

97.5 Subdivision 1. **Establishment.** The association shall establish the following
97.6 maximum premiums to be charged for membership in the comprehensive health insurance
97.7 plan:

97.8 (a) the premium for the number one qualified plan shall range from a minimum of
97.9 101 percent to a maximum of 125 percent of the weighted average of rates charged by
97.10 those insurers and health maintenance organizations with individuals enrolled in:

97.11 (1) \$1,000 annual deductible individual plans of insurance in force in Minnesota;

97.12 (2) individual health maintenance organization contracts of coverage with a \$1,000
97.13 annual deductible which are in force in Minnesota; and

97.14 (3) other plans of coverage similar to plans offered by the association based on
97.15 generally accepted actuarial principles;

97.16 (b) the premium for the number two qualified plan shall range from a minimum of
97.17 101 percent to a maximum of 125 percent of the weighted average of rates charged by
97.18 those insurers and health maintenance organizations with individuals enrolled in:

97.19 (1) \$500 annual deductible individual plans of insurance in force in Minnesota;

97.20 (2) individual health maintenance organization contracts of coverage with a \$500
97.21 annual deductible which are in force in Minnesota; and

97.22 (3) other plans of coverage similar to plans offered by the association based on
97.23 generally accepted actuarial principles;

97.24 (c) the premiums for the plans with a \$2,000, \$5,000, or \$10,000 annual deductible
97.25 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted
97.26 average of rates charged by those insurers and health maintenance organizations with
97.27 individuals enrolled in:

97.28 (1) \$2,000, \$5,000, or \$10,000 annual deductible individual plans, respectively, in
97.29 force in Minnesota; and

97.30 (2) individual health maintenance organization contracts of coverage with a \$2,000,
97.31 \$5,000, or \$10,000 annual deductible, respectively, which are in force in Minnesota; or

97.32 (3) other plans of coverage similar to plans offered by the association based on
97.33 generally accepted actuarial principles;

97.34 (d) the premium for each type of Medicare supplement plan required to be offered
97.35 by the association pursuant to section 62E.12 shall range from a minimum of 101 percent

98.1 to a maximum of 125 percent of the weighted average of rates charged by those insurers
98.2 and health maintenance organizations with individuals enrolled in:

98.3 (1) Medicare supplement plans in force in Minnesota;

98.4 (2) health maintenance organization Medicare supplement contracts of coverage
98.5 which are in force in Minnesota; and

98.6 (3) other plans of coverage similar to plans offered by the association based on
98.7 generally accepted actuarial principles; ~~and~~

98.8 (e) the charge for health maintenance organization coverage shall be based on
98.9 generally accepted actuarial principles; and

98.10 (f) the premium for a high-deductible, basic plan offered under section 62E.121 shall
98.11 range from a minimum of 101 percent to a maximum of 125 percent of the weighted
98.12 average of rates charged by those insurers and health maintenance organizations offering
98.13 comparable plans outside of the Minnesota Comprehensive Health Association.

98.14 The list of insurers and health maintenance organizations whose rates are used to
98.15 establish the premium for coverage offered by the association pursuant to paragraphs (a)
98.16 to (d) and (f) shall be established by the commissioner on the basis of information which
98.17 shall be provided to the association by all insurers and health maintenance organizations
98.18 annually at the commissioner's request. This information shall include the number of
98.19 individuals covered by each type of plan or contract specified in paragraphs (a) to (d) and
98.20 (f) that is sold, issued, and renewed by the insurers and health maintenance organizations,
98.21 including those plans or contracts available only on a renewal basis. The information shall
98.22 also include the rates charged for each type of plan or contract.

98.23 In establishing premiums pursuant to this section, the association shall utilize
98.24 generally accepted actuarial principles, provided that the association shall not discriminate
98.25 in charging premiums based upon sex. In order to compute a weighted average for each
98.26 type of plan or contract specified under paragraphs (a) to (d) and (f), the association
98.27 shall, using the information collected pursuant to this subdivision, list insurers and health
98.28 maintenance organizations in rank order of the total number of individuals covered by
98.29 each insurer or health maintenance organization. The association shall then compute
98.30 a weighted average of the rates charged for coverage by all the insurers and health
98.31 maintenance organizations by:

98.32 (1) multiplying the numbers of individuals covered by each insurer or health
98.33 maintenance organization by the rates charged for coverage;

98.34 (2) separately summing both the number of individuals covered by all the insurers
98.35 and health maintenance organizations and all the products computed under clause (1); and

99.1 (3) dividing the total of the products computed under clause (1) by the total number
99.2 of individuals covered.

99.3 The association may elect to use a sample of information from the insurers and
99.4 health maintenance organizations for purposes of computing a weighted average. In no
99.5 case, however, may a sample used by the association to compute a weighted average
99.6 include information from fewer than the two insurers or health maintenance organizations
99.7 highest in rank order.

99.8 Sec. 3. **[62E.121] HIGH-DEDUCTIBLE, BASIC PLAN.**

99.9 **Subdivision 1. Required offering.** The Minnesota Comprehensive Health
99.10 Association shall offer a high-deductible, basic plan that meets the requirements specified
99.11 in this section. The high-deductible, basic plan is a one-person plan. Any dependents
99.12 must be covered separately.

99.13 **Subd. 2. Annual deductible; out-of-pocket maximum.** (a) The plan shall provide
99.14 the following in-network annual deductible options: \$3,000, \$6,000, \$9,000, and \$12,000.
99.15 The in-network annual out-of-pocket maximum for each annual deductible option shall be
99.16 \$1,000 greater than the amount of the annual deductible.

99.17 (b) The deductible is subject to an annual increase based on the change in the
99.18 Consumer Price Index (CPI).

99.19 **Subd. 3. Office visits for nonpreventive care.** The following co-payments shall
99.20 apply for each of the first three office visits per calendar year for nonpreventive care:

99.21 (1) \$30 per visit for the \$3,000 annual deductible option;

99.22 (2) \$40 per visit for the \$6,000 annual deductible option;

99.23 (3) \$50 per visit for the \$9,000 annual deductible option; and

99.24 (4) \$60 per visit for the \$12,000 annual deductible option.

99.25 For the fourth and subsequent visits during the calendar year, 80 percent coverage is
99.26 provided under all deductible options, after the deductible is met.

99.27 **Subd. 4. Preventive care.** One hundred percent coverage is provided for preventive
99.28 care, and no co-payment, coinsurance, or deductible requirements apply.

99.29 **Subd. 5. Prescription drugs.** A \$10 co-payment applies to preferred generic drugs.
99.30 Preferred brand-name drugs require an enrollee payment of 100 percent of the health
99.31 plan's discounted rate.

99.32 **Subd. 6. Convenience care center visits.** A \$20 co-payment applies for the first
99.33 three convenience care center visits during a calendar year. For the fourth and subsequent
99.34 visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 7. **Urgent care center visits.** A \$100 co-payment applies for the first urgent care center visit during a calendar year. For the second and subsequent visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 8. **Emergency room visits.** A \$200 co-payment applies for the first emergency room visit during a calendar year. For the second and subsequent visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 9. **Lab and x-ray; hospital services; ambulance; surgery.** Lab and x-ray services, hospital services, ambulance services, and surgery are covered at 80 percent after the deductible is met.

Subd. 10. **Eyewear.** The health plan pays up to \$50 per calendar year for eyewear.

Subd. 11. **Maternity.** Maternity, labor and delivery, and postpartum care are not covered. One hundred percent coverage is provided for prenatal care and no deductible applies.

Subd. 12. **Other eligible health care services.** Other eligible health care services are covered at 80 percent after the deductible is met.

Subd. 13. **Option to remove mental health and substance abuse coverage.** Enrollees have the option of removing mental health and substance abuse coverage in exchange for a reduced premium.

Subd. 14. **Option to upgrade prescription drug coverage.** Enrollees have the option to upgrade prescription drug coverage to include coverage for preferred brand-name drugs with a \$50 co-payment and coverage for nonpreferred drugs with a \$100 co-payment in exchange for an increased premium.

Subd. 15. **Out-of-network services.** (a) The out-of-network annual deductible is double the in-network annual deductible.

(b) There is no out-of-pocket maximum for out-of-network services.

(c) Benefits for out-of-network services are covered at 60 percent after the deductible is met.

(d) The lifetime maximum benefit for out-of-network services is \$1,000,000.

Subd. 16. **Services not covered.** Services not covered include: custodial care or rest care; most dental services; cosmetic services; refractive eye surgery; infertility services; and services that are investigational, not medically necessary, or received while on military duty.

Sec. 4. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision to read:

101.1 Subd. 4f. **Waiver of preexisting conditions for persons covered by healthy**
101.2 **Minnesota contribution program.** A person may enroll in the comprehensive plan with
101.3 a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for
101.4 the healthy Minnesota contribution program, and has been denied coverage as described
101.5 under section 256L.031, subdivision 6.

101.6 Sec. 5. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

101.7 Subd. 9. **Growth limits; federal programs.** The commissioners of health and
101.8 human services shall establish a rate methodology for Medicare and Medicaid risk-based
101.9 contracting with health plan companies that is consistent with statewide growth limits.
101.10 ~~The methodology shall be presented for review by the Minnesota Health Care Commission~~
101.11 ~~and the Legislative Commission on Health Care Access prior to the submission of a~~
101.12 ~~waiver request to the Centers for Medicare and Medicaid Services and subsequent~~
101.13 ~~implementation of the methodology.~~

101.14 Sec. 6. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

101.15 Subd. 9. **Review of eligible providers.** The commissioner and the Medical
101.16 Education and Research Costs Advisory Committee may review provider groups included
101.17 in the definition of a clinical medical education program to assure that the distribution of
101.18 the funds continue to be consistent with the purpose of this section. The results of any
101.19 such reviews must be reported to the ~~Legislative Commission on Health Care Access~~
101.20 chairs and ranking minority members of the legislative committees with jurisdiction over
101.21 health care policy and finance.

101.22 Sec. 7. **[62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL**
101.23 **ERRORS PROHIBITED.**

101.24 A health care provider shall not bill a patient, and shall not be reimbursed, for
101.25 any operation, treatment, or other care that is provided to reverse, correct, or otherwise
101.26 minimize the affects of an adverse health care event, as described in section 144.7065,
101.27 subdivisions 2 to 7, for which that health care provider is responsible.

101.28 Sec. 8. Minnesota Statutes 2010, section 62Q.32, is amended to read:

101.29 **62Q.32 LOCAL OMBUDSPERSON.**

101.30 County board or community health service agencies may establish an office of
101.31 ombudsperson to provide a system of consumer advocacy for persons receiving health

102.1 care services through a health plan company. The ombudsperson's functions may include,
102.2 but are not limited to:

102.3 (a) mediation or advocacy on behalf of a person accessing the complaint and appeal
102.4 procedures to ensure that necessary medical services are provided by the health plan
102.5 company; and

102.6 (b) investigation of the quality of services provided to a person and determine the
102.7 extent to which quality assurance mechanisms are needed or any other system change
102.8 may be needed. ~~The commissioner of health shall make recommendations for funding~~
102.9 ~~these functions including the amount of funding needed and a plan for distribution. The~~
102.10 ~~commissioner shall submit these recommendations to the Legislative Commission on~~
102.11 ~~Health Care Access by January 15, 1996.~~

102.12 Sec. 9. **[62Q.46] PAYMENT TO OUT-OF-NETWORK PROVIDERS.**

102.13 A health plan company may limit payments to out-of-network providers to the usual
102.14 and customary payment rate that applies to similarly situated providers participating in the
102.15 health plan company's provider network.

102.16 Sec. 10. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

102.17 Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer
102.18 grouping system for providers based on a combined measure that incorporates both
102.19 provider risk-adjusted cost of care and quality of care, and for specific conditions as
102.20 determined by the commissioner. In developing this system, the commissioner shall
102.21 consult and coordinate with health care providers, health plan companies, state agencies,
102.22 and organizations that work to improve health care quality in Minnesota. For purposes of
102.23 the final establishment of the peer grouping system, the commissioner shall not contract
102.24 with any private entity, organization, or consortium of entities that has or will have a direct
102.25 financial interest in the outcome of the system.

102.26 (b) By no later than October 15, 2010, the commissioner shall disseminate
102.27 information to providers on their total cost of care, total resource use, total quality of care,
102.28 and the total care results of the grouping developed under this subdivision in comparison
102.29 to an appropriate peer group. Any analyses or reports that identify providers may only be
102.30 published after the provider has been provided the opportunity by the commissioner to
102.31 review the underlying data and submit comments. Providers may be given any data for
102.32 which they are the subject of the data. The provider shall have 30 days to review the data
102.33 for accuracy and initiate an appeal as specified in paragraph (d).

103.1 (c) By no later than January 1, 2011, the commissioner shall disseminate information
103.2 to providers on their condition-specific cost of care, condition-specific resource use,
103.3 condition-specific quality of care, and the condition-specific results of the grouping
103.4 developed under this subdivision in comparison to an appropriate peer group. Any
103.5 analyses or reports that identify providers may only be published after the provider has
103.6 been provided the opportunity by the commissioner to review the underlying data and
103.7 submit comments. Providers may be given any data for which they are the subject of the
103.8 data. The provider shall have 30 days to review the data for accuracy and initiate an
103.9 appeal as specified in paragraph (d).

103.10 (d) The commissioner shall establish an appeals process to resolve disputes from
103.11 providers regarding the accuracy of the data used to develop analyses or reports. When
103.12 a provider appeals the accuracy of the data used to calculate the peer grouping system
103.13 results, the provider shall:

103.14 (1) clearly indicate the reason they believe the data used to calculate the peer group
103.15 system results are not accurate;

103.16 (2) provide evidence and documentation to support the reason that data was not
103.17 accurate; and

103.18 (3) cooperate with the commissioner, including allowing the commissioner access to
103.19 data necessary and relevant to resolving the dispute.

103.20 If a provider does not meet the requirements of this paragraph, a provider's appeal shall be
103.21 considered withdrawn. The commissioner shall not publish results for a specific provider
103.22 under paragraph (e) or (f) while that provider has an unresolved appeal.

103.23 (e) Beginning January 1, 2011, the commissioner shall, no less than annually,
103.24 publish information on providers' total cost, total resource use, total quality, and the results
103.25 of the total care portion of the peer grouping process. The results that are published must
103.26 be on a risk-adjusted basis.

103.27 (f) Beginning March 30, 2011, the commissioner shall no less than annually publish
103.28 information on providers' condition-specific cost, condition-specific resource use, and
103.29 condition-specific quality, and the results of the condition-specific portion of the peer
103.30 grouping process. The results that are published must be on a risk-adjusted basis.

103.31 (g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing
103.32 information under paragraph (e) or (f), the commissioner shall ensure the scientific
103.33 validity and reliability of the results according to the standards described in paragraph (h).
103.34 If additional time is needed to establish the scientific validity and reliability of the results,
103.35 the commissioner may delay the dissemination of data to providers under paragraph (b)
103.36 or (c), or the publication of information under paragraph (e) or (f). If the delay is more

104.1 than 60 days, the commissioner shall report in writing to the ~~Legislative Commission on~~
104.2 ~~Health Care Access~~ chairs and ranking minority members of the legislative committees
104.3 with jurisdiction over health care policy and finance the following information:

104.4 (1) the reason for the delay;

104.5 (2) the actions being taken to resolve the delay and establish the scientific validity
104.6 and reliability of the results; and

104.7 (3) the new dates by which the results shall be disseminated.

104.8 If there is a delay under this paragraph, the commissioner must disseminate the
104.9 information to providers under paragraph (b) or (c) at least 90 days before publishing
104.10 results under paragraph (e) or (f).

104.11 (h) The commissioner's assurance of valid and reliable clinic and hospital peer
104.12 grouping performance results shall include, at a minimum, the following:

104.13 (1) use of the best available evidence, research, and methodologies; and

104.14 (2) establishment of an explicit minimum reliability threshold developed in
104.15 collaboration with the subjects of the data and the users of the data, at a level not below
104.16 nationally accepted standards where such standards exist.

104.17 In achieving these thresholds, the commissioner shall not aggregate clinics that are not
104.18 part of the same system or practice group. The commissioner shall consult with and solicit
104.19 feedback from representatives of physician clinics and hospitals during the peer grouping
104.20 data analysis process to obtain input on the methodological options prior to final analysis
104.21 and on the design, development, and testing of provider reports.

104.22 Sec. 11. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

104.23 Subd. 9. **Uses of information.** (a) ~~By no later than 12 months after the commissioner~~
104.24 ~~publishes the information in subdivision 3, paragraph (c):~~ For product renewals or for
104.25 new products that are offered, after 12 months have elapsed from publication by the
104.26 commissioner of the information in subdivision 3, paragraph (e):

104.27 (1) the commissioner of management and budget shall use the information and
104.28 methods developed under subdivision 3 to strengthen incentives for members of the state
104.29 employee group insurance program to use high-quality, low-cost providers;

104.30 (2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer
104.31 health benefits to their employees must offer plans that differentiate providers on their
104.32 cost and quality performance and create incentives for members to use better-performing
104.33 providers;

105.1 (3) all health plan companies shall use the information and methods developed
105.2 under subdivision 3 to develop products that encourage consumers to use high-quality,
105.3 low-cost providers; and

105.4 (4) health plan companies that issue health plans in the individual market or the
105.5 small employer market must offer at least one health plan that uses the information
105.6 developed under subdivision 3 to establish financial incentives for consumers to choose
105.7 higher-quality, lower-cost providers through enrollee cost-sharing or selective provider
105.8 networks.

105.9 (b) By January 1, 2011, the commissioner of health shall report to the governor
105.10 and the legislature on recommendations to encourage health plan companies to promote
105.11 widespread adoption of products that encourage the use of high-quality, low-cost providers.
105.12 The commissioner's recommendations may include tax incentives, public reporting of
105.13 health plan performance, regulatory incentives or changes, and other strategies.

105.14 Sec. 12. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:

105.15 Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner
105.16 of health shall submit to the ~~Legislative Commission on Health Care Access~~ chairs and
105.17 ranking minority members of the legislative committees with jurisdiction over health care
105.18 policy and finance periodic progress reports on the implementation of this chapter and
105.19 sections 256B.0751 to 256B.0754.

105.20 Sec. 13. Minnesota Statutes 2010, section 256.01, subdivision 2b, is amended to read:

105.21 Subd. 2b. **Performance payments.** ~~The commissioner shall develop and implement~~
105.22 ~~a pay-for-performance system to provide performance payments to eligible medical~~
105.23 ~~groups and clinics that demonstrate optimum care in serving individuals with chronic~~
105.24 ~~diseases who are enrolled in health care programs administered by the commissioner under~~
105.25 ~~chapters 256B, 256D, and 256L.~~ The commissioner may receive any federal matching
105.26 money that is made available through the medical assistance program for managed care
105.27 oversight contracted through vendors, including consumer surveys, studies, and external
105.28 quality reviews as required by the federal Balanced Budget Act of 1997, Code of Federal
105.29 Regulations, title 42, part 438-managed care, subpart E-external quality review. Any
105.30 federal money received for managed care oversight is appropriated to the commissioner
105.31 for this purpose. The commissioner may expend the federal money received in either
105.32 year of the biennium.

106.1 Sec. 14. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
106.2 to read:

106.3 Subd. 33. **Contingency contract fees.** When the commissioner enters into
106.4 a contingency-based contract for the purpose of recovering medical assistance or
106.5 MinnesotaCare funds, the commissioner may retain that portion of the recovered funds
106.6 equal to the amount of the contingency fee.

106.7 Sec. 15. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
106.8 to read:

106.9 Subd. 34. **Elimination of certain provider reporting requirements; sunset of**
106.10 **new requirements.** (a) Notwithstanding any other law, rule, or provision to the contrary,
106.11 effective July 1, 2012, the commissioner shall cease collecting from health care providers
106.12 and purchasers all reports and data related to health care costs, quality, utilization, access,
106.13 patient encounters, and disease surveillance and public health, and related to provider
106.14 licensure, monitoring, finances, and regulation, unless the reports or data are necessary for
106.15 federal compliance. For purposes of this subdivision, the term "health care providers and
106.16 purchasers" has the meaning provided in section 62J.03, subdivision 8, except that it also
106.17 includes nursing homes, health plan companies as defined in section 62Q.01, subdivision
106.18 4, and managed care and county-based purchasing plans delivering services under sections
106.19 256B.69 and 256B.692.

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

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

106.28 Sec. 16. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

106.29 Subd. 2b. **Operating payment rates.** In determining operating payment rates for
106.30 admissions occurring on or after the rate year beginning January 1, 1991, and every two
106.31 years after, or more frequently as determined by the commissioner, the commissioner
106.32 shall obtain operating data from an updated base year and establish operating payment
106.33 rates per admission for each hospital based on the cost-finding methods and allowable
106.34 costs of the Medicare program in effect during the base year. Rates under the general

107.1 assistance medical care, medical assistance, and MinnesotaCare programs shall not be
107.2 rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months
107.3 of the rebased period beginning January 1, 2009. For the first 24 months of the rebased
107.4 period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota
107.5 long-term hospital shall be rebased effective January 1, 2011, based on its most recent
107.6 Medicare cost report ending on or before September 1, 2008, with the provisions under
107.7 subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent
107.8 rate setting periods in which the base years are updated, a Minnesota long-term hospital's
107.9 base year shall remain within the same period as other hospitals. ~~Effective January 1,~~
107.10 ~~2013, rates shall be rebased at full value.~~ Rates must not be rebased to more current data
107.11 for the first six months of the rebased period beginning January 1, 2013. The base year
107.12 operating payment rate per admission is standardized by the case mix index and adjusted
107.13 by the hospital cost index, relative values, and disproportionate population adjustment.
107.14 The cost and charge data used to establish operating rates shall only reflect inpatient
107.15 services covered by medical assistance and shall not include property cost information
107.16 and costs recognized in outlier payments.

107.17 Sec. 17. Minnesota Statutes 2010, section 256.969, is amended by adding a subdivision
107.18 to read:

107.19 Subd. 31. **Initiatives to reduce incidence of low birth-weight.** The commissioner
107.20 shall require hospitals located in the seven-county metropolitan area, as a condition of
107.21 contract, to implement strategies to reduce the incidence of low birth-weight in geographic
107.22 areas identified by the commissioner as having a higher than average incidence of low
107.23 birth-weight, with special emphasis on areas within a one-mile radius of the hospital.
107.24 These strategies may focus on smoking prevention and cessation, ensuring that pregnant
107.25 women get adequate nutrition, and addressing demographic, social, and environmental
107.26 risk factors. The strategies must coordinate health care with social services and the
107.27 local public health system, and offer patient education through appropriate means.
107.28 The commissioner shall require hospitals to submit proposed initiatives for approval
107.29 to the commissioner by January 1, 2012, and the commissioner shall require hospitals
107.30 to implement approved initiatives by July 1, 2012. The commissioner shall evaluate
107.31 the strategies adopted to reduce low birth-weight, and shall require hospitals to submit
107.32 outcome and other data necessary for the evaluation.

107.33 Sec. 18. Minnesota Statutes 2010, section 256B.04, subdivision 18, is amended to read:

108.1 Subd. 18. **Applications for medical assistance.** (a) The state agency may
108.2 take applications for medical assistance and conduct eligibility determinations for
108.3 MinnesotaCare enrollees.

108.4 (b) The commissioner of human services shall modify the Minnesota health care
108.5 programs application form to add a question asking applicants: "Are you a United States
108.6 military veteran?"

108.7 Sec. 19. Minnesota Statutes 2010, section 256B.05, is amended by adding a
108.8 subdivision to read:

108.9 Subd. 5. **Technical assistance.** The commissioner shall provide technical assistance
108.10 to county agencies in processing complex medical assistance applications, including but
108.11 not limited to applications for long-term care services. The commissioner shall provide
108.12 this technical assistance using existing financial resources.

108.13 Sec. 20. Minnesota Statutes 2010, section 256B.055, subdivision 15, is amended to
108.14 read:

108.15 Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a
108.16 person who is:

108.17 (1) at least age 21 and under age 65;

108.18 (2) not pregnant;

108.19 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII
108.20 of the Social Security Act;

108.21 (4) not an adult in a family with children as defined in section 256L.01, subdivision
108.22 3a; and

108.23 (5) not described in another subdivision of this section.

108.24 (b) If the federal government eliminates the federal Medicaid match or reduces the
108.25 federal Medicaid matching rate beyond any adjustment required as part of the annual
108.26 recalculation of the state's overall Medicaid matching rate for persons eligible under this
108.27 subdivision, the commissioner shall eliminate coverage for persons enrolled under this
108.28 subdivision and suspend new enrollment under this subdivision effective on the date
108.29 of the elimination or reduction.

108.30 **EFFECTIVE DATE.** The amendments to this section are effective the day
108.31 following final enactment and expire January 1, 2014.

108.32 Sec. 21. Minnesota Statutes 2010, 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).

~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.~~

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

Sec. 22. Minnesota Statutes 2010, 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,

110.1 recipients of supplemental security income may have an income up to the supplemental
110.2 security income standard in effect on that date.

110.3 (b) To be eligible for medical assistance, families and children may have an income
110.4 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
110.5 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
110.6 1996, shall be increased by three percent.

110.7 (c) Effective July 1, 2002, to be eligible for medical assistance, families and children
110.8 may have an income up to 100 percent of the federal poverty guidelines for the family size.

110.9 ~~(d) To be eligible for medical assistance under section 256B.055, subdivision 15, a~~
110.10 ~~person may have an income up to 75 percent of federal poverty guidelines for the family~~
110.11 ~~size.~~

110.12 ~~(e)~~ (d) In computing income to determine eligibility of persons under paragraphs
110.13 (a) to ~~(d)~~ (c) who are not residents of long-term care facilities, the commissioner shall
110.14 disregard increases in income as required by Public Law Numbers 94-566, section 503;
110.15 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration
110.16 unusual medical expense payments are considered income to the recipient.

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

110.18 Sec. 23. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

110.19 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
110.20 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
110.21 other persons residing lawfully in the United States. Citizens or nationals of the United
110.22 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
110.23 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
110.24 Public Law 109-171.

110.25 (b) "Qualified noncitizen" means a person who meets one of the following
110.26 immigration criteria:

110.27 (1) admitted for lawful permanent residence according to United States Code, title 8;

110.28 (2) admitted to the United States as a refugee according to United States Code,
110.29 title 8, section 1157;

110.30 (3) granted asylum according to United States Code, title 8, section 1158;

110.31 (4) granted withholding of deportation according to United States Code, title 8,
110.32 section 1253(h);

110.33 (5) paroled for a period of at least one year according to United States Code, title 8,
110.34 section 1182(d)(5);

111.1 (6) granted conditional entrant status according to United States Code, title 8,
111.2 section 1153(a)(7);

111.3 (7) determined to be a battered noncitizen by the United States Attorney General
111.4 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
111.5 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

111.6 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
111.7 States Attorney General according to the Illegal Immigration Reform and Immigrant
111.8 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
111.9 Public Law 104-200; or

111.10 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
111.11 Law 96-422, the Refugee Education Assistance Act of 1980.

111.12 (c) All qualified noncitizens who were residing in the United States before August
111.13 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
111.14 medical assistance with federal financial participation.

111.15 (d) All qualified noncitizens who entered the United States on or after August 22,
111.16 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
111.17 medical assistance with federal financial participation through November 30, 1996.

111.18 Beginning December 1, 1996, qualified noncitizens who entered the United States
111.19 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
111.20 chapter are eligible for medical assistance with federal participation for five years if they
111.21 meet one of the following criteria:

111.22 (i) refugees admitted to the United States according to United States Code, title 8,
111.23 section 1157;

111.24 (ii) persons granted asylum according to United States Code, title 8, section 1158;

111.25 (iii) persons granted withholding of deportation according to United States Code,
111.26 title 8, section 1253(h);

111.27 (iv) veterans of the United States armed forces with an honorable discharge for
111.28 a reason other than noncitizen status, their spouses and unmarried minor dependent
111.29 children; or

111.30 (v) persons on active duty in the United States armed forces, other than for training,
111.31 their spouses and unmarried minor dependent children.

111.32 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
111.33 criteria in items (i) to (v) are eligible for medical assistance without federal financial
111.34 participation as described in paragraph (j).

111.35 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
111.36 women who are noncitizens described in paragraph (b) or (e), are eligible for medical

112.1 assistance with federal financial participation as provided by the federal Children's Health
112.2 Insurance Program Reauthorization Act of 2009, Public Law 111-3.

112.3 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
112.4 are lawfully present in the United States, as defined in Code of Federal Regulations, title
112.5 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
112.6 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
112.7 with the United States Citizenship and Immigration Services to pursue any applicable
112.8 immigration status, including citizenship, that would qualify them for medical assistance
112.9 with federal financial participation.

112.10 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
112.11 for medical assistance with federal financial participation through December 31, 1996.

112.12 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
112.13 medical assistance without federal financial participation as described in paragraph (j).

112.14 (3) Beginning December 1, 1996, persons residing in the United States prior to
112.15 August 22, 1996, who were not receiving medical assistance and persons who arrived on
112.16 or after August 22, 1996, are eligible for medical assistance without federal financial
112.17 participation as described in paragraph (j).

112.18 (f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
112.19 are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this
112.20 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
112.21 Code, title 8, section 1101(a)(15).

112.22 (g) Payment shall also be made for care and services that are furnished to noncitizens,
112.23 regardless of immigration status, who otherwise meet the eligibility requirements of
112.24 this chapter, if such care and services are necessary for the treatment of an emergency
112.25 medical condition, ~~except for organ transplants and related care and services and routine~~
112.26 ~~prenatal care.~~

112.27 (h) For purposes of this subdivision, the term "emergency medical condition" means
112.28 a medical condition that meets the requirements of United States Code, title 42, section
112.29 1396b(v).

112.30 (i)(1) Notwithstanding paragraph (h), services that are necessary for the treatment of
112.31 an emergency medical condition are limited to the following:

112.32 (i) services delivered in an emergency room that are directly related to the treatment
112.33 of an emergency medical condition;

112.34 (ii) services delivered in an inpatient hospital setting following admission from an
112.35 emergency room or clinic for an acute emergency condition; and

113.1 (iii) follow-up services that are directly related to the original service provided to
113.2 treat the emergency medical condition and that are covered by the global payment made
113.3 to the provider.

113.4 (2) Services for the treatment of emergency medical conditions do not include:
113.5 (i) services delivered in an emergency room or inpatient setting to treat a
113.6 nonemergency condition;
113.7 (ii) organ and stem cell transplants and related care;
113.8 (iii) services for routine prenatal care;
113.9 (iv) continuing care, including long-term care, nursing facility services, home health
113.10 care, adult day care, day training, or supportive living services;
113.11 (v) elective surgery;
113.12 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
113.13 part of an emergency room visit;
113.14 (vii) preventative health care and family planning services;
113.15 (viii) dialysis;
113.16 (ix) chemotherapy or therapeutic radiation services;
113.17 (x) rehabilitation services;
113.18 (xi) physical, occupational, or speech therapy;
113.19 (xii) transportation services;
113.20 (xiii) case management;
113.21 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
113.22 (xv) dental services;
113.23 (xvi) hospice care;
113.24 (xvii) audiology services and hearing aids;
113.25 (xviii) podiatry services;
113.26 (xix) chiropractic services;
113.27 (xx) immunizations;
113.28 (xxi) vision services and eyeglasses;
113.29 (xxii) waiver services;
113.30 (xxiii) individualized education programs; or
113.31 (xxiv) chemical dependency treatment.

113.32 ~~(†)~~ (j) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
113.33 nonimmigrants, or lawfully present as designated in paragraph (e) and who are not
113.34 covered by a group health plan or health insurance coverage according to Code of
113.35 Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility
113.36 requirements of this chapter, are eligible for medical assistance through the period of

114.1 pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal
114.2 funds are available under title XXI of the Social Security Act, and the state children's
114.3 health insurance program.

114.4 ~~(j)~~ (k) Qualified noncitizens as described in paragraph (d), and all other noncitizens
114.5 lawfully residing in the United States as described in paragraph (e), who are ineligible
114.6 for medical assistance with federal financial participation and who otherwise meet the
114.7 eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
114.8 assistance without federal financial participation. Qualified noncitizens as described
114.9 in paragraph (d) are only eligible for medical assistance without federal financial
114.10 participation for five years from their date of entry into the United States.

114.11 ~~(k)~~ (l) Beginning October 1, 2003, persons who are receiving care and rehabilitation
114.12 services from a nonprofit center established to serve victims of torture and are otherwise
114.13 ineligible for medical assistance under this chapter are eligible for medical assistance
114.14 without federal financial participation. These individuals are eligible only for the period
114.15 during which they are receiving services from the center. Individuals eligible under this
114.16 paragraph shall not be required to participate in prepaid medical assistance.

114.17 Sec. 24. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
114.18 subdivision to read:

114.19 Subd. 1b. Care coordination services provided through pediatric hospitals.

114.20 (a) Medical assistance covers care coordination services provided by certain pediatric
114.21 hospitals to children with high-cost medical conditions and children at risk of recurrent
114.22 hospitalization for acute or chronic illnesses. There must be Level I and Level II pediatric
114.23 care coordination services.

114.24 (b) Level I pediatric care coordination services are provided by advanced practice
114.25 nurses employed by or under contract with pediatric hospitals that have a neonatal
114.26 intensive care unit and are either recipients of payments to support the training of residents
114.27 from an approved graduate medical residency program under United States Code, title
114.28 42, section 256e, or the major pediatric teaching hospital affiliate of the University of
114.29 Minnesota Medical School, and that meet the criteria in this subdivision.

114.30 (c) The services in paragraph (b) must be available through in-home video telehealth
114.31 management and other methods, and must be designed to improve patient outcomes
114.32 and reduce unnecessary hospital and emergency room utilization. The services must
114.33 streamline communication, reduce redundancy, and eliminate unnecessary documentation
114.34 through the use of a Web-accessible, uniform document that contains critical patient care
114.35 management information, and which is accessible to all providers with patient consent.

115.1 The commissioner shall develop the uniform document and associated Web site and shall
115.2 implement procedures to assess patient outcomes and evaluate the effectiveness of the
115.3 care coordination services provided under this subdivision.

115.4 (d) Medical assistance also covers, as durable medical equipment, computers,
115.5 webcams, and other technology necessary to allow in-home video telehealth management.

115.6 (e) For purposes of paragraph (b), a child has a high-cost medical condition if
115.7 inpatient hospital expenses for that child related to complex or chronic illnesses or
115.8 conditions for the most recent calendar year exceeded \$100,000, or if the expenses for that
115.9 child are projected to exceed \$100,000 for the current calendar year. For purposes of this
115.10 subdivision, a child is at risk of recurrent hospitalization if the child was hospitalized three
115.11 or more times for acute or chronic illness in the most recent calendar year.

115.12 (f) For purposes of paragraph (b), "care coordination" means collaboration between
115.13 the advanced practice nurse and primary care physicians and specialists to manage
115.14 care and reduce hospitalizations, patient case management, development of medical
115.15 management plans for chronic illnesses and recurrent acute illnesses, oversight and
115.16 coordination of all aspects of care in partnership with families, organization of medical
115.17 information into a summary of critical information, coordination and appropriate
115.18 sequencing of tests and multiple appointments, information and assistance with accessing
115.19 resources, and telephone triage for acute illnesses or problems.

115.20 (g) The commissioner shall adjust managed care and county-based purchasing plan
115.21 capitation rates to reflect savings from the coverage of this service.

115.22 (h) Level II pediatric care coordination services are provided by registered nurses
115.23 employed by or under contract with a pediatric hospital that has been designated as
115.24 an essential community provider under section 62Q.19, subdivision 1, clause (4), and
115.25 has been a recipient of payments to support the training of residents from an approved
115.26 graduate medical residency program pursuant to United States Code, title 42, section
115.27 256e, and that meets the following criteria:

115.28 (1) the services must be provided through telehealth management and other methods,
115.29 be available on a regular schedule seven days per week, and be designed to provide
115.30 collaboration in patient care as provided by the patient's family, primary care providers,
115.31 and the hospital and specialized physicians;

115.32 (2) for purposes of this paragraph, a child has a high-cost medical condition if the
115.33 child has a serious chronic physical disability caused by a congenital anomaly, birth
115.34 injury or traumatic injury, complications which can be expected to cause further injury,
115.35 hospitalization, or death, but that can be effectively addressed through ongoing family

116.1 and primary care supported by communication of ongoing care information and care
116.2 coordination; and

116.3 (3) for purposes of this paragraph, "care coordination" means the ready availability
116.4 of telehealth management services to support collaboration through a registered nurse
116.5 between a child's family, the primary care professional that is available to care for the
116.6 child, and appropriate professionals to address urgent questions about and minimize the
116.7 consequences of medical complications, develop medical management plans for complex
116.8 conditions, and avoid serious health consequences and hospitalizations to treat such
116.9 complications.

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

116.11 Sec. 25. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
116.12 subdivision to read:

116.13 Subd. 3q. **Evidence-based childbirth program.** (a) The commissioner shall
116.14 implement a program to reduce the number of elective inductions of labor prior to 39
116.15 weeks' gestation. In this subdivision, the term "elective induction of labor" means the
116.16 use of artificial means to stimulate labor in a woman without the presence of a medical
116.17 condition affecting the woman or the child that makes the onset of labor a medical
116.18 necessity. The program must promote the implementation of policies within hospitals
116.19 providing services to recipients of medical assistance or MinnesotaCare that prohibit the
116.20 use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by
116.21 the attending providers.

116.22 (b) For all births covered by medical assistance or MinnesotaCare on or after
116.23 January 1, 2012, a payment for professional services associated with the delivery of a
116.24 child in a hospital must not be made unless the provider has submitted information about
116.25 the nature of the labor and delivery including any induction of labor that was performed
116.26 in conjunction with that specific birth. The information must be on a form prescribed by
116.27 the commissioner.

116.28 (c) The requirements in paragraph (b) must not apply to deliveries performed
116.29 at a hospital that has policies and processes in place that have been approved by the
116.30 commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process
116.31 for review of hospital induction policies must be established by the commissioner and
116.32 review of policies must occur at the discretion of the commissioner. The commissioner's
116.33 decision to approve or rescind approval must include verification and review of items
116.34 including, but not limited to:

116.35 (1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

117.1 (2) policies that encourage providers to document and communicate with patients a
117.2 final expected date of delivery by 20 weeks' gestation that includes data from ultrasound
117.3 measurements as applicable;

117.4 (3) policies that encourage patient education regarding elective inductions, and
117.5 requires documentation of the processes used to educate patients;

117.6 (4) ongoing quality improvement review as determined by the commissioner; and

117.7 (5) any data that has been collected by the commissioner.

117.8 (d) All hospitals must report annually to the commissioner induction information
117.9 for all births that were covered by medical assistance or MinnesotaCare in a format and
117.10 manner to be established by the commissioner.

117.11 (e) The commissioner at any time may choose not to implement or may discontinue
117.12 any or all aspects of the program if the commissioner is able to determine that hospitals
117.13 representing at least 90 percent of births covered by medical assistance or MinnesotaCare
117.14 have approved policies in place.

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

117.16 Sec. 26. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to
117.17 read:

117.18 Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to
117.19 one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater
117.20 number of visits is obtained.

117.21 Sec. 27. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
117.22 subdivision to read:

117.23 Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined
117.24 in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by
117.25 another Minnesota licensed practitioner for whom acupuncture is within the practitioner's
117.26 scope of practice and who has specific acupuncture training or credentialing.

117.27 Sec. 28. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to
117.28 read:

117.29 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
117.30 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
117.31 the maximum allowable cost set by the federal government or by the commissioner plus
117.32 the fixed dispensing fee; or the usual and customary price charged to the public. The
117.33 amount of payment basis must be reduced to reflect all discount amounts applied to the

118.1 charge by any provider/insurer agreement or contract for submitted charges to medical
118.2 assistance programs. The net submitted charge may not be greater than the patient liability
118.3 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee
118.4 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per
118.5 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral
118.6 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral
118.7 nutritional products dispensed in quantities greater than one liter. Actual acquisition cost
118.8 includes quantity and other special discounts except time and cash discounts. ~~Effective~~
118.9 ~~July 1, 2009,~~ The actual acquisition cost of a drug shall be estimated by the commissioner;
118.10 ~~at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic~~
118.11 ~~factor drugs shall be estimated at the average wholesale price minus 30 percent. wholesale~~
118.12 ~~acquisition cost plus four percent for independently owned pharmacies located in a~~
118.13 ~~designated rural area within Minnesota, and at wholesale acquisition cost plus two percent~~
118.14 ~~for all other pharmacies. A pharmacy is "independently owned" if it is one of four or~~
118.15 ~~fewer pharmacies under the same ownership nationally. A "designated rural area" means~~
118.16 ~~an area defined as a small rural area or isolated rural area according to the four-category~~
118.17 ~~classification of the Rural Urban Commuting Area system developed for the United States~~
118.18 ~~Health Resources and Services Administration. Wholesale acquisition cost is defined as~~
118.19 ~~the manufacturer's list price for a drug or biological to wholesalers or direct purchasers~~
118.20 ~~in the United States, not including prompt pay or other discounts, rebates, or reductions~~
118.21 ~~in price, for the most recent month for which information is available, as reported in~~
118.22 ~~wholesale price guides or other publications of drug or biological pricing data. The~~
118.23 maximum allowable cost of a multisource drug may be set by the commissioner and it
118.24 shall be comparable to, but no higher than, the maximum amount paid by other third-party
118.25 payors in this state who have maximum allowable cost programs. Establishment of the
118.26 amount of payment for drugs shall not be subject to the requirements of the Administrative
118.27 Procedure Act.

118.28 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
118.29 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
118.30 facilities when a unit dose blister card system, approved by the department, is used. Under
118.31 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
118.32 The National Drug Code (NDC) from the drug container used to fill the blister card must
118.33 be identified on the claim to the department. The unit dose blister card containing the
118.34 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
118.35 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
118.36 will be required to credit the department for the actual acquisition cost of all unused

119.1 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
119.2 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
119.3 dispensed in a quantity that is less than a 30-day supply.

119.4 (c) Whenever a maximum allowable cost has been set for a multisource drug,
119.5 payment shall be on the basis of the maximum allowable cost established by the
119.6 commissioner unless prior authorization for the brand name product has been granted
119.7 according to the criteria established by the Drug Formulary Committee as required by
119.8 subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on
119.9 the prescription in a manner consistent with section 151.21, subdivision 2.

119.10 (d) The basis for determining the amount of payment for drugs administered in an
119.11 outpatient setting shall be the lower of the usual and customary cost submitted by the
119.12 provider or ~~the amount established for Medicare by the~~ 106 percent of the average sales
119.13 price as determined by the United States Department of Health and Human Services
119.14 pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales
119.15 price is unavailable, the amount of payment must be lower of the usual and customary cost
119.16 submitted by the provider or the wholesale acquisition cost.

119.17 (e) The commissioner may negotiate lower reimbursement rates for specialty
119.18 pharmacy products than the rates specified in paragraph (a). The commissioner may
119.19 require individuals enrolled in the health care programs administered by the department
119.20 to obtain specialty pharmacy products from providers with whom the commissioner has
119.21 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
119.22 used by a small number of recipients or recipients with complex and chronic diseases
119.23 that require expensive and challenging drug regimens. Examples of these conditions
119.24 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
119.25 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
119.26 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
119.27 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
119.28 that require complex care. The commissioner shall consult with the formulary committee
119.29 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
119.30 with the formulary committee in developing this list, the commissioner shall take into
119.31 consideration the population served by specialty pharmacy products, the current delivery
119.32 system and standard of care in the state, and access to care issues. The commissioner shall
119.33 have the discretion to adjust the reimbursement rate to prevent access to care issues.

119.34 (f) Home infusion therapy services provided by home infusion therapy pharmacies
119.35 must be paid at rates according to subdivision 8d.

120.1 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
120.2 approval, whichever is later.

120.3 Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to
120.4 read:

120.5 Subd. 13h. **Medication therapy management services.** (a) Medical assistance
120.6 and general assistance medical care cover medication therapy management services for
120.7 a recipient taking ~~four~~ three or more prescriptions to treat or prevent ~~two~~ one or more
120.8 chronic medical conditions, ~~or~~ or; a recipient with a drug therapy problem that is identified
120.9 by the commissioner or identified by a pharmacist and approved by the commissioner; or
120.10 prior authorized by the commissioner that has resulted or is likely to result in significant
120.11 nondrug program costs. The commissioner may cover medical therapy management
120.12 services under MinnesotaCare if the commissioner determines this is cost-effective. For
120.13 purposes of this subdivision, "medication therapy management" means the provision
120.14 of the following pharmaceutical care services by a licensed pharmacist to optimize the
120.15 therapeutic outcomes of the patient's medications:

120.16 (1) performing or obtaining necessary assessments of the patient's health status;

120.17 (2) formulating a medication treatment plan;

120.18 (3) monitoring and evaluating the patient's response to therapy, including safety
120.19 and effectiveness;

120.20 (4) performing a comprehensive medication review to identify, resolve, and prevent
120.21 medication-related problems, including adverse drug events;

120.22 (5) documenting the care delivered and communicating essential information to
120.23 the patient's other primary care providers;

120.24 (6) providing verbal education and training designed to enhance patient
120.25 understanding and appropriate use of the patient's medications;

120.26 (7) providing information, support services, and resources designed to enhance
120.27 patient adherence with the patient's therapeutic regimens; and

120.28 (8) coordinating and integrating medication therapy management services within the
120.29 broader health care management services being provided to the patient.

120.30 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
120.31 the pharmacist as defined in section 151.01, subdivision 27.

120.32 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
120.33 must meet the following requirements:

120.34 (1) have a valid license issued under chapter 151;

121.1 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
121.2 completed a structured and comprehensive education program approved by the Board of
121.3 Pharmacy and the American Council of Pharmaceutical Education for the provision and
121.4 documentation of pharmaceutical care management services that has both clinical and
121.5 didactic elements;

121.6 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
121.7 have developed a structured patient care process that is offered in a private or semiprivate
121.8 patient care area that is separate from the commercial business that also occurs in the
121.9 setting, or in home settings, ~~excluding~~ including long-term care ~~and settings~~, group homes,
121.10 ~~if the service is ordered by the provider-directed care coordination team and facilities~~
121.11 providing assisted living services; and

121.12 (4) make use of an electronic patient record system that meets state standards.

121.13 (c) For purposes of reimbursement for medication therapy management services,
121.14 the commissioner may enroll individual pharmacists as medical assistance and general
121.15 assistance medical care providers. The commissioner may also establish contact
121.16 requirements between the pharmacist and recipient, including limiting the number of
121.17 reimbursable consultations per recipient.

121.18 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing
121.19 within a reasonable geographic distance of the patient, a pharmacist who meets the
121.20 requirements may provide the services via two-way interactive video. Reimbursement
121.21 shall be at the same rates and under the same conditions that would otherwise apply to
121.22 the services provided. To qualify for reimbursement under this paragraph, the pharmacist
121.23 providing the services must meet the requirements of paragraph (b), and must be located
121.24 within an ambulatory care setting approved by the commissioner. The patient must also
121.25 be located within an ambulatory care setting approved by the commissioner. Services
121.26 provided under this paragraph may not be transmitted into the patient's residence.

121.27 (e) The commissioner shall establish a pilot project for an intensive medication
121.28 therapy management program for patients identified by the commissioner with multiple
121.29 chronic conditions and a high number of medications who are at high risk of preventable
121.30 hospitalizations, emergency room use, medication complications, and suboptimal
121.31 treatment outcomes due to medication-related problems. For purposes of the pilot
121.32 project, medication therapy management services may be provided in a patient's home
121.33 or community setting, in addition to other authorized settings. The commissioner may
121.34 waive existing payment policies and establish special payment rates for the pilot project.
121.35 The pilot project must be designed to produce a net savings to the state compared to the

- 122.1 estimated costs that would otherwise be incurred for similar patients without the program.
- 122.2 The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

122.4 Sec. 30. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to

122.5 read:

122.6 Subd. 17. **Transportation costs.** (a) Medical assistance covers medical

122.7 transportation costs incurred solely for obtaining emergency medical care or transportation

122.8 costs incurred by eligible persons in obtaining emergency or nonemergency medical

122.9 care when paid directly to an ambulance company, common carrier, or other recognized

122.10 providers of transportation services. Medical transportation must be provided by:

122.11 (1) an ambulance, as defined in section 144E.001, subdivision 2;

122.12 (2) special transportation; or

122.13 (3) common carrier including, but not limited to, bus, taxicab, other commercial

122.14 carrier, or private automobile.

122.15 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,

122.16 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that

122.17 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial

122.18 transportation, or private automobile.

122.19 The commissioner may use an order by the recipient's attending physician to certify that

122.20 the recipient requires special transportation services. Special transportation providers shall

122.21 perform driver-assisted services for eligible individuals. Driver-assisted service includes

122.22 passenger pickup at and return to the individual's residence or place of business, assistance

122.23 with admittance of the individual to the medical facility, and assistance in passenger

122.24 securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation

122.25 providers must obtain written documentation from the health care service provider who

122.26 is serving the recipient being transported, identifying the time that the recipient arrived.

122.27 Special transportation providers may not bill for separate base rates for the continuation of

122.28 a trip beyond the original destination. Special transportation providers must take recipients

122.29 to the nearest appropriate health care provider, using the most direct route. The minimum

122.30 medical assistance reimbursement rates for special transportation services are:

122.31 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to

122.32 eligible persons who need a wheelchair-accessible van;

122.33 (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to

122.34 eligible persons who do not need a wheelchair-accessible van; and

123.1 (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
123.2 special transportation services to eligible persons who need a stretcher-accessible vehicle;

123.3 (2) the base rates for special transportation services in areas defined under RUCA
123.4 to be super rural shall be equal to the reimbursement rate established in clause (1) plus
123.5 11.3 percent; and

123.6 (3) for special transportation services in areas defined under RUCA to be rural
123.7 or super rural areas:

123.8 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
123.9 percent of the respective mileage rate in clause (1); and

123.10 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
123.11 112.5 percent of the respective mileage rate in clause (1).

123.12 (c) For purposes of reimbursement rates for special transportation services under
123.13 paragraph (b), the zip code of the recipient's place of residence shall determine whether
123.14 the urban, rural, or super rural reimbursement rate applies.

123.15 (d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"
123.16 means a census-tract based classification system under which a geographical area is
123.17 determined to be urban, rural, or super rural.

123.18 (e) Effective for services provided on or after July 1, 2011, nonemergency
123.19 transportation rates, including special transportation, taxi, and other commercial carriers,
123.20 are reduced 4.5 percent. Payments made to managed care plans and county-based
123.21 purchasing plans must be reduced for services provided on or after January 1, 2012,
123.22 to reflect this reduction.

123.23 Sec. 31. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to
123.24 read:

123.25 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers
123.26 ambulance services. Providers shall bill ambulance services according to Medicare
123.27 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
123.28 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
123.29 services shall be paid at the Medicare reimbursement rate or at the medical assistance
123.30 payment rate in effect on July 1, 2000, whichever is greater.

123.31 (b) Effective for services provided on or after July 1, 2011, ambulance services
123.32 payment rates are reduced 4.5 percent. Payments made to managed care plans and
123.33 county-based purchasing plans must be reduced for services provided on or after January
123.34 1, 2012, to reflect this reduction.

124.1 Sec. 32. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to
124.2 read:

124.3 Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the
124.4 state agency, medical assistance covers ~~costs of~~ the most appropriate and cost-effective
124.5 form of transportation incurred by any ambulatory eligible person for obtaining
124.6 nonemergency medical care.

124.7 Sec. 33. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
124.8 subdivision to read:

124.9 Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise
124.10 allowed under this subdivision or required under federal or state regulations, the
124.11 commissioner must not consider a request for authorization of a service when the recipient
124.12 has coverage from a third-party payer unless the provider requesting authorization has
124.13 made a good faith effort to receive payment or authorization from the third-party payer.
124.14 A good faith effort is established by supplying with the authorization request to the
124.15 commissioner the following:

124.16 (1) a determination of payment for the service from the third-party payer, a
124.17 determination of authorization for the service from the third-party payer, or a verification
124.18 of noncoverage of the service by the third-party payer; and

124.19 (2) the information or records required by the department to document the reason for
124.20 the determination or to validate noncoverage from the third-party payer.

124.21 (b) A provider requesting authorization for services covered by Medicare is not
124.22 required to bill Medicare before requesting authorization from the commissioner if the
124.23 provider has reason to believe that a service covered by Medicare is not eligible for
124.24 payment. The provider must document that, because of recent claim experiences with
124.25 Medicare or because of written communication from Medicare, coverage is not available
124.26 for the service.

124.27 (c) Authorization is not required if a third-party payer has made payment that is
124.28 equal to or greater than 60 percent of the maximum payment amount for the service
124.29 allowed under medical assistance.

124.30 Sec. 34. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to
124.31 read:

124.32 Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical
124.33 assistance covers augmentative and alternative communication systems consisting of
124.34 electronic or nonelectronic devices and the related components necessary to enable a

person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

~~(b) Until the volume of systems purchased increases to allow a discount price, the commissioner shall reimburse augmentative and alternative communication manufacturers and vendors at the manufacturer's suggested retail price for augmentative and alternative communication systems and related components. The commissioner shall separately reimburse providers for purchasing and integrating individual communication systems which are unavailable as a package from an augmentative and alternative communication vendor. Augmentative and alternative communication systems must be paid the lower of the:~~

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

Sec. 35. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Payment for multiple services provided on same day.** The commissioner shall not prohibit payment, including any supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health services or dental services were provided on the same day as other covered health care services furnished by the same provider.

Sec. 36. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56. **Medical care coordination.** (a) Medical assistance covers in-reach community-based care coordination that is performed in a hospital emergency department as an eligible procedure under a state health care program or private insurance for a frequent user.

(b) Reimbursement must be made in 15-minute increments under current Medicaid mental health social work reimbursement methodology and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. A frequent user who is participating in care coordination within

- 126.1 a health care home framework is ineligible for reimbursement under this subdivision.
- 126.2 Eligible in-reach care coordinators must hold a minimum of a bachelor's degree in social
- 126.3 work, public health, corrections, or related field. The commissioner shall submit any
- 126.4 necessary application for waivers to the Centers for Medicare and Medicaid Services to
- 126.5 implement this subdivision.
- 126.6 (c) A frequent user is defined as an individual who:
- 126.7 (1) has frequented the hospital emergency department for services three or more
- 126.8 times in the previous six consecutive months;
- 126.9 (2) would benefit from the provision of in-reach community-based services; and
- 126.10 (3) has two or more of the following risk factors:
- 126.11 (i) on one or more occasions within the last 24 months, the individual was diagnosed
- 126.12 with a chronic or life-threatening condition that requires management of symptoms,
- 126.13 medications, health care, or changes in lifestyle or risk-related behaviors that may
- 126.14 include, but are not limited to, HIV/AIDS, hepatitis, diabetes, heart disease, hypertension,
- 126.15 emphysema, asthma, or cancer;
- 126.16 (ii) on one or more occasions within the last 24 months, the individual was diagnosed
- 126.17 or, in the judgment of an emergency department physician, would likely be diagnosed,
- 126.18 if provided a mental assessment, with an Axis I or II mental disorder identified in the
- 126.19 Diagnostic and Statistical Manual of Mental Disorders;
- 126.20 (iii) on one or more occasions within the last 24 months, the individual was
- 126.21 diagnosed or, in the judgment of an emergency department physician, would likely be
- 126.22 diagnosed, if provided an assessment, with a substance use problem that interferes with
- 126.23 the individual's health or appropriate utilization of health services; or
- 126.24 (iv) the individual is currently experiencing homelessness. "Homelessness" means
- 126.25 lacking a fixed, regular, or adequate nighttime residence or a primary nighttime residence
- 126.26 that is a supervised publicly or privately operated shelter designed to provide temporary
- 126.27 living accommodations or a public or private place not designed for, or ordinarily used
- 126.28 as, regular sleeping accommodations for human beings.
- 126.29 (d) Any hospital choosing to participate in medical care coordination under this
- 126.30 subdivision must, upon request by the commissioner of human services, make available
- 126.31 program utilization data. Frequent users who are enrolled in a program must track:
- 126.32 (1) the total number of program participants in the frequent user program for a
- 126.33 defined period of time established by the commissioner;
- 126.34 (2) the total number of program participants and what form of health care coverage
- 126.35 they had at the time of enrollment and the number of beneficiaries who did not remain
- 126.36 enrolled in the program for at least two months;

127.1 (3) the frequency of emergency department visits during the 12 months prior to
127.2 enrollment in the program and associated costs to the hospital;

127.3 (4) the frequency of emergency department visits during the 12 months after
127.4 program enrollment and the associated costs to the hospital;

127.5 (5) the total number of inpatient admissions during the 12 months immediately
127.6 preceding enrollment and the associated costs to the hospital;

127.7 (6) the total number of inpatient admissions during the 12 months after enrollment in
127.8 the program and the associated costs to the hospital;

127.9 (7) the total number of inpatient days during the 12 months immediately preceding
127.10 enrollment and the associated costs to the hospital; and

127.11 (8) the total number of inpatient days during the 12 months after program enrollment
127.12 and the associated costs to the hospital.

127.13 (e) For the purposes of this subdivision, "in-reach community-based care
127.14 coordination" means the practice of a community-based worker with training, knowledge,
127.15 skills, and ability to access a continuum of services, including housing, transportation,
127.16 chemical and mental health treatment, employment, and peer support services, by working
127.17 with an organization's staff to transition an individual back into the individual's living
127.18 environment. In-reach community-based care coordination includes working with the
127.19 individual during their discharge and for up to a defined amount of time in the individual's
127.20 living environment, reducing the individual's need for readmittance.

127.21 Sec. 37. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
127.22 subdivision to read:

127.23 Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services
127.24 provided on or after January 1, 2012, medical assistance payment for an enrollee's cost
127.25 sharing associated with Medicare Part B is limited to an amount up to the medical
127.26 assistance total allowed, when the medical assistance rate exceeds the amount paid by
127.27 Medicare.

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

127.29 Sec. 38. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
127.30 subdivision to read:

127.31 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**
127.32 Medical assistance covers early and periodic screening, diagnosis, and treatment services
127.33 (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate
127.34 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

128.1 Sec. 39. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
128.2 subdivision to read:

128.3 Subd. 59. **Services provided by advanced dental therapists and dental**
128.4 **therapists.** Medical assistance covers services provided by advanced dental therapists
128.5 and dental therapists when provided within the scope of practice identified in sections
128.6 150A.105 and 150A.106.

128.7 Sec. 40. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
128.8 subdivision to read:

128.9 Subd. 60. **Payment for noncovered services.** (a) Except when specifically
128.10 prohibited by the commissioner or federal law, a provider may seek payment from the
128.11 recipient for services not eligible for payment under the medical assistance program when
128.12 the provider, prior to delivering the service, reviews and considers all other available
128.13 covered alternatives with the recipient and obtains a signed acknowledgment from the
128.14 recipient of the potential of the recipient's liability. The signed acknowledgment must be
128.15 in a form approved by the commissioner.

128.16 (b) Conditions under which a provider must not request payment from the recipient
128.17 include, but are not limited to:

128.18 (1) a service that requires prior authorization, unless authorization has been denied
128.19 as not medically necessary and all other therapeutic alternatives have been reviewed;

128.20 (2) a service for which payment has been denied for reasons relating to billing
128.21 requirements;

128.22 (3) standard shipping or delivery and setup of medical equipment or medical
128.23 supplies;

128.24 (4) services that are included in the recipient's long-term care per diem;

128.25 (5) the recipient is enrolled in the restricted recipient program and the provider is
128.26 one of a provider type designated for the recipient's health care services; and

128.27 (6) the noncovered service is a prescriptive drug identified by the commissioner as
128.28 having the potential for abuse and overuse, except where payment by the recipient is
128.29 specifically approved by the commissioner on the date of service based upon compelling
128.30 evidence supplied by the prescribing provider that establishes medical necessity for that
128.31 particular drug.

128.32 (c) The payment requested from recipients for noncovered services under this
128.33 subdivision must not exceed the provider's usual and customary charge for the actual
128.34 service received by the recipient. A recipient must not be billed for the difference between

129.1 what medical assistance paid for the service or would pay for a less costly alternative
129.2 service.

129.3 Sec. 41. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to
129.4 read:

129.5 Subdivision 1. ~~Co-payments~~ Cost-sharing. (a) Except as provided in subdivision
129.6 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing
129.7 for all recipients, effective for services provided on or after ~~October 1, 2003, and before~~
129.8 ~~January 1, 2009~~ July 1, 2011:

129.9 (1) \$3 per nonpreventive visit, except as provided in paragraph (c). For purposes
129.10 of this subdivision, a visit means an episode of service which is required because of
129.11 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
129.12 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
129.13 midwife, advanced practice nurse, audiologist, optician, or optometrist;

129.14 (2) \$3 for eyeglasses;

129.15 (3) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room, except
129.16 that this co-payment shall be increased to \$20 upon federal approval; and

129.17 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
129.18 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
129.19 shall apply to antipsychotic drugs when used for the treatment of mental illness;

129.20 (5) a family deductible equal to the maximum amount allowed under Code of
129.21 Federal Regulations, title 42, part 447.54; and

129.22 ~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall~~
129.23 ~~include the following co-payments for all recipients, effective for services provided on~~
129.24 ~~or after January 1, 2009:~~

129.25 ~~(1) \$3.50 for nonemergency visits to a hospital-based emergency room;~~

129.26 ~~(2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,~~
129.27 ~~subject to a \$7 per month maximum for prescription drug co-payments. No co-payments~~
129.28 ~~shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

129.29 ~~(3)~~ (6) for individuals identified by the commissioner with income at or below 100
129.30 percent of the federal poverty guidelines, total monthly ~~co-payments~~ cost-sharing must
129.31 not exceed five percent of family income. For purposes of this paragraph, family income
129.32 is the total earned and unearned income of the individual and the individual's spouse, if
129.33 the spouse is enrolled in medical assistance and also subject to the five percent limit on
129.34 ~~co-payments~~ cost-sharing.

130.1 ~~(e)~~ (b) Recipients of medical assistance are responsible for all co-payments and
130.2 deductibles in this subdivision.

130.3 (c) Effective January 1, 2012, or upon federal approval, whichever is later, the
130.4 following co-payments for nonpreventive visits shall apply to providers included in
130.5 provider peer grouping:

130.6 (1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of
130.7 care per medical assistance enrollee is at the 60th percentile or lower for providers of
130.8 the same type;

130.9 (2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care
130.10 per medical assistance enrollee is greater than the 60th percentile but does not exceed the
130.11 80th percentile for providers of the same type; and

130.12 (3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of
130.13 care per medical assistance enrollee is greater than the 80th percentile for providers of
130.14 the same type.

130.15 Each managed care and county-based purchasing plan shall calculate the average,
130.16 risk-adjusted, total annual cost of care for providers under this paragraph using a
130.17 methodology approved by the commissioner. The commissioner shall develop a
130.18 methodology for calculating the average, risk-adjusted, total annual cost of care for
130.19 fee-for-service providers.

130.20 (d) The commissioner shall seek any federal waivers and approvals necessary to
130.21 increase the co-payment for nonemergency visits to a hospital-based emergency room
130.22 under paragraph (a), clause (3), and to implement paragraph (c).

130.23 Sec. 42. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to
130.24 read:

130.25 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
130.26 exceptions:

130.27 (1) children under the age of 21;

130.28 (2) pregnant women for services that relate to the pregnancy or any other medical
130.29 condition that may complicate the pregnancy;

130.30 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
130.31 intermediate care facility for the developmentally disabled;

130.32 (4) recipients receiving hospice care;

130.33 (5) 100 percent federally funded services provided by an Indian health service;

130.34 (6) emergency services;

130.35 (7) family planning services;

131.1 (8) services that are paid by Medicare, resulting in the medical assistance program
131.2 paying for the coinsurance and deductible; and

131.3 (9) co-payments that exceed one per day per provider for nonpreventive visits,
131.4 eyeglasses, and nonemergency visits to a hospital-based emergency room.

131.5 Sec. 43. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to
131.6 read:

131.7 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall
131.8 be reduced by the amount of the co-payment or deductible, except that reimbursements
131.9 shall not be reduced:

131.10 (1) once a recipient has reached the \$12 per month maximum ~~or the \$7 per month~~
131.11 ~~maximum effective January 1, 2009~~, for prescription drug co-payments; or

131.12 (2) for a recipient identified by the commissioner under 100 percent of the federal
131.13 poverty guidelines who has met their monthly five percent ~~co-payment~~ cost-sharing limit.

131.14 (b) The provider collects the co-payment or deductible from the recipient. Providers
131.15 may not deny services to recipients who are unable to pay the co-payment or deductible.

131.16 (c) Medical assistance reimbursement to fee-for-service providers and payments to
131.17 managed care plans shall not be increased as a result of the removal of co-payments or
131.18 deductibles effective on or after January 1, 2009.

131.19 Sec. 44. Minnesota Statutes 2010, section 256B.0644, is amended to read:

131.20 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
131.21 **PROGRAMS.**

131.22 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
131.23 health maintenance organization, as defined in chapter 62D, must participate as a provider
131.24 or contractor in the medical assistance program, general assistance medical care program,
131.25 and MinnesotaCare as a condition of participating as a provider in health insurance plans
131.26 and programs or contractor for state employees established under section 43A.18, the
131.27 public employees insurance program under section 43A.316, for health insurance plans
131.28 offered to local statutory or home rule charter city, county, and school district employees,
131.29 the workers' compensation system under section 176.135, and insurance plans provided
131.30 through the Minnesota Comprehensive Health Association under sections 62E.01 to
131.31 62E.19. The limitations on insurance plans offered to local government employees shall
131.32 not be applicable in geographic areas where provider participation is limited by managed
131.33 care contracts with the Department of Human Services.

132.1 (b) For providers other than health maintenance organizations, participation in the
132.2 medical assistance program means that:

132.3 (1) the provider accepts new medical assistance, general assistance medical care,
132.4 and MinnesotaCare patients;

132.5 (2) for providers other than dental service providers, at least 20 percent of the
132.6 provider's patients are covered by medical assistance, general assistance medical care,
132.7 and MinnesotaCare as their primary source of coverage; or

132.8 (3) for dental service providers, at least ten percent of the provider's patients are
132.9 covered by medical assistance, general assistance medical care, and MinnesotaCare as
132.10 their primary source of coverage, or the provider accepts new medical assistance and
132.11 MinnesotaCare patients who are children with special health care needs. For purposes
132.12 of this section, "children with special health care needs" means children up to age 18
132.13 who: (i) require health and related services beyond that required by children generally;
132.14 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
132.15 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
132.16 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
132.17 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
132.18 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
132.19 commissioner after consultation with representatives of pediatric dental providers and
132.20 consumers.

132.21 (c) Patients seen on a volunteer basis by the provider at a location other than
132.22 the provider's usual place of practice may be considered in meeting the participation
132.23 requirement in this section. The commissioner shall establish participation requirements
132.24 for health maintenance organizations. The commissioner shall provide lists of participating
132.25 medical assistance providers on a quarterly basis to the commissioner of management and
132.26 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
132.27 of the commissioners shall develop and implement procedures to exclude as participating
132.28 providers in the program or programs under their jurisdiction those providers who do
132.29 not participate in the medical assistance program. The commissioner of management
132.30 and budget shall implement this section through contracts with participating health and
132.31 dental carriers.

132.32 (d) For purposes of paragraphs (a) and (b), participation in the general assistance
132.33 medical care program applies only to pharmacy providers.

132.34 (e) A provider described in section 256B.76, subdivision 5, may limit the eligibility
132.35 of new medical assistance, general assistance medical care, and MinnesotaCare patients
132.36 for specific categories of rehabilitative services, if medical assistance, general assistance

133.1 medical care, and MinnesotaCare patients served by the provider in the aggregate exceed
133.2 30 percent of the provider's overall patient population.

133.3 Sec. 45. Minnesota Statutes 2010, section 256B.0751, subdivision 1, is amended to
133.4 read:

133.5 Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753,
133.6 the following definitions apply.

133.7 (b) "Commissioner" means the commissioner of human services.

133.8 (c) "Commissioners" means the commissioner of humans services and the
133.9 commissioner of health, acting jointly.

133.10 (d) "Health plan company" has the meaning provided in section 62Q.01, subdivision
133.11 4.

133.12 (e) "Personal clinician" means a physician licensed under chapter 147, a physician
133.13 assistant licensed and practicing under chapter 147A, ~~or~~ a mental health professional
133.14 licensed under section 245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision
133.15 27, clauses (1) to (6), or an advanced practice nurse licensed and registered to practice
133.16 under chapter 148.

133.17 (f) "State health care program" means the medical assistance, MinnesotaCare, and
133.18 general assistance medical care programs.

133.19 Sec. 46. Minnesota Statutes 2010, section 256B.0751, subdivision 2, is amended to
133.20 read:

133.21 Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009,
133.22 the commissioners of health and human services shall develop and implement standards
133.23 of certification for health care homes for state health care programs. In developing these
133.24 standards, the commissioners shall consider existing standards developed by national
133.25 independent accrediting and medical home organizations. The standards developed by the
133.26 commissioners must meet the following criteria:

133.27 (1) emphasize, enhance, and encourage the use of primary care, and include the use
133.28 of primary care physicians, advanced practice nurses, ~~and~~ mental health professionals,
133.29 and physician assistants as personal clinicians but permitting multidisciplinary teams of
133.30 other health professionals;

133.31 (2) focus on delivering high-quality, efficient, and effective health care services
133.32 and providing, arranging, or coordinating related social and public health services and
133.33 other services that directly affect an individual's health, access to services, quality and
133.34 outcomes, and patient satisfaction;

134.1 (3) encourage patient-centered care and services, including active participation by
134.2 the patient and family or a legal guardian, or a health care agent as defined in chapter
134.3 145C, as appropriate in decision making and care plan development, and providing care
134.4 that is appropriate to the patient's race, ethnicity, and language;

134.5 (4) provide patients with a consistent, ongoing contact with a personal clinician or
134.6 team of ~~clinical~~ professionals to ensure continuous and appropriate care for the patient's
134.7 condition;

134.8 (5) ensure that health care homes develop and maintain appropriate comprehensive
134.9 care and wellness plans for their patients with complex or chronic conditions, including an
134.10 assessment of health risks ~~and~~ chronic conditions, and socioeconomic factors affecting
134.11 health and treatment;

134.12 (6) enable and encourage utilization of a range of qualified health care professionals
134.13 and other professionals or services related to the health and treatment of the patient,
134.14 including dedicated care coordinators, in a manner that enables providers to practice to
134.15 the fullest extent of their license;

134.16 (7) focus initially on patients who have or are at risk of developing chronic health
134.17 conditions;

134.18 (8) incorporate measures of quality, resource use, cost of care, and patient
134.19 experience, with appropriate adjustments for socioeconomic factors;

134.20 (9) ensure the use of health information technology and systematic follow-up,
134.21 including the use of patient registries; and

134.22 (10) encourage the use of scientifically based health care, patient decision-making
134.23 aids that provide patients with information about treatment and service options and their
134.24 associated benefits, risks, costs, and comparative outcomes, and other clinical decision
134.25 support tools.

134.26 (b) In developing these standards, the commissioners shall consult with national
134.27 and local organizations working on health care home models, physicians, relevant
134.28 state agencies, health plan companies, hospitals, other providers, patients, and patient
134.29 advocates. The commissioners may satisfy this requirement by continuing the provider
134.30 directed care coordination advisory committee.

134.31 (c) For the purposes of developing and implementing these standards, the
134.32 commissioners may use the expedited rulemaking process under section 14.389.

134.33 Sec. 47. Minnesota Statutes 2010, section 256B.0751, subdivision 3, is amended to
134.34 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. If a primary care clinic or mental health center is certified, all of the primary care clinic's or mental health center's clinicians who may provide care to persons enrolled with the health care home must meet the criteria of a health care home. In order to be certified as a health care home, a clinician ~~or~~ clinic, or community mental health center must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians ~~or~~ clinics, or mental health centers certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Sec. 48. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to read:

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner of health shall modify the health care homes application for certification to add an item allowing an applicant to indicate status as a federally qualified health center or a federally qualified health center look-alike, as defined in section 145.9269, subdivision 1. Effective July 1, 2012, the commissioner shall certify as a health care home each applicant that indicates this status on a completed application for certification, without requiring the applicant to meet the standards in Minnesota Rules, part 4764.0040. In order to retain certification, a federally qualified health center or federally qualified health center look-alike certified under this paragraph must seek annual

136.1 recertification by submitting a letter of intent stating its desire to be recertified but is not
136.2 required to meet the standards for recertification in Minnesota Rules, part 4764.0040.

136.3 (c) The commissioner of health shall waive health care home certification
136.4 requirements if an applicant demonstrates that compliance with a certification requirement
136.5 will create a major financial hardship or is not feasible, and the applicant establishes an
136.6 alternative way to accomplish the objectives of the certification requirement.

136.7 Sec. 49. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
136.8 subdivision to read:

136.9 Subd. 8. **Coordination with local services.** The health care home and the county
136.10 shall coordinate care and services provided to patients enrolled with a health care home
136.11 who have complex medical or socioeconomic needs or a disability, and who need and are
136.12 eligible for additional local services administered by counties, including but not limited
136.13 to waived services, mental health services, social services, public health services,
136.14 transportation, and housing. The coordination of care and services must be as provided in
136.15 the plan established by the patient and health care home.

136.16 Sec. 50. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
136.17 subdivision to read:

136.18 Subd. 9. **Patient choice of health care home.** Notwithstanding section 256B.69,
136.19 subdivisions 4 and 23, and subject to any necessary federal approval, the commissioner
136.20 may require a patient enrolled in a state health care program through a managed care
136.21 plan, county-based purchasing plan, fee-for-service, or demonstration project under
136.22 section 256B.0755 to select a health care home and agree to receive primary care and
136.23 care coordination services through the health care home as a condition of enrollment in
136.24 the state health care program. The patient must be allowed to choose from among all
136.25 available qualified health care providers, including an essential community provider as
136.26 defined in section 62Q.19, if the provider is certified as a health care home and agrees to
136.27 accept the terms, conditions, and payment rates for participation in the managed care plan,
136.28 county-based purchasing plan, fee-for-service program, or demonstration project, except
136.29 that reimbursement to federally qualified health centers and federally qualified health
136.30 center look-alikes as defined in section 145.9269 must comply with federal law.

136.31 Sec. 51. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
136.32 subdivision to read:

137.1 Subd. 10. **Engagement of patients and communities in health care home.** The
137.2 commissioner of health shall require health care homes to demonstrate that their health
137.3 care home patients, and the racial and ethnic communities of current or potential patients,
137.4 participate in evaluating the health care home and recommending improvements and
137.5 changes to the health care home's methods and procedures in order to improve health,
137.6 quality, and patient satisfaction for patients from those communities. The commissioner
137.7 shall consult with racial and ethnic communities to determine whether the requirements of
137.8 this section and rules adopted under it are barriers to effective health care home methods
137.9 and procedures for serving patients of racial and ethnic communities.

137.10 Sec. 52. Minnesota Statutes 2010, section 256B.0753, is amended by adding a
137.11 subdivision to read:

137.12 Subd. 4. **Waiver recipients.** A health care home shall receive the highest care
137.13 coordination payment established under section 256B.0753 for providing services to an
137.14 enrollee receiving home and community-based waiver services.

137.15 Sec. 53. Minnesota Statutes 2010, section 256B.0754, is amended by adding a
137.16 subdivision to read:

137.17 Subd. 3. **Primary care provider tiering.** (a) The commissioner shall establish
137.18 a tiering system for all providers participating in Minnesota health care programs.
137.19 The tiering system must differentiate providers on the basis of their ability to provide
137.20 cost-effective, quality care and must incorporate the provider peer grouping measures
137.21 established under section 62U.04. The tier assignments must be established annually based
137.22 on the most recent peer grouping measures available. Differentiation of tier assignments
137.23 must be statistically valid. The commissioner may set specific quality standards for
137.24 providers designated as high-performing providers under this subdivision.

137.25 (b) The commissioner may adjust the rates paid to providers within each tier group
137.26 established under paragraph (a) on an annual basis. Adjustments to rates shall not include
137.27 the rate paid for care coordination services to certified health care homes under section
137.28 256B.0753. Providers designated high-performing providers under paragraph (c) are not
137.29 eligible for rate increases unless the provider also meets the cost and quality criteria
137.30 associated with that tier level.

137.31 (c) Health care homes certified under section 256B.0751, rural health clinics, and
137.32 federally qualified health care clinics are designated as high-performing providers under
137.33 this subdivision.

138.1 (d) Providers reimbursed on a cost basis are subject to rate adjustments under this
138.2 section.

138.3 (e) The commissioner may phase in the tiering system by service type.

138.4 **EFFECTIVE DATE.** This section is effective one year from the public release of
138.5 provider peer grouping measures under Minnesota Statutes, section 62U.04, or upon
138.6 federal approval, whichever is later.

138.7 Sec. 54. Minnesota Statutes 2010, section 256B.0755, subdivision 4, is amended to
138.8 read:

138.9 Subd. 4. **Payment system.** (a) In developing a payment system for health care
138.10 delivery systems, the commissioner shall establish a total cost of care benchmark or a
138.11 risk/gain sharing payment model to be paid for services provided to the recipients enrolled
138.12 in a health care delivery system.

138.13 (b) The payment system may include incentive payments to health care delivery
138.14 systems that meet or exceed annual quality and performance targets realized through
138.15 the coordination of care.

138.16 (c) An amount equal to the savings realized to the general fund as a result of the
138.17 demonstration project shall be transferred each fiscal year to the health care access fund.

138.18 (d) The total cost of care benchmark for demonstration projects must be no
138.19 greater than the capitation rate that would have been paid to a managed care plan for a
138.20 substantially similar enrollee population based on the per-member per-month rate in
138.21 effect on December 31, 2010. The commissioner shall adjust benchmark payment rates
138.22 for demonstration projects as necessary to reflect the higher level of service and cost
138.23 necessary to serve a patient population with a higher incidence of socioeconomic barriers
138.24 and complexity, and shall make corresponding reductions in payment rates for projects
138.25 with a lower concentration of patients with socioeconomic barriers and complexity.

138.26 Sec. 55. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
138.27 subdivision to read:

138.28 **Subd. 8. Coordination with local services.** The health care home and the county
138.29 shall coordinate care and services provided to patients enrolled in a demonstration project
138.30 who have complex medical or socioeconomic needs or a disability, and who need and are
138.31 eligible for additional local services administered by counties, including but not limited
138.32 to waived services, mental health services, social services, public health services,
138.33 transportation, or housing. The coordination of care and services must be as provided in
138.34 the plan established by the patient and primary care provider or health care home.

139.1 Sec. 56. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
139.2 subdivision to read:

139.3 Subd. 9. **Rural demonstration projects.** For demonstration projects serving
139.4 rural areas, the commissioner shall consult with rural hospitals, primary care providers,
139.5 county boards, health plans, and other key stakeholders primarily domiciled in the
139.6 service area regarding the development and approval of alternative rural health care
139.7 delivery demonstration projects under this section. In addition to organizations eligible
139.8 to establish a demonstration project under subdivision 1, a rural demonstration project
139.9 may be established by a county public health or social services agency or a county-based
139.10 purchasing plan. In a rural area where multiple, competing provider-based demonstration
139.11 projects are not possible, the commissioner shall not approve more than one demonstration
139.12 project to serve the primary geographic area and shall follow the applicable procedures
139.13 and requirements in section 256B.692 regarding participation of county boards in
139.14 reviewing and approving demonstration project proposals.

139.15 Sec. 57. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
139.16 subdivision to read:

139.17 Subd. 10. **Patient choice of qualified provider.** The commissioner shall implement
139.18 and approve demonstration projects in a manner that allows a patient to choose a primary
139.19 care provider and health care home from among all available qualified options. The
139.20 commissioner may require the patient to remain with the chosen provider, health care
139.21 home, or demonstration project organization for a period of time determined by the
139.22 commissioner. The commissioner shall implement the demonstration projects in a manner
139.23 that ensures that a patient has the option of receiving services, including health care home
139.24 services, through a provider designated as an essential community provider under section
139.25 62Q.19. Demonstration projects and essential community providers must comply with
139.26 section 62Q.19, subdivisions 3 to 7, for purposes of participation of providers in the
139.27 demonstration project, except that reimbursement to federally qualified health centers
139.28 and federally qualified health center look-alikes as defined in section 145.9269 must be
139.29 in compliance with federal law.

139.30 Sec. 58. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
139.31 subdivision to read:

139.32 Subd. 11. **Patient and community engagement.** As a condition of approval of
139.33 a demonstration project, the commissioner shall require the applicant to demonstrate
139.34 that consumers and communities to be served under the project were consulted with and

140.1 engaged in the process of developing the project proposal. The proposal must identify the
140.2 needs and preferences of consumers and communities that were identified through this
140.3 process of consultation and engagement. The consumers and communities consulted with
140.4 and engaged in the development of the proposal must generally reflect the demographics,
140.5 race, and ethnicity of those likely to be served under the demonstration project, with a
140.6 special focus on those who experience the greatest health disparities. The commissioner
140.7 shall require that demonstration project providers continue to consult with and engage
140.8 consumers and communities during implementation and operation of the demonstration
140.9 project.

140.10 Sec. 59. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
140.11 subdivision to read:

140.12 Subd. 12. **Care coordination system.** The commissioner of human services, in
140.13 consultation with the commissioner of health, shall convene an advisory committee of
140.14 small, independent, rural, and safety net primary care clinics, community hospitals,
140.15 mental health centers, dental clinics, and other providers to advise the commissioner
140.16 on the establishment of a system that will allow providers participating in payment
140.17 reform demonstration projects established under this section and section 256B.0756 to
140.18 effectively coordinate and deliver care to patients. In consultation with the advisory
140.19 committee, the commissioner shall develop a plan for the care coordination system, issue a
140.20 request for proposals, and contract with a vendor or vendors to establish and maintain the
140.21 technology for the care coordination system. Using appropriations made for this purpose,
140.22 the commissioner shall fund the planning, development, and establishment of the system.
140.23 Ongoing costs must be covered by payments made by the providers who use the system.

140.24 Sec. 60. Minnesota Statutes 2010, section 256B.0755, is amended by adding a
140.25 subdivision to read:

140.26 Subd. 13. **Approval and implementation.** Beginning January 1, 2012, the
140.27 commissioner of human services shall approve payment reform projects authorized under
140.28 this section for medical assistance and MinnesotaCare. The commissioner may approve
140.29 projects for persons enrolled in fee-for-service programs and may require managed care
140.30 plans and county-based purchasing plans to contract with a demonstration project provider
140.31 on the same terms, conditions, and payment arrangements as are established by the
140.32 commissioner for fee-for-service programs.

141.1 Sec. 61. Minnesota Statutes 2010, section 256B.0756, is amended to read:

141.2 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

141.3 (a) The commissioner, upon federal approval of a new waiver request or amendment
141.4 of an existing demonstration, may establish a pilot program in Hennepin County or
141.5 Ramsey County, or both, to test alternative and innovative integrated health care delivery
141.6 networks.

141.7 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
141.8 medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin
141.9 County or Ramsey County.

141.10 (c) Individuals enrolled in the pilot program shall be enrolled in an integrated
141.11 health care delivery network in their county of residence. The integrated health care
141.12 delivery network in Hennepin County shall be a network, such as an accountable care
141.13 organization or a community-based collaborative care network, created by or including
141.14 Hennepin County Medical Center. The integrated health care delivery network in Ramsey
141.15 County shall be a network, such as an accountable care organization or community-based
141.16 collaborative care network, created by or including Regions Hospital.

141.17 (d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for
141.18 Hennepin County and 3,500 enrollees for Ramsey County.

141.19 (e) In developing a payment system for the pilot programs, the commissioner shall
141.20 establish a total cost of care for the recipients enrolled in the pilot programs that equals
141.21 the cost of care that would otherwise be spent for these enrollees in the prepaid medical
141.22 assistance program.

141.23 (f) Counties may transfer funds necessary to support the nonfederal share of
141.24 payments for integrated health care delivery networks in their county. Such transfers per
141.25 county shall not exceed 15 percent of the expected expenses for county enrollees.

141.26 (g) The commissioner shall apply to the federal government for, or as appropriate,
141.27 cooperate with counties, providers, or other entities that are applying for any applicable
141.28 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
141.29 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
141.30 111-152, that would further the purposes of or assist in the creation of an integrated health
141.31 care delivery network for the purposes of this subdivision, including, but not limited to, a
141.32 global payment demonstration or the community-based collaborative care network grants.

141.33 (h) A demonstration project established under this section must meet the
141.34 requirements of section 256B.0755, subdivisions 8, 9, 10, and 11.

141.35 Sec. 62. **[256B.0758] PREGNANCY CARE HOMES.**

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

142.3 (b) "Pregnancy care home" means a health care home certified by the commissioner
142.4 of health under section 256B.0751 that provides pregnancy care services in a way that
142.5 is patient-centered, outcome-driven, comprehensive, and coordinated, and meets the
142.6 standards specified and developed under subdivision 3.

142.7 (c) "Pregnancy care services" means prenatal care, consultative perinatal services,
142.8 intrapartum and postpartum care, and well-baby care for the first week.

142.9 (d) "State health care program" means the medical assistance and MinnesotaCare
142.10 programs.

142.11 Subd. 2. **Development and implementation of standards.** (a) The commissioners
142.12 of human services and health shall develop and implement standards of certification
142.13 of pregnancy care homes for state health care programs. In developing standards, the
142.14 commissioners shall consult with representatives of the American College of Nurse
142.15 Midwives, the American Congress of OB/GYN, the American Academy of Family
142.16 Practice, the American Academy of Pediatrics, and relevant local consumer groups.

142.17 Subd. 3. **Criteria for development of standards.** (a) A pregnancy care home must
142.18 meet the general health care home standards developed by the commissioners under
142.19 section 256B.0751, subdivision 2, paragraph (a), clauses (1) to (4), (6), and (8) to (10), and
142.20 must also meet specific standards for pregnancy care homes. The specific standards for
142.21 pregnancy care homes developed by the commissioners must meet the criteria specified
142.22 in this subdivision.

142.23 (b) A pregnancy care home must provide pregnancy care services. Nonpregnancy
142.24 complications, such as preexisting illness, shall be covered by medical assistance outside
142.25 of the pregnancy care home. During a pregnancy episode, the pregnancy care home must
142.26 coordinate necessary nonpregnancy health care services with the mother's primary care
142.27 provider or another appropriate provider.

142.28 (c) Each pregnancy care home must have adequate malpractice insurance that meets
142.29 the standards specified by the commissioners.

142.30 (d) A pregnancy care home may provide pregnancy services through any health care
142.31 professional licensed to provide the service in Minnesota, including but not limited to
142.32 licensed traditional midwives, certified nurse midwives, family practitioners, obstetricians,
142.33 perinatologists, neonatologists, and other advanced practice registered nurses.

142.34 (e) Pregnancy care within a pregnancy care home may be provided at any Minnesota
142.35 facility licensed to provide pregnancy care and birth, including but not limited to
142.36 freestanding birth centers, integrated birth centers, and hospitals. Each pregnancy care

143.1 home must offer the option of midwife-directed pregnancy care services in a licensed
143.2 integrated or freestanding birth center.

143.3 (f) A pregnancy care home must have a governing board comprised of at least
143.4 eight members. One-half of the governing board members must be providers licensed to
143.5 attend births.

143.6 (g) Each pregnancy care home must have a formal consultative relationship with at
143.7 least one level III perinatal center to provide care for mothers and babies who develop
143.8 pregnancy complications.

143.9 (h) Each pregnancy care home must comply with state and federal requirements for
143.10 the use of interoperable electronic medical records.

143.11 (i) Each pregnancy care home must submit annual reports to the commissioners of
143.12 human services and health that document:

143.13 (1) all relevant pregnancy care outcomes and patient satisfaction measures; and

143.14 (2) the financial status of the pregnancy care home.

143.15 All reports are public data under section 13.02.

143.16 (j) Each pregnancy care home must offer culturally competent care coordination
143.17 services in a manner that is consistent with health care home requirements.

143.18 (k) For the purposes of developing and implementing the standards in this
143.19 subdivision, the commissioners may use the expedited rulemaking process under section
143.20 14.389.

143.21 Subd. 4. **Certification process.** Providers seeking certification as a pregnancy care
143.22 home must apply to the commissioner of health. Providers certified by the commissioner
143.23 of health may provide pregnancy care services through pregnancy care homes beginning
143.24 July 1, 2012. Certification as a pregnancy care home is voluntary, except that beginning
143.25 July 1, 2014, all nonemergency pregnancy care services covered under state health care
143.26 programs must be provided through providers certified as pregnancy care homes.

143.27 Subd. 5. **Payments to pregnancy care homes.** (a) The commissioner of human
143.28 services, in coordination with the commissioner of health, shall develop a payment system
143.29 that provides a single per-person payment to pregnancy care homes to cover all pregnancy
143.30 care services provided to each mother and infant enrolled in a state health care program.
143.31 Pregnancy care homes receiving payments under this subdivision remain eligible for care
143.32 coordination payments under section 256B.0753.

143.33 (b) Payment amounts for pregnancy care homes shall be uniform statewide and
143.34 determined annually by the commissioner, based initially upon a specified percentage
143.35 of the calculated average cost of care for mothers and infants under state health care
143.36 programs for the three most recent fiscal years for which cost information is available.

144.1 Beginning July 1, 2014, statewide payment amounts for pregnancy care homes shall be
144.2 determined annually by the commissioner by adjusting the current payment amount by
144.3 a measure of medical inflation selected by the commissioner that best represents the
144.4 change in the cost of pregnancy-related services provided to patients covered by private
144.5 sector health coverage.

144.6 (c) Pregnancy care home payments must initially be made for pregnancy care
144.7 services provided to pregnant women who are not high risk, beginning July 1, 2012.
144.8 Beginning January 1, 2013, the commissioner shall phase in higher payments for high-risk
144.9 pregnancy categories so that beginning July 1, 2014, pregnancy care services for all
144.10 low-risk and high-risk pregnancies are reimbursed under this subdivision.

144.11 Sec. 63. **[256B.0759] CARE COORDINATION FOR ENROLLEES.**

144.12 Subdivision 1. **Qualified enrollee.** For purposes of this section, a "qualified
144.13 enrollee" means: (1) a medical assistance enrollee eligible under this chapter; or (2) a
144.14 MinnesotaCare enrollee eligible under chapter 256L.

144.15 Subd. 2. **Selection of primary care provider.** The commissioner shall require
144.16 qualified enrollees who do not have a designated medical condition to select a primary
144.17 care provider and agree to receive primary care services from that provider as a condition
144.18 of medical assistance or MinnesotaCare enrollment.

144.19 Subd. 3. **Selection of health care home; care coordination.** (a) The commissioner
144.20 shall require qualified enrollees who have a medical condition designated by the
144.21 commissioner to select a health care home certified under section 256B.0751 and agree
144.22 to receive primary care and care coordination services through that health care home as
144.23 a condition of medical assistance or MinnesotaCare enrollment. For purposes of this
144.24 subdivision, the commissioner shall designate medical conditions with a high likelihood
144.25 of inappropriate inpatient hospital admissions for which care coordination and prior
144.26 authorization of admissions are expected to improve the quality of care and lead to costs
144.27 savings for state health care programs.

144.28 (b) The commissioner shall include on Minnesota health care program enrollment
144.29 cards a designation as to whether an enrollee meets the criteria in paragraph (a). In order
144.30 to receive medical assistance or MinnesotaCare payment for nonemergency inpatient
144.31 hospital admissions for enrollees meeting the criteria in paragraph (a), a hospital must
144.32 receive prior authorization from the enrollee's health care home.

144.33 **EFFECTIVE DATE.** This section is effective January 1, 2012, for MinnesotaCare
144.34 enrollees not eligible for a federal match, and is effective January 1, 2012, or upon federal

145.1 approval, whichever is later, for medical assistance enrollees and for MinnesotaCare
145.2 enrollees eligible for a federal match.

145.3 Sec. 64. **[256B.0760] ELECTIVE SURGERY.**

145.4 Subdivision 1. **Payment prohibition.** The commissioner, in consultation with
145.5 health care providers, health care homes certified under section 256B.0751, managed
145.6 care plans providing services under section 256B.69, and county-based purchasing plans
145.7 providing services under section 256B.692, shall identify elective or nonemergency
145.8 surgical procedures for which less invasive and less costly alternative treatment methods
145.9 are available, and shall prohibit payment for these elective or nonemergency surgical
145.10 procedures if the alternative treatment methods have not first been evaluated for use
145.11 and, if appropriate, provided to the enrollee.

145.12 Subd. 2. **Implementation.** The commissioner shall implement the payment
145.13 prohibitions in paragraph (a) for fee-for-service medical assistance providers by January
145.14 1, 2012, and shall require managed care and county-based purchasing plans to implement
145.15 the payment prohibitions in paragraph (a) for providers employed or under contract for
145.16 services provided to medical assistance and MinnesotaCare enrollees beginning January
145.17 1, 2012.

145.18 Subd. 3. **Reduction in capitation rates.** The commissioner shall reduce medical
145.19 assistance and MinnesotaCare capitation rates to managed care and county-based
145.20 purchasing plans beginning January 1, 2012, to reflect cost-savings to plans resulting from
145.21 implementation of the payment prohibitions required by this subdivision.

145.22 Sec. 65. Minnesota Statutes 2010, section 256B.37, subdivision 5, is amended to read:

145.23 Subd. 5. **Private benefits to be used first.** Private accident and health care
145.24 coverage, including Medicare for medical services and coverage provided through the
145.25 United States Department of Veterans Affairs, is primary coverage and must be exhausted
145.26 before medical assistance or alternative care services are paid for medical services
145.27 including home health care, personal care assistance services, hospice, supplies and
145.28 equipment, or services covered under a Centers for Medicare and Medicaid Services
145.29 waiver. When a person who is otherwise eligible for medical assistance has private
145.30 accident or health care coverage, including Medicare or a prepaid health plan or coverage
145.31 provided through the United States Department of Veterans Affairs, the private health care
145.32 benefits available to the person must be used first and to the fullest extent.

145.33 Sec. 66. Minnesota Statutes 2010, section 256B.69, subdivision 3a, is amended to read:

146.1 Subd. 3a. **County authority.** (a) The commissioner, when implementing or
146.2 administering the medical assistance prepayment program within a county, must include
146.3 the county board in the process of development, approval, and issuance of the request for
146.4 proposals to provide services to eligible individuals within the proposed county, including
146.5 proposals for demonstration projects established under section 256B.0755. County boards
146.6 must be given reasonable opportunity to ~~make recommendations regarding~~ assist in
146.7 the development, issuance, review of responses, and changes needed in the request for
146.8 proposals. The commissioner must provide county boards the opportunity to review
146.9 each proposal based on the identification of community needs under chapters 145A and
146.10 256E and county advocacy activities. If a county board finds that a proposal does not
146.11 address certain community needs, the county board and commissioner shall continue
146.12 efforts for improving the proposal and network prior to the approval of the contract.
146.13 The county board shall make ~~recommendations~~ determinations regarding the approval
146.14 of local networks and their operations to ensure adequate local availability and access to
146.15 covered services. The provider or health plan must respond directly to county advocates
146.16 and the state prepaid medical assistance ombudsperson regarding service delivery and
146.17 must be accountable to the state regarding contracts with medical assistance funds. The
146.18 county board ~~may recommend~~ shall decide a maximum number of participating health
146.19 plans including county-based purchasing plans after considering the size of the enrolling
146.20 population; ensuring adequate access and capacity; considering the client and county
146.21 administrative complexity; and considering the need to promote the viability of locally
146.22 developed health plans, managed care plans, or demonstration projects established under
146.23 section 256B.0755. The county board or a single entity representing a group of county
146.24 boards and the commissioner shall mutually select one or more qualified health plans or
146.25 county-based purchasing plans for participation at the time of initial implementation of the
146.26 prepaid medical assistance program or a demonstration project established under section
146.27 256B.0755 in that county or group of counties and at the time of contract renewal. The
146.28 commissioner shall also seek input for contract requirements from the county or single
146.29 entity representing a group of county boards at each contract renewal and incorporate
146.30 those recommendations into the contract negotiation process.

146.31 (b) At the option of the county board, the board may develop contract requirements
146.32 related to the achievement of local public health goals and health care delivery and access
146.33 goals to meet the health needs of medical assistance enrollees. These requirements must
146.34 be reasonably related to the performance of health plan managed care or delivery system
146.35 demonstration project functions and within the scope of the medical assistance benefit
146.36 set. ~~If the county board and the commissioner mutually agree to such requirements, the~~

147.1 ~~department~~ The commissioner shall include such requirements in all ~~health plan~~ contracts
147.2 governing the prepaid medical assistance program in that county at initial implementation
147.3 of the program or demonstration project in that county and at the time of contract renewal.
147.4 The county board may participate in the enforcement of the contract ~~provisions related to~~
147.5 ~~local public health goals~~.

147.6 (c) For counties in which a prepaid medical assistance program has not been
147.7 established, the commissioner shall not implement that program if a county board submits
147.8 an acceptable and timely preliminary and final proposal under section 256B.692, until
147.9 county-based purchasing is no longer operational in that county. For counties in which
147.10 a prepaid medical assistance program is in existence on or after September 1, 1997, the
147.11 commissioner must terminate contracts with health plans according to section 256B.692,
147.12 subdivision 5, if the county board submits and the commissioner accepts a ~~preliminary and~~
147.13 ~~final~~ proposal according to that subdivision. The commissioner is not required to terminate
147.14 contracts that begin on or after September 1, 1997, according to section 256B.692 until
147.15 two years have elapsed from the date of initial enrollment.

147.16 (d) In the event that a county board or a single entity representing a group of county
147.17 boards and the commissioner cannot reach agreement regarding: (i) the selection of
147.18 participating health plans or demonstration projects under section 256B.0755 in that
147.19 county; (ii) contract requirements; or (iii) implementation and enforcement of county
147.20 requirements including provisions regarding local public health goals, the commissioner
147.21 shall resolve all disputes ~~after taking into account~~ by approving the recommendations of
147.22 a three-person mediation panel. The panel shall be composed of one designee of the
147.23 president of the association of Minnesota counties, one designee of the commissioner of
147.24 human services, and one person selected jointly by the designee of the commissioner of
147.25 human services and the designee of the Association of Minnesota Counties. Within a
147.26 reasonable period of time before the hearing, the panelists must be provided all documents
147.27 and information relevant to the mediation. The parties to the mediation must be given
147.28 30 days' notice of a hearing before the mediation panel.

147.29 (e) If a county which elects to implement county-based purchasing ceases to
147.30 implement county-based purchasing, it is prohibited from assuming the responsibility of
147.31 county-based purchasing for a period of five years from the date it discontinues purchasing.

147.32 (f) The commissioner shall not require that contractual disputes between
147.33 county-based purchasing entities and the commissioner be mediated by a panel that
147.34 includes a representative of the Minnesota Council of Health Plans.

148.1 (g) At the request of a county-purchasing entity, the commissioner shall adopt a
148.2 contract reprocurement or renewal schedule under which all counties included in the
148.3 entity's service area are reprocured or renewed at the same time.

148.4 (h) The commissioner shall provide a written report under section 3.195 to the chairs
148.5 of the legislative committees having jurisdiction over human services in the senate and the
148.6 house of representatives describing in detail the activities undertaken by the commissioner
148.7 to ensure full compliance with this section. The report must also provide an explanation
148.8 for any decisions of the commissioner not to accept the recommendations of a county or
148.9 group of counties required to be consulted under this section. The report must be provided
148.10 at least 30 days prior to the effective date of a new or renewed prepaid or managed care
148.11 contract in a county.

148.12 (i) This section also applies to other Minnesota health care programs administered
148.13 by the commissioner, including but not limited to the MinnesotaCare program.

148.14 Sec. 67. Minnesota Statutes 2010, section 256B.69, subdivision 4, is amended to read:

148.15 Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to
148.16 determine when limitation of choice may be implemented in the experimental counties.
148.17 The criteria shall ensure that all eligible individuals in the county have continuing access
148.18 to the full range of medical assistance services as specified in subdivision 6.

148.19 (b) The commissioner shall exempt the following persons from participation in the
148.20 project, in addition to those who do not meet the criteria for limitation of choice:

148.21 (1) persons eligible for medical assistance according to section 256B.055,
148.22 subdivision 1;

148.23 (2) persons eligible for medical assistance due to blindness or disability as
148.24 determined by the Social Security Administration or the state medical review team, unless:

148.25 (i) they are 65 years of age or older; or

148.26 (ii) they reside in Itasca County or they reside in a county in which the commissioner
148.27 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social
148.28 Security Act;

148.29 (3) recipients who currently have private coverage through a health maintenance
148.30 organization;

148.31 (4) recipients who are eligible for medical assistance by spending down excess
148.32 income for medical expenses other than the nursing facility per diem expense;

148.33 (5) recipients who receive benefits under the Refugee Assistance Program,
148.34 established under United States Code, title 8, section 1522(e);

149.1 (6) children who are both determined to be severely emotionally disturbed and
149.2 receiving case management services according to section 256B.0625, subdivision 20,
149.3 except children who are eligible for and who decline enrollment in an approved preferred
149.4 integrated network under section 245.4682;

149.5 (7) adults who are both determined to be seriously and persistently mentally ill and
149.6 received case management services according to section 256B.0625, subdivision 20;

149.7 (8) persons eligible for medical assistance according to section 256B.057,
149.8 subdivision 10; and

149.9 (9) persons with access to cost-effective employer-sponsored private health
149.10 insurance or persons enrolled in a non-Medicare individual health plan determined to be
149.11 cost-effective according to section 256B.0625, subdivision 15.

149.12 Children under age 21 who are in foster placement may enroll in the project on an elective
149.13 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an
149.14 elective basis. The commissioner may enroll recipients in the prepaid medical assistance
149.15 program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by
149.16 spending down excess income.

149.17 (c) The commissioner may allow persons with a one-month spenddown who are
149.18 otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay
149.19 their monthly spenddown to the state.

149.20 (d) The commissioner may require those individuals to enroll in the prepaid medical
149.21 assistance program who otherwise would have been excluded under paragraph (b), clauses
149.22 (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

149.23 (e) Before limitation of choice is implemented, eligible individuals shall be notified
149.24 and after notification, shall be allowed to choose only among demonstration providers.
149.25 The commissioner may assign an individual with private coverage through a health
149.26 maintenance organization, to the same health maintenance organization for medical
149.27 assistance coverage, if the health maintenance organization is under contract for medical
149.28 assistance in the individual's county of residence. After initially choosing a provider,
149.29 the recipient is allowed to change that choice only at specified times as allowed by the
149.30 commissioner. If a demonstration provider ends participation in the project for any reason,
149.31 a recipient enrolled with that provider must select a new provider but may change providers
149.32 without cause once more within the first 60 days after enrollment with the second provider.

149.33 (f) An infant born to a woman who is eligible for and receiving medical assistance
149.34 and who is enrolled in the prepaid medical assistance program shall be retroactively
149.35 enrolled to the month of birth in the same managed care plan as the mother once the

150.1 child is enrolled in medical assistance unless the child is determined to be excluded from
150.2 enrollment in a prepaid plan under this section.

150.3 (g) For an eligible individual under the age of 65, in the absence of a specific
150.4 managed care plan choice by the individual, the commissioner shall assign the individual to
150.5 the county-based purchasing plan, if any, in the county of the individual's residence. For an
150.6 eligible individual over the age of 65, the commissioner shall make the default assignment
150.7 on the county-based purchasing plan entering into a contract with the commissioner to
150.8 serve this population and receiving federal approval as a special needs plan.

150.9 Sec. 68. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

150.10 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
150.11 and section 256L.12 shall be entered into or renewed on a calendar year basis beginning
150.12 January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to
150.13 renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December
150.14 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may
150.15 issue separate contracts with requirements specific to services to medical assistance
150.16 recipients age 65 and older.

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

150.22 (c) Effective for services rendered on or after January 1, 2003, the commissioner
150.23 shall withhold five percent of managed care plan payments under this section and
150.24 county-based purchasing plan payments under section 256B.692 for the prepaid medical
150.25 assistance program pending completion of performance targets. Each performance target
150.26 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
150.27 of a performance target based on a federal or state law or rule. Criteria for assessment
150.28 of each performance target must be outlined in writing prior to the contract effective
150.29 date. The managed care plan must demonstrate, to the commissioner's satisfaction,
150.30 that the data submitted regarding attainment of the performance target is accurate. The
150.31 commissioner shall periodically change the administrative measures used as performance
150.32 targets in order to improve plan performance across a broader range of administrative
150.33 services. The performance targets must include measurement of plan efforts to contain
150.34 spending on health care services and administrative activities. The commissioner may
150.35 adopt plan-specific performance targets that take into account factors affecting only one

151.1 plan, including characteristics of the plan's enrollee population. The withheld funds
151.2 must be returned no sooner than July of the following year if performance targets in the
151.3 contract are achieved. The commissioner may exclude special demonstration projects
151.4 under subdivision 23.

151.5 (d) Effective for services rendered on or after January 1, 2009, through December
151.6 31, 2009, the commissioner shall withhold three percent of managed care plan payments
151.7 under this section and county-based purchasing plan payments under section 256B.692
151.8 for the prepaid medical assistance program. The withheld funds must be returned no
151.9 sooner than July 1 and no later than July 31 of the following year. The commissioner may
151.10 exclude special demonstration projects under subdivision 23.

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

151.18 (f) Effective for services rendered on or after January 1, 2010, through December
151.19 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments
151.20 under this section and county-based purchasing plan payments under section 256B.692
151.21 for the prepaid medical assistance program. The withheld funds must be returned no
151.22 sooner than July 1 and no later than July 31 of the following year. The commissioner may
151.23 exclude special demonstration projects under subdivision 23.

151.24 (g) Effective for services rendered on or after January 1, 2011, the commissioner
151.25 shall include as part of the performance targets described in paragraph (c) a reduction in
151.26 the health plan's emergency room utilization rate for state health care program enrollees
151.27 by a measurable rate of five percent from the plan's utilization rate for state health care
151.28 program enrollees for the previous calendar year.

151.29 The withheld funds must be returned no sooner than July 1 and no later than July 31
151.30 of the following calendar year if the managed care plan demonstrates to the satisfaction of
151.31 the commissioner that a reduction in the utilization rate was achieved.

151.32 The withhold described in this paragraph shall continue for each consecutive
151.33 contract period until the plan's emergency room utilization rate for state health care
151.34 program enrollees is reduced by 25 percent of the plan's emergency room utilization
151.35 rate for state health care program enrollees for calendar year 2009. Hospitals shall
151.36 cooperate with the health plans in meeting this performance target and shall accept

152.1 payment withholds that may be returned to the hospitals if the performance target is
152.2 achieved. The commissioner shall structure the withhold so that the commissioner returns
152.3 a portion of the withheld funds in amounts commensurate with achieved reductions in
152.4 utilization less than the targeted amount. The withhold in this paragraph does not apply to
152.5 county-based purchasing plans.

152.6 (h) Effective for services rendered on or after January 1, 2012, the commissioner
152.7 shall include as part of the performance targets described in paragraph (c) a reduction in
152.8 the plan's hospitalization rates or subsequent hospitalizations within 30 days of a previous
152.9 hospitalization of a patient regardless of the reason for the hospitalization for state health
152.10 care program enrollees by a measurable rate of five percent from the plan's utilization rate
152.11 for state health care program enrollees for the previous calendar year.

152.12 The withheld funds must be returned no sooner than July 1 and no later than July 31
152.13 of the following calendar year if the managed care plan or county-based purchasing plan
152.14 demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization
152.15 rate was achieved.

152.16 The withhold described in this paragraph must continue for each consecutive
152.17 contract period until the plan's subsequent hospitalization rate for state health care
152.18 program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate
152.19 for state health care program enrollees for calendar year 2010. Hospitals shall cooperate
152.20 with the plans in meeting this performance target and shall accept payment withholds that
152.21 must be returned to the hospitals if the performance target is achieved. The commissioner
152.22 shall structure the withhold so that the commissioner returns a portion of the withheld
152.23 funds in amounts commensurate with achieved reductions in utilization less than the
152.24 targeted amount.

152.25 ~~(h)~~ (i) Effective for services rendered on or after January 1, 2011, through December
152.26 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments
152.27 under this section and county-based purchasing plan payments under section 256B.692
152.28 for the prepaid medical assistance program. The withheld funds must be returned no
152.29 sooner than July 1 and no later than July 31 of the following year. The commissioner may
152.30 exclude special demonstration projects under subdivision 23.

152.31 ~~(i)~~ (j) Effective for services rendered on or after January 1, 2012, through December
152.32 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
152.33 under this section and county-based purchasing plan payments under section 256B.692
152.34 for the prepaid medical assistance program. The withheld funds must be returned no
152.35 sooner than July 1 and no later than July 31 of the following year. The commissioner may
152.36 exclude special demonstration projects under subdivision 23.

153.1 ~~(j)~~ (k) Effective for services rendered on or after January 1, 2013, through December
153.2 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
153.3 under this section and county-based purchasing plan payments under section 256B.692
153.4 for the prepaid medical assistance program. The withheld funds must be returned no
153.5 sooner than July 1 and no later than July 31 of the following year. The commissioner may
153.6 exclude special demonstration projects under subdivision 23.

153.7 ~~(k)~~ (l) Effective for services rendered on or after January 1, 2014, the commissioner
153.8 shall withhold three percent of managed care plan payments under this section and
153.9 county-based purchasing plan payments under section 256B.692 for the prepaid medical
153.10 assistance program. The withheld funds must be returned no sooner than July 1 and
153.11 no later than July 31 of the following year. The commissioner may exclude special
153.12 demonstration projects under subdivision 23.

153.13 ~~(l)~~ (m) A managed care plan or a county-based purchasing plan under section
153.14 256B.692 may include as admitted assets under section 62D.044 any amount withheld
153.15 under this section that is reasonably expected to be returned.

153.16 ~~(m)~~ (n) Contracts between the commissioner and a prepaid health plan are exempt
153.17 from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
153.18 (a), and 7.

153.19 ~~(n)~~ (o) The return of the withhold under paragraphs (d), (f), and (h) to (k) is not
153.20 subject to the requirements of paragraph (c).

153.21 Sec. 69. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

153.22 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
153.23 services shall transfer each year to the medical education and research fund established
153.24 under section 62J.692, the following:

153.25 (1) an amount equal to the reduction in the prepaid medical assistance payments as
153.26 specified in this clause. Until January 1, 2002, the county medical assistance capitation
153.27 base rate prior to plan specific adjustments and after the regional rate adjustments under
153.28 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
153.29 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
153.30 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
153.31 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
153.32 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
153.33 facility and elderly waiver payments and demonstration project payments operating
153.34 under subdivision 23 are excluded from this reduction. The amount calculated under

154.1 this clause shall not be adjusted for periods already paid due to subsequent changes to
154.2 the capitation payments;

154.3 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
154.4 section;

154.5 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
154.6 paid under this section; and

154.7 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
154.8 under this section.

154.9 (b) This subdivision shall be effective upon approval of a federal waiver which
154.10 allows federal financial participation in the medical education and research fund. Effective
154.11 July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4),
154.12 shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first
154.13 reduce the amounts otherwise required to be transferred under paragraph (a), clauses
154.14 (2) to (4). Any excess following this reduction shall proportionally reduce the transfers
154.15 under paragraph (a), clause (1).

154.16 (c) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall
154.17 transfer \$21,714,000 each fiscal year to the medical education and research fund. The
154.18 balance of the transfers under paragraph (a) shall be transferred to the medical education
154.19 and research fund no earlier than July 1 of the following fiscal year.

154.20 (d) Beginning in fiscal year 2012, the commissioner shall reduce the amount
154.21 transferred to the medical education research fund under paragraph (a), by \$4,500,000
154.22 each fiscal year. This reduction must be applied to the amount available for general
154.23 distribution under section 62J.692, subdivision 7, clause (5).

154.24 Sec. 70. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

154.25 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for
154.26 the health care coordination for eligible individuals. Demonstration providers:

154.27 (1) shall authorize and arrange for the provision of all needed health services
154.28 including but not limited to the full range of services listed in sections 256B.02,
154.29 subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to
154.30 enrollees. Notwithstanding section 256B.0621, demonstration providers that provide
154.31 nursing home and community-based services under this section shall provide relocation
154.32 service coordination to enrolled persons age 65 and over;

154.33 (2) shall accept the prospective, per capita payment from the commissioner in return
154.34 for the provision of comprehensive and coordinated health care services for eligible
154.35 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. 71. 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

156.1 the benchmark percentile, the plan shall return only the portion of the withhold sufficient
156.2 to bring the provider's payment rate to the average for providers within the provider type
156.3 whose risk-adjusted total annual cost of care is at the benchmark percentile. Each plan shall
156.4 establish the benchmark percentile at a level that allows the plan to adjust expenditures for
156.5 provider payments to reflect the reduction in capitation rates under paragraph (f).

156.6 (d) Each managed care and county-based purchasing plan must establish an appeals
156.7 process to allow providers to appeal determinations of risk-adjusted total annual cost of
156.8 care. Each plan's appeals process must be approved by the commissioner.

156.9 (e) The commissioner shall require each plan to submit to the commissioner, in
156.10 the form and manner specified by the commissioner, all provider payment data and
156.11 information on the withhold methodology that the commissioner determines is necessary
156.12 to verify compliance with this subdivision.

156.13 (f) The commissioner, for the contract year beginning January 1, 2012, shall reduce
156.14 plan capitation rates by 12 percent from the rates that would otherwise apply, absent
156.15 application of this subdivision. The reduced rate shall be the historical base rate for
156.16 negotiating capitation rates for future contract years. The commissioner may recommend
156.17 additional reductions in capitation rates for future contract years to the legislature, if the
156.18 commissioner determines this is necessary to ensure that health care providers under
156.19 contract with managed care and county-based purchasing plans practice in an efficient
156.20 manner. Effective for services rendered on or after January 1, 2012, managed care plans
156.21 and county-based purchasing plans contracted with the state to administer the health
156.22 care programs provided under sections 256B.69, 256B.692, and 256L.12, may reduce
156.23 payments made to providers employed or under contract with the plan.

156.24 (g) The commissioner of human services, in consultation with the commissioner of
156.25 health, shall develop and provide to managed care and county-based purchasing plans, by
156.26 September 1, 2011, standard criteria and definitions necessary for consistent calculation
156.27 of the total annual risk-adjusted cost of care across plans. The commissioner may use
156.28 encounter data to implement this subdivision, and may provide encounter data or analyses
156.29 to plans.

156.30 (h) For purposes of this subdivision, "provider" means a vendor of medical care
156.31 as defined in section 256B.02, subdivision 7, for which sufficient encounter data on
156.32 utilization and costs is available to implement this subdivision.

156.33 (i) A managed care or county-based purchasing plan must use the methodology
156.34 described in paragraphs (a) to (e), unless the plan develops an alternative model consistent
156.35 with the purpose of this subdivision.

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

157.1 Sec. 72. Minnesota Statutes 2010, section 256B.69, is amended by adding a
157.2 subdivision to read:

157.3 Subd. 31. **Initiatives to reduce incidence of low birth weight.** The commissioner
157.4 shall require managed care and county-based purchasing plans as a condition of contract
157.5 to implement strategies to reduce the incidence of low birth weight in geographic areas
157.6 identified by the commissioner as having a higher than average incidence of low birth
157.7 weight, with special emphasis on areas within a one-mile radius of hospitals within their
157.8 provider networks. These strategies may focus on smoking prevention and cessation,
157.9 ensuring that pregnant women get adequate nutrition, and addressing demographic,
157.10 social, and environmental risk factors. The strategies must coordinate health care with
157.11 social services and the local public health system, and offer patient education through
157.12 appropriate means. The commissioner shall require plans to submit proposed initiatives
157.13 for approval to the commissioner by January 1, 2012, and the commissioner shall require
157.14 plans to implement approved initiatives by July 1, 2012. The commissioner shall evaluate
157.15 the strategies adopted to reduce low birth weight and shall require plans to submit outcome
157.16 and other data necessary for the evaluation.

157.17 Sec. 73. Minnesota Statutes 2010, section 256B.69, is amended by adding a
157.18 subdivision to read:

157.19 Subd. 32. **Health education.** The commissioner shall require managed care and
157.20 county-based purchasing plans, as a condition of contract, to provide health education,
157.21 wellness training, and information about the availability and benefits of preventive
157.22 services to all medical assistance and MinnesotaCare enrollees, beginning January 1,
157.23 2012. Plan initiatives developed or implemented to comply with this requirement must be
157.24 approved by the commissioner.

157.25 Sec. 74. Minnesota Statutes 2010, section 256B.692, subdivision 2, is amended to read:

157.26 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and
157.27 62N, a county that elects to purchase medical assistance in return for a fixed sum without
157.28 regard to the frequency or extent of services furnished to any particular enrollee is not
157.29 required to obtain a certificate of authority under chapter 62D or 62N. The county board
157.30 of commissioners is the governing body of a county-based purchasing program. In a
157.31 multicounty arrangement, the governing body is a joint powers board established under
157.32 section 471.59.

157.33 (b) A county that elects to purchase medical assistance services under this section
157.34 must satisfy the commissioner of health that the requirements for assurance of consumer

158.1 protection, provider protection, and, effective January 1, 2010, fiscal solvency of chapter
158.2 62D, applicable to health maintenance organizations will be met according to the
158.3 following schedule:

158.4 (1) for a county-based purchasing plan approved on or before June 30, 2008, the
158.5 plan must have in reserve:

158.6 (i) at least 50 percent of the minimum amount required under chapter 62D as
158.7 of January 1, 2010;

158.8 (ii) at least 75 percent of the minimum amount required under chapter 62D as of
158.9 January 1, 2011;

158.10 (iii) at least 87.5 percent of the minimum amount required under chapter 62D as
158.11 of January 1, 2012; and

158.12 (iv) at least 100 percent of the minimum amount required under chapter 62D as
158.13 of January 1, 2013; and

158.14 (2) for a county-based purchasing plan first approved after June 30, 2008, the plan
158.15 must have in reserve:

158.16 (i) at least 50 percent of the minimum amount required under chapter 62D at the
158.17 time the plan begins enrolling enrollees;

158.18 (ii) at least 75 percent of the minimum amount required under chapter 62D after
158.19 the first full calendar year;

158.20 (iii) at least 87.5 percent of the minimum amount required under chapter 62D after
158.21 the second full calendar year; and

158.22 (iv) at least 100 percent of the minimum amount required under chapter 62D after
158.23 the third full calendar year.

158.24 (c) Until a plan is required to have reserves equaling at least 100 percent of the
158.25 minimum amount required under chapter 62D, the plan may demonstrate its ability
158.26 to cover any losses by satisfying the requirements of chapter 62N. Notwithstanding
158.27 this paragraph and paragraph (b), a county-based purchasing plan may satisfy its fiscal
158.28 solvency requirements by obtaining written financial guarantees from participating
158.29 counties in amounts equivalent to the minimum amounts that would otherwise apply.

158.30 A county-based purchasing plan must also assure the commissioner of health that the
158.31 requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all
158.32 applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106;
158.33 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47;
158.34 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

159.1 (d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M,
159.2 62N, and 62Q are hereby granted to the commissioner of health with respect to counties
159.3 that purchase medical assistance services under this section.

159.4 (e) The commissioner, in consultation with county government, shall develop
159.5 administrative and financial reporting requirements for county-based purchasing programs
159.6 relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31,
159.7 and other sections as necessary, that are specific to county administrative, accounting, and
159.8 reporting systems and consistent with other statutory requirements of counties.

159.9 (f) The commissioner shall collect from a county-based purchasing plan under
159.10 this section the following fees:

159.11 (1) fees attributable to the costs of audits and other examinations of plan financial
159.12 operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800,
159.13 subpart 1, item F;

159.14 (2) an annual fee of \$21,500, to be paid by June 15 of each calendar year, beginning
159.15 in calendar year 2009; and

159.16 (3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of
159.17 enrollees as of December 31, 2008.

159.18 All fees collected under this paragraph shall be deposited in the state government special
159.19 revenue fund.

159.20 Sec. 75. Minnesota Statutes 2010, section 256B.692, subdivision 5, is amended to read:

159.21 Subd. 5. **County proposals.** (a) On or before September 1, 1997, a county board
159.22 that wishes to purchase or provide health care under this section must submit a preliminary
159.23 proposal that substantially demonstrates the county's ability to meet all the requirements
159.24 of this section in response to criteria for proposals issued by the department on or before
159.25 July 1, 1997. Counties submitting preliminary proposals must establish a local planning
159.26 process that involves input from medical assistance recipients, recipient advocates,
159.27 providers and representatives of local school districts, labor, and tribal government to
159.28 advise on the development of a final proposal and its implementation.

159.29 (b) The county board must submit a final proposal on or before July 1, 1998, that
159.30 demonstrates the ability to meet all the requirements of this section, including beginning
159.31 enrollment on January 1, 1999, unless a delay has been granted under section 256B.69,
159.32 subdivision 3a, paragraph (g).

159.33 (c) After January 1, 1999, for a county in which the prepaid medical assistance
159.34 program is in existence, the county board must submit a preliminary proposal at least 15
159.35 months prior to termination of health plan contracts in that county and a final proposal

160.1 that meets the requirements of this section six months prior to the health plan contract
160.2 termination date in order to begin enrollment after the termination. Nothing in this section
160.3 shall impede or delay implementation or continuation of the prepaid medical assistance
160.4 program in counties for which the board does not submit a proposal, or submits a proposal
160.5 that is not in compliance with this section.

160.6 (d) The commissioner is not required to terminate contracts for the prepaid medical
160.7 assistance program that begin on or after September 1, 1997, in a county for which a
160.8 county board has submitted a proposal under this paragraph, until two years have elapsed
160.9 from the date of initial enrollment in the prepaid medical assistance program.

160.10 Sec. 76. Minnesota Statutes 2010, section 256B.692, subdivision 7, is amended to read:

160.11 Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal
160.12 under subdivision 6, the county board may request the ~~recommendation~~ decision of a
160.13 three-person mediation panel. The commissioner shall resolve all disputes ~~after taking~~
160.14 ~~into account~~ by following the recommendations decision of the mediation panel. The
160.15 panel shall be composed of one designee of the president of the Association of Minnesota
160.16 Counties, one designee of the commissioner of human services, and one person selected
160.17 jointly by the designee of the commissioner of human services and the designee of
160.18 the Association of Minnesota Counties. Within a reasonable period of time before the
160.19 hearing, the panelists must be provided all documents and information relevant to the
160.20 mediation. The parties to the mediation must be given 30 days' notice of a hearing before
160.21 the mediation panel.

160.22 Sec. 77. Minnesota Statutes 2010, section 256B.692, is amended by adding a
160.23 subdivision to read:

160.24 Subd. 11. **Patient choice of qualified provider.** Effective January 1, 2012, a county
160.25 board operating a county-based purchasing plan must ensure that each enrollee has the
160.26 option of choosing a primary care provider or a health care home from all qualified
160.27 providers who agree to accept the terms, conditions, and payment rates offered by the
160.28 plan to similarly situated providers. Notwithstanding this requirement, reimbursement
160.29 to federally qualified health centers and federally qualified health center look-alikes as
160.30 defined in section 145.9269 must be in compliance with federal law.

160.31 Sec. 78. Minnesota Statutes 2010, section 256B.694, is amended to read:

160.32 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
160.33 **CONTRACT.**

161.1 (a) Notwithstanding section 256B.692, subdivision 6, clause (1), paragraph (c),
161.2 the commissioner of human services shall approve a county-based purchasing health
161.3 plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena
161.4 Counties, that requires county-based purchasing on a single-plan basis contract if the
161.5 implementation of the single-plan purchasing proposal does not limit an enrollee's
161.6 provider choice or access to services and all other requirements applicable to health plan
161.7 purchasing are satisfied. The commissioner shall continue to use single-health plan,
161.8 county-based purchasing arrangements for medical assistance and general assistance
161.9 medical care programs and products for the counties that were in single-health plan,
161.10 county-based purchasing arrangements on March 1, 2008. This paragraph does not require
161.11 the commissioner to terminate an existing contract with a noncounty-based purchasing
161.12 plan that had enrollment in a medical assistance program or product in these counties on
161.13 March 1, 2008. This paragraph expires on December 31, 2010, or the effective date
161.14 of a new contract for medical assistance and general assistance medical care managed
161.15 care programs entered into at the conclusion of the commissioner's next scheduled
161.16 procurement process for the county-based purchasing entities covered by this paragraph,
161.17 whichever is later.

161.18 (b) At the request of a county or group of counties, the commissioner shall ~~consider,~~
161.19 ~~and may~~ approve, contracting on a single-health plan basis with ~~other~~ county-based
161.20 purchasing plans, or with other qualified health plans that have coordination arrangements
161.21 with counties, to serve persons ~~with a disability who voluntarily enroll,~~ enrolled in
161.22 Minnesota health care programs in order to promote better coordination or integration
161.23 of health care services, social services and other community-based services, provided
161.24 that all requirements applicable to health plan purchasing, including those in section
161.25 256B.69, subdivision 23, are satisfied. Nothing in this paragraph supersedes or modifies
161.26 the requirements in paragraph (a).

161.27 Sec. 79. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

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

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

162.3 (1) nonprofit community clinics that:

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

162.5 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
162.6 501(c)(3);

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

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

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

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

162.15 (vii) have free care available as needed;

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

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

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

162.22 (5) a dental clinic ~~associated with an oral health or dental education program~~ owned
162.23 and operated by the University of Minnesota or ~~an institution within~~ the Minnesota State
162.24 Colleges and Universities system.

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

162.29 (d) Notwithstanding paragraph (a), critical access payments must not be made for
162.30 dental services provided from April 1, 2010, through June 30, 2010.

162.31 (e) Notwithstanding section 256B.04, subdivision 2, the commissioner of human
162.32 services shall not adopt rules governing this section or section 256L.11, subdivision 7.

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

162.34 Sec. 80. **[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. 81. **[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

164.1 implement a five-year demonstration project in conjunction with federally qualified health
164.2 centers and federally qualified health center look-alikes as defined in section 145.9269, to
164.3 improve the quality and cost-effectiveness of care provided under medical assistance to
164.4 enrollees with neck and back problems. The demonstration project must maximize the use
164.5 of complementary and alternative medicine-oriented primary care providers, including but
164.6 not limited to physicians and chiropractors. The demonstration project must be designed
164.7 to significantly improve physical and mental health for enrollees who present with
164.8 neck and back problems while decreasing medical treatment costs. The commissioner,
164.9 in consultation with the commissioner of health, shall deliver services through the
164.10 demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

164.11 Subd. 2. **RFP and project criteria.** The commissioner, in consultation with the
164.12 commissioner of health, shall develop and issue a request for proposal (RFP) for the
164.13 demonstration project. The RFP must require the academic and research institution
164.14 selected to demonstrate a proven track record over at least five years of conducting
164.15 high-quality, federally funded clinical research. The institution and the federally qualified
164.16 health centers and federally qualified health center look-alikes shall also:

164.17 (1) provide patient education, provider education, and enrollment training
164.18 components on health and lifestyle issues in order to promote enrollee responsibility for
164.19 health care decisions, enhance productivity, prepare enrollees to reenter the workforce,
164.20 and reduce future health care expenditures;

164.21 (2) use high-quality and cost-effective integrated disease management that includes
164.22 the best practices of traditional and complementary and alternative medicine;

164.23 (3) incorporate holistic medical care, appropriate nutrition, exercise, medications,
164.24 and conflict resolution techniques;

164.25 (4) include a provider education component that makes use of professional
164.26 organizations representing chiropractors, nurses, and other primary care providers
164.27 and provides appropriate educational materials and activities in order to improve the
164.28 integration of traditional medical care with licensed chiropractic services and other
164.29 alternative health care services and achieve program enrollment objectives; and

164.30 (5) provide to the commissioner the information and data necessary for the
164.31 commissioner to prepare the annual reports required under subdivision 6.

164.32 Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the
164.33 commissioner from current enrollees in the prepaid medical assistance program who
164.34 have, or are determined to be at significant risk of developing, neck and back problems.
164.35 Participation in the demonstration project shall be voluntary. The commissioner shall
164.36 seek to enroll, over the term of the demonstration project, ten percent of current and

165.1 future medical assistance enrollees who have, or are determined to be at significant risk
165.2 of developing, neck and back problems.

165.3 Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and
165.4 approvals necessary to implement the demonstration project.

165.5 Subd. 5. **Project costs.** The commissioner shall require the academic and research
165.6 institution selected, federally qualified health centers, and federally qualified health center
165.7 look-alikes to fund all net costs of the demonstration project.

165.8 Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner
165.9 of health, beginning December 15, 2011, and each December 15 thereafter through
165.10 December 15, 2015, shall report annually to the legislature on the functional and mental
165.11 improvements of the populations served by the demonstration project, patient satisfaction,
165.12 and the cost-effectiveness of the program. The reports must also include data on hospital
165.13 admissions, days in hospital, rates of outpatient surgery and other services, and drug
165.14 utilization. The report, due December 15, 2015, must include recommendations on
165.15 whether the demonstration project should be continued and expanded.

165.16 Sec. 82. **[256B.841] WAIVER APPLICATION AND PROCESS.**

165.17 Subdivision 1. **Intent.** It is the intent of the legislature that medical assistance be:

165.18 (1) a sustainable, cost-effective, person-centered, and opportunity-driven program
165.19 utilizing competitive and value-based purchasing to maximize available service options;
165.20 and

165.21 (2) a results-oriented system of coordinated care that focuses on independence
165.22 and choice, promotes accountability and transparency, encourages and rewards healthy
165.23 outcomes and responsible choices, and promotes efficiency.

165.24 Subd. 2. **Waiver application.** (a) By September 1, 2011, the commissioner of
165.25 human services shall apply for a waiver and any necessary state plan amendments from
165.26 the secretary of the United States Department of Health and Human Services, including,
165.27 but not limited to, a waiver of the appropriate sections of title XIX of the federal Social
165.28 Security Act, United States Code, title 42, section 1396 et seq., or other provisions of
165.29 federal law that provide program flexibility and under which Minnesota will operate all
165.30 facets of the state's medical assistance program.

165.31 (b) The commissioner of human services shall provide the legislative committees
165.32 with jurisdiction over health and human services finance and policy with the waiver
165.33 application and financial and other related materials, at least ten days prior to submitting
165.34 the application and materials to the federal Centers for Medicare and Medicaid Services.

166.1 (c) If the state's waiver application is approved, the commissioner of human services
166.2 shall:

166.3 (1) notify the chairs of the legislative committees with jurisdiction over health and
166.4 human services finance and policy and allow the legislative committees with jurisdiction
166.5 over health and human services finance and policy to review the terms of the waiver; and

166.6 (2) not implement the waiver until ten legislative days have passed following
166.7 notification of the chairs.

166.8 Subd. 3. **Rulemaking; legislative proposals.** Upon acceptance of the terms of the
166.9 waiver, the commissioner of human services shall:

166.10 (1) adopt rules to implement the waiver; and

166.11 (2) propose any legislative changes necessary to implement the terms of the waiver.

166.12 Subd. 4. **Joint commission on waiver implementation.** (a) After acceptance
166.13 of the terms of the waiver, the governor shall establish a joint commission on waiver
166.14 implementation. The commission shall consist of eight members; four of whom shall
166.15 be members of the senate, not more than three from the same political party, to be
166.16 appointed by the Subcommittee on Committees of the senate Committee on Rules and
166.17 Administration, and four of whom shall be members of the house of representatives, not
166.18 more than three from the same political party, to be appointed by the speaker of the house.

166.19 (b) The commission shall:

166.20 (1) oversee implementation of the waiver;

166.21 (2) confer as necessary with state agency commissioners;

166.22 (3) make recommendations on services covered under the medical assistance
166.23 program;

166.24 (4) monitor and make recommendations on quality and access to care under the
166.25 global waiver; and

166.26 (5) make recommendations for the efficient and cost-effective administration of the
166.27 medical assistance program under the terms of the waiver.

166.28 Sec. 83. **[256B.842] PRINCIPLES AND GOALS FOR MEDICAL ASSISTANCE**
166.29 **REFORM.**

166.30 Subdivision 1. **Goals for reform.** In developing the waiver application and
166.31 implementing the waiver, the commissioner of human services shall ensure that the
166.32 reformed medical assistance program is a person-centered, financially sustainable, and
166.33 cost-effective program.

166.34 Subd. 2. **Reformed medical assistance criteria.** The reformed medical assistance
166.35 program established through the waiver must:

- 167.1 (1) empower consumers to make informed and cost-effective choices about their
167.2 health and offer consumers rewards for healthy decisions;
- 167.3 (2) ensure adequate access to needed services;
- 167.4 (3) enable consumers to receive individualized health care that is outcome-oriented
167.5 and focused on prevention, disease management, recovery, and maintaining independence;
- 167.6 (4) promote competition between health care providers to ensure best value
167.7 purchasing, leverage resources, and to create opportunities for improving service quality
167.8 and performance;
- 167.9 (5) redesign purchasing and payment methods and encourage and reward
167.10 high-quality and cost-effective care by incorporating and expanding upon current payment
167.11 reform and quality of care initiatives, including but not limited to those initiatives
167.12 authorized under chapter 62U; and
- 167.13 (6) continually improve technology to take advantage of recent innovations and
167.14 advances that help decision makers, consumers, and providers make informed and
167.15 cost-effective decisions regarding health care.

167.16 Subd. 3. **Annual report.** The commissioner of human services shall annually
167.17 submit a report to the governor and the legislature, beginning December 1, 2012, and each
167.18 December 1 thereafter, describing the status of the administration and implementation
167.19 of the waiver.

167.20 Sec. 84. **[256B.843] WAIVER APPLICATION REQUIREMENTS.**

167.21 Subdivision 1. **Requirements for waiver request.** The commissioner shall seek
167.22 federal approval to:

- 167.23 (1) enter into a five-year agreement with the United States Department of Health and
167.24 Human Services and Centers for Medicaid and Medicare Services (CMS) under section
167.25 1115a to waive provisions of title XIX of the federal Social Security Act, United States
167.26 Code, title 42, section 1396 et seq., requiring:
- 167.27 (i) statewideness to allow for the provision of different services in different areas or
167.28 regions of the state;
- 167.29 (ii) comparability of services to allow for the provision of different services to
167.30 members of the same or different coverage groups;
- 167.31 (iii) no prohibitions restricting the amount, duration, and scope of services included
167.32 in the medical assistance state plan;
- 167.33 (iv) no prohibitions limiting freedom of choice of providers; and
- 167.34 (v) retroactive payment for medical assistance, at the state's discretion;

168.1 (2) waive the applicable provisions of title XIX of the federal Social Security Act,
168.2 United States Code, title 42, section 1396 et seq., in order to:

168.3 (i) expand cost sharing requirements above the five percent of income threshold for
168.4 beneficiaries in certain populations;

168.5 (ii) establish health savings or power accounts that encourage and reward
168.6 beneficiaries who reach certain prevention and wellness targets; and

168.7 (iii) implement a tiered set of parameters to use as the basis for determining
168.8 long-term service care and setting needs;

168.9 (3) modify income and resource rules in a manner consistent with the goals of the
168.10 reformed program;

168.11 (4) provide enrollees with a choice of appropriate private sector health coverage
168.12 options, with full federal financial participation;

168.13 (5) treat payments made toward the cost of care as a monthly premium for
168.14 beneficiaries receiving home and community-based services when applicable;

168.15 (6) provide health coverage and services to individuals over the age of 65 that are
168.16 limited in scope and are available only in the home and community-based setting;

168.17 (7) consolidate all home and community-based services currently provided under
168.18 title XIX of the federal Social Security Act, United States Code, title 42, section 1915(c),
168.19 into a single program of home and community-based services that include options for
168.20 consumer direction and shared living;

168.21 (8) expand disease management, care coordination, and wellness programs for all
168.22 medical assistance recipients; and

168.23 (9) empower and encourage able-bodied medical assistance recipients to work,
168.24 whenever possible.

168.25 Subd. 2. **Agency coordination.** The commissioner shall establish an intraagency
168.26 assessment and coordination unit to ensure that decision making and program planning for
168.27 recipients who may need long-term care, residential placement, and community support
168.28 services are coordinated. The assessment and coordination unit shall determine level of
168.29 care, develop service plans and a service budget, make referrals to appropriate settings,
168.30 provide education and choice counseling to consumers and providers, track utilization,
168.31 and monitor outcomes.

168.32 Sec. 85. Minnesota Statutes 2010, section 256D.03, subdivision 3, is amended to read:

168.33 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning ~~April 1,~~
168.34 ~~2010~~ January 1, 2012, the general assistance medical care program shall be administered
168.35 according to section 256D.031, unless otherwise stated, ~~except for outpatient prescription~~

169.1 ~~drug coverage, which shall continue to be administered under this section and funded~~
169.2 ~~under section 256D.031, subdivision 9, beginning June 1, 2010.~~

169.3 (b) Outpatient prescription drug coverage under general assistance medical care is
169.4 limited to prescription drugs that:

169.5 (1) are covered under the medical assistance program as described in section
169.6 256B.0625, subdivisions 13 and 13d; and

169.7 (2) are provided by manufacturers that have fully executed general assistance
169.8 medical care rebate agreements with the commissioner and comply with the agreements.
169.9 Outpatient prescription drug coverage under general assistance medical care must conform
169.10 to coverage under the medical assistance program according to section 256B.0625,
169.11 subdivisions 13 to 13h.

169.12 ~~(c) Outpatient prescription drug coverage does not include drugs administered in a~~
169.13 ~~clinic or other outpatient setting.~~

169.14 ~~(d) For the period beginning April 1, 2010, to May 31, 2010, general assistance~~
169.15 ~~medical care covers the services listed in subdivision 4.~~

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

169.17 Sec. 86. Minnesota Statutes 2010, section 256D.031, subdivision 6, is amended to read:

169.18 Subd. 6. **Coordinated care delivery systems.** (a) Effective ~~June 1, 2010~~ January
169.19 1, 2012, the commissioner shall contract with hospitals or groups of hospitals, or
169.20 county-based purchasing plans, that qualify under paragraph (b) and agree to deliver
169.21 services according to this subdivision. Contracting hospitals or plans shall develop
169.22 and implement a coordinated care delivery system to provide health care services to
169.23 individuals who are eligible for general assistance medical care under this section and who
169.24 either choose to receive services through the coordinated care delivery system or who are
169.25 enrolled by the commissioner under paragraph (c). The health care services provided by
169.26 the system must include: (1) the services described in subdivision 4 ~~with the exception~~
169.27 ~~of outpatient prescription drug coverage but shall include drugs administered in a clinic~~
169.28 ~~or other outpatient setting~~; or (2) a set of comprehensive and medically necessary health
169.29 services that the recipients might reasonably require to be maintained in good health and
169.30 that has been approved by the commissioner, including at a minimum, but not limited
169.31 to, emergency care, medical transportation services, inpatient hospital and physician
169.32 care, outpatient health services, preventive health services, mental health services,
169.33 and prescription drugs ~~administered in a clinic or other outpatient setting. Outpatient~~
169.34 ~~prescription drug coverage is covered on a fee-for-service basis in accordance with section~~
169.35 ~~256D.03, subdivision 3, and funded under subdivision 9.~~ A hospital or plan establishing a

coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals, or a county-based purchasing plan established under section 256B.692, may contract with the commissioner to develop and implement a coordinated care delivery system ~~as follows:~~ if the hospital or group of hospitals or plan agrees to satisfy the requirements of this subdivision.

~~(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and~~

~~(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.~~

Participation by hospitals or plans shall become effective quarterly on ~~June 1, September 1, December 1, or March 1~~ January 1, April 1, July 1, or October 1. Hospital or plan participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system but services are only available through a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. ~~A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants and recipients not enrolled in a coordinated care delivery~~

171.1 ~~system may seek services from a hospital eligible for reimbursement under the temporary~~
171.2 ~~uncompensated care pool established under subdivision 8. After February 28, 2011,~~
171.3 ~~services are available only through a coordinated care delivery system.~~

171.4 (d) The hospital or plan may contract and coordinate with providers and clinics
171.5 for the delivery of services and shall contract with essential community providers as
171.6 defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the
171.7 extent practicable. When contracting with providers and clinics, the hospital or plan
171.8 shall give preference to providers and clinics certified as health care homes under section
171.9 256B.0751. The hospital or plan must contract with federally qualified health centers or
171.10 federally qualified health center look-alikes, as defined in section 145.9269, subdivision 1,
171.11 and essential community providers as defined in section 62Q.19, that agree to accept the
171.12 terms, conditions, and payment rates offered by the hospital or plan to similarly situated
171.13 providers, except that reimbursement to federally qualified health centers and federally
171.14 qualified health center look-alikes must comply with federal law. If a provider or clinic or
171.15 health center contracts with a hospital or plan to provide services through the coordinated
171.16 care delivery system, the provider may not refuse to provide services to any recipient
171.17 enrolled in the system, and payment for services shall be negotiated with the hospital or
171.18 plan and paid by the hospital or plan from the system's allocation under subdivision 7.

171.19 (e) A coordinated care delivery system must:

171.20 (1) provide the covered services required under paragraph (a) to recipients enrolled
171.21 in the coordinated care delivery system, and comply with the requirements of subdivision
171.22 4, paragraphs (b) to (g);

171.23 (2) establish a process to monitor enrollment and ensure the quality of care provided;

171.24 (3) in cooperation with counties, coordinate the delivery of health care services with
171.25 existing homeless prevention, supportive housing, and rent subsidy programs and funding
171.26 administered by the Minnesota Housing Finance Agency under chapter 462A; and

171.27 (4) adopt innovative and cost-effective methods of care delivery and coordination,
171.28 which may include the use of allied health professionals, telemedicine, patient educators,
171.29 care coordinators, and community health workers.

171.30 (f) The hospital or plan may require a recipient to designate a primary care provider
171.31 or a primary care clinic. The hospital or plan may limit the delivery of services to a
171.32 network of providers who have contracted with the hospital or plan to deliver services in
171.33 accordance with this subdivision, and require a recipient to seek services only within this
171.34 network. The hospital or plan may also require a referral to a provider before the service
171.35 is eligible for payment. A coordinated care delivery system is not required to provide
171.36 payment to a provider who is not employed by or under contract with the system for

172.1 services provided to a recipient enrolled in the system, except in cases of an emergency.
172.2 For purposes of this section, emergency services are defined in accordance with Code of
172.3 Federal Regulations, title 42, section 438.114 (a).

172.4 (g) A recipient enrolled in a coordinated care delivery system has the right to appeal
172.5 to the commissioner according to section 256.045.

172.6 (h) The state shall not be liable for the payment of any cost or obligation incurred
172.7 by the coordinated care delivery system.

172.8 (i) The hospital or plan must provide the commissioner with data necessary for
172.9 assessing enrollment, quality of care, cost, and utilization of services. Each hospital or
172.10 plan must provide, on a quarterly basis on a form prescribed by the commissioner for each
172.11 recipient served by the coordinated care delivery system, the services provided, the cost of
172.12 services provided, and the actual payment amount for the services provided and any other
172.13 information the commissioner deems necessary to claim federal Medicaid match. The
172.14 commissioner must provide this data to the legislature on a quarterly basis.

172.15 (j) ~~Effective June 1, 2010,~~ The provisions of section 256.9695, subdivision 2,
172.16 paragraph (b), do not apply to general assistance medical care provided under this section.

172.17 (k) Notwithstanding any other provision in this section to the contrary, ~~for~~
172.18 ~~participation beginning September 1, 2010,~~ the commissioner ~~shall offer the same contract~~
172.19 ~~terms related to~~ shall negotiate an enrollment threshold formula and financial liability
172.20 protections ~~to~~ with a hospital or group of hospitals or plan qualified under this subdivision
172.21 to develop and implement a coordinated care delivery system ~~as those contained in the~~
172.22 ~~coordinated care delivery system contracts effective June 1, 2010.~~

172.23 (l) ~~If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are~~
172.24 ~~implemented effective July 1, 2010, this subdivision must not be implemented.~~

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

172.26 Sec. 87. Minnesota Statutes 2010, section 256D.031, subdivision 7, is amended to read:

172.27 Subd. 7. **Payments; rate setting for the ~~hospital~~ coordinated care delivery**
172.28 **system.** (a) Effective for general assistance medical care services, with the exception
172.29 of outpatient prescription drug coverage, provided ~~on or after June 1, 2010,~~ through a
172.30 coordinated care delivery system, the commissioner shall allocate the annual appropriation
172.31 for the coordinated care delivery system to hospitals or plans participating under
172.32 subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after
172.33 ~~June 1, 2010~~ March 1, 2012. The payment shall be allocated among all hospitals or plans
172.34 qualified to participate on the allocation date ~~as follows:~~ based upon the enrollment
172.35 thresholds negotiated with the commissioner.

173.1 ~~(1) each hospital or group of hospitals shall be allocated an initial amount based on~~
173.2 ~~the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for~~
173.3 ~~general assistance medical care services to all participating hospitals;~~

173.4 ~~(2) the initial allocations to Hennepin County Medical Center; Regions Hospital;~~
173.5 ~~Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview,~~
173.6 ~~shall be increased to 110 percent of the value determined in clause (1);~~

173.7 ~~(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata~~
173.8 ~~amount in order to keep the allocations within the limit of available appropriations; and~~

173.9 ~~(4) the amounts determined under clauses (1) to (3) shall be allocated to participating~~
173.10 ~~hospitals.~~

173.11 The commissioner may prospectively reallocate payments to participating hospitals or
173.12 plans on a biannual basis to ensure that final allocations reflect actual coordinated care
173.13 delivery system enrollment. ~~The 2008 base year shall be updated by one calendar year~~
173.14 ~~each June 1, beginning June 1, 2011.~~

173.15 ~~(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the~~
173.16 ~~commissioner shall make one-third of the quarterly payment in June and the remaining~~
173.17 ~~two-thirds of the quarterly payment in July to each participating hospital or group of~~
173.18 ~~hospitals.~~

173.19 ~~(e)~~ (b) In order to be reimbursed under this section, nonhospital providers of health
173.20 care services shall contract with one or more hospitals or plans described in paragraph (a)
173.21 to provide services to general assistance medical care recipients through the coordinated
173.22 care delivery system established by the hospital or plan. The hospital or plan shall
173.23 reimburse bills submitted by nonhospital providers participating under this paragraph at a
173.24 rate negotiated between the hospital or plan and the nonhospital provider.

173.25 ~~(d)~~ (c) The commissioner shall apply for federal matching funds under section
173.26 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

173.27 ~~(e)~~ (d) Outpatient prescription drug coverage is provided in accordance with section
173.28 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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

173.30 Sec. 88. Minnesota Statutes 2010, section 256D.031, subdivision 10, is amended to
173.31 read:

173.32 Subd. 10. **Assistance for veterans.** Hospitals and plans participating in the
173.33 coordinated care delivery system under subdivision 6 shall consult with counties, county

174.1 veterans service officers, and the Veterans Administration to identify other programs for
174.2 which general assistance medical care recipients enrolled in their system are qualified.

174.3 Sec. 89. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:

174.4 Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross
174.5 family income" for nonfarm self-employed means income calculated for the ~~12-month~~
174.6 six-month period of eligibility using as a baseline the adjusted gross income reported
174.7 on the applicant's federal income tax form for the previous year and adding back in
174.8 depreciation, and carryover net operating loss amounts that apply to the business in which
174.9 the family is currently engaged.

174.10 (b) "Gross individual or gross family income" for farm self-employed means
174.11 income calculated for the ~~12-month~~ six-month period of eligibility using as the baseline
174.12 the adjusted gross income reported on the applicant's federal income tax form for the
174.13 previous year.

174.14 (c) "Gross individual or gross family income" means the total income for all family
174.15 members, calculated for the ~~12-month~~ six-month period of eligibility.

174.16 Sec. 90. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

174.17 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for
174.18 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
174.19 each state revenue and expenditure forecast, the commissioner must make an assessment
174.20 of the expected expenditures for the covered services for the remainder of the current
174.21 biennium and for the following biennium. The estimated expenditure, including the
174.22 reserve, shall be compared to an estimate of the revenues that will be available in the health
174.23 care access fund. Based on this comparison, and after consulting with the chairs of the
174.24 house of representatives Ways and Means Committee and the senate Finance Committee,
174.25 and the Legislative Commission on Health Care Access, the commissioner shall, as
174.26 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures
174.27 remain within the limits of available revenues for the remainder of the current biennium
174.28 and for the following biennium. The commissioner shall not hire additional staff using
174.29 appropriations from the health care access fund until the commissioner of management
174.30 and budget makes a determination that the adjustments implemented under paragraph (b)
174.31 are sufficient to allow MinnesotaCare expenditures to remain within the limits of available
174.32 revenues for the remainder of the current biennium and for the following biennium.

174.33 (b) The adjustments the commissioner shall use must be implemented in this order:
174.34 first, stop enrollment of single adults and households without children; second, upon 45

175.1 days' notice, stop coverage of single adults and households without children already
175.2 enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium
175.3 subsidy amounts by ten percent for children in families with gross annual income above
175.4 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the
175.5 premium subsidy amounts by ten percent for children in families with gross annual income
175.6 at or below 200 percent; and fifth, require applicants to be uninsured for at least six months
175.7 prior to eligibility in the MinnesotaCare program. If these measures are insufficient to
175.8 limit the expenditures to the estimated amount of revenue, the commissioner shall further
175.9 limit enrollment or decrease premium subsidies.

175.10 **EFFECTIVE DATE.** This section is effective January 1, 2012, or upon federal
175.11 approval, whichever is later, and expires June 30, 2013. The commissioner shall notify
175.12 the revisor of statutes when federal approval is obtained and publish a notice in the State
175.13 Register.

175.14 Sec. 91. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

175.15 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for
175.16 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
175.17 each state revenue and expenditure forecast, the commissioner must make an assessment
175.18 of the expected expenditures for the covered services for the remainder of the current
175.19 biennium and for the following biennium. The estimated expenditure, including the
175.20 reserve, shall be compared to an estimate of the revenues that will be available in the health
175.21 care access fund. Based on this comparison, and after consulting with the chairs of the
175.22 house of representatives Ways and Means Committee and the senate Finance Committee,
175.23 ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as
175.24 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures
175.25 remain within the limits of available revenues for the remainder of the current biennium
175.26 and for the following biennium. The commissioner shall not hire additional staff using
175.27 appropriations from the health care access fund until the commissioner of management
175.28 and budget makes a determination that the adjustments implemented under paragraph (b)
175.29 are sufficient to allow MinnesotaCare expenditures to remain within the limits of available
175.30 revenues for the remainder of the current biennium and for the following biennium.

175.31 (b) The adjustments the commissioner shall use must be implemented in this order:
175.32 first, stop enrollment of single adults and households without children; second, upon 45
175.33 days' notice, stop coverage of single adults and households without children already
175.34 enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium
175.35 subsidy amounts by ten percent for families with gross annual income above 200 percent

176.1 of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium
176.2 subsidy amounts by ten percent for families with gross annual income at or below 200
176.3 percent; and fifth, require applicants to be uninsured for at least six months prior to
176.4 eligibility in the MinnesotaCare program. If these measures are insufficient to limit the
176.5 expenditures to the estimated amount of revenue, the commissioner shall further limit
176.6 enrollment or decrease premium subsidies.

176.7 Sec. 92. Minnesota Statutes 2010, section 256L.03, subdivision 3, is amended to read:

176.8 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
176.9 inpatient hospital services, including inpatient hospital mental health services and inpatient
176.10 hospital and residential chemical dependency treatment, subject to those limitations
176.11 necessary to coordinate the provision of these services with eligibility under the medical
176.12 assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under
176.13 section 256L.04, subdivision 7, ~~or who qualify under section 256L.04, subdivisions 1 and~~
176.14 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~
176.15 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
176.16 ~~pregnant~~, is subject to an annual limit of \$10,000.

176.17 (b) Admissions for inpatient hospital services paid for under section 256L.11,
176.18 subdivision 3, must be certified as medically necessary in accordance with Minnesota
176.19 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

176.20 (1) all admissions must be certified, except those authorized under rules established
176.21 under section 254A.03, subdivision 3, or approved under Medicare; and

176.22 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
176.23 for admissions for which certification is requested more than 30 days after the day of
176.24 admission. The hospital may not seek payment from the enrollee for the amount of the
176.25 payment reduction under this clause.

176.26 **EFFECTIVE DATE.** This section is effective January 1, 2012, or upon federal
176.27 approval, whichever is later, and expires June 30, 2013. The commissioner shall notify
176.28 the revisor of statutes when federal approval is obtained and publish a notice in the State
176.29 Register.

176.30 Sec. 93. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

176.31 Subd. 5. ~~**Co-payments and coinsurance**~~ **Cost-sharing.** (a) Except as provided in
176.32 paragraphs (b) ~~and~~ (c), and (h), the MinnesotaCare benefit plan shall include the following
176.33 ~~co-payments and coinsurance~~ cost-sharing requirements for all enrollees:

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

177.3 (2) \$3 per prescription for adult enrollees;

177.4 (3) \$25 for eyeglasses for adult enrollees;

177.5 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
177.6 episode of service which is required because of a recipient's symptoms, diagnosis, or
177.7 established illness, and which is delivered in an ambulatory setting by a physician or
177.8 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
177.9 audiologist, optician, or optometrist; ~~and~~

177.10 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
177.11 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

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

177.14 (b) Paragraph (a), clause (1), ~~does~~ and paragraph (e) do not apply to parents and
177.15 relative caretakers of children under the age of 21.

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

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

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

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

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

177.30 (h) Effective January 1, 2012, the following co-payments for nonpreventive visits
177.31 shall apply to enrollees who are adults without children eligible under section 256L.04,
177.32 subdivision 7:

177.33 (1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of care
177.34 per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same
177.35 type;

178.1 (2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care
178.2 per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the
178.3 80th percentile for providers of the same type; and

178.4 (3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of
178.5 care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the
178.6 same type.

178.7 Each managed care and county-based purchasing plan shall calculate the average,
178.8 risk-adjusted, total annual cost of care for providers under this paragraph using a
178.9 methodology that has been approved by the commissioner.

178.10 **EFFECTIVE DATE.** The amendments to paragraph (e) are effective January 1,
178.11 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The
178.12 commissioner shall notify the revisor of statutes when federal approval is obtained and
178.13 publish a notice in the State Register.

178.14 Sec. 94. **[256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

178.15 Subdivision 1. **Defined contributions to enrollees.** (a) Beginning January 1, 2012,
178.16 the commissioner shall provide each MinnesotaCare enrollee eligible under section
178.17 256L.04, subdivision 7, with gross family income equal to or greater than 133 percent
178.18 of the federal poverty guidelines, with a monthly defined contribution to purchase health
178.19 coverage under a health plan as defined in section 62A.011, subdivision 3. Beginning
178.20 January 1, 2012, or upon federal approval, whichever is later, the commissioner shall
178.21 provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 1, with
178.22 gross family income equal to or greater than 133 percent of the federal poverty guidelines,
178.23 with a monthly defined contribution to purchase health coverage under a health plan as
178.24 defined in section 62A.011, subdivision 3, offered by a health plan company as defined
178.25 in section 62Q.01, subdivision 4.

178.26 (b) Enrollees eligible under paragraph (a) shall not be charged premiums under
178.27 section 256L.15 and are exempt from the managed care enrollment requirement of section
178.28 256L.12.

178.29 (c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to
178.30 enrollees eligible under paragraph (a). Covered services, cost-sharing, disenrollment
178.31 for nonpayment of premium, enrollee appeal rights and complaint procedures, and the
178.32 effective date of coverage for enrollees eligible under paragraph (a) shall be as provided
178.33 under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply to enrollees obtaining coverage under this section.

Subd. 2. Use of defined contribution. An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3.

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

(1) persons with household incomes equal to 133 percent of the federal poverty guidelines with a defined contribution of 150 percent of the base contribution;

(2) persons with household incomes equal to 175 percent of the federal poverty guidelines with a defined contribution of 100 percent of the base contribution;

(3) persons with household incomes equal to or greater than 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(4) persons with household incomes in evenly spaced increments between the 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).

Age	Monthly Per-Person Base Contribution
Under 21	\$122.79
21-29	122.79
30-31	129.19
32-33	132.38
34-35	134.31
36-37	136.06
38-39	141.02
40-41	151.25
42-43	159.89
44-45	175.08
46-47	191.71
48-49	213.13
50-51	239.51
52-53	266.69
54-55	293.88
56-57	323.77

180.1	<u>58-59</u>	<u>341.20</u>
180.2	<u>60+</u>	<u>357.19</u>

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

180.7 (c) Notwithstanding paragraphs (a) and (b), the monthly defined contribution shall
180.8 not exceed 90 percent of the monthly premium for the health plan purchased by the
180.9 enrollee. If the enrollee purchases coverage under a health plan that does not include
180.10 mental health services and chemical dependency treatment services, the monthly defined
180.11 contribution amount determined under this subdivision shall be reduced by five percent.

180.12 Subd. 4. **Administration by commissioner.** The commissioner shall administer the
180.13 defined contributions. The commissioner shall:

180.14 (1) calculate and process defined contributions for enrollees; and

180.15 (2) pay the defined contribution amount to health plan companies or the Minnesota
180.16 Comprehensive Health Association, as applicable, for enrollee health plan coverage.

180.17 Subd. 5. **Assistance to enrollees.** The commissioner of human services, in
180.18 consultation with the commissioner of commerce, shall develop an efficient and
180.19 cost-effective method of referring eligible applicants to professional insurance agent
180.20 associations.

180.21 Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning
180.22 January 1, 2012, MinnesotaCare enrollees who are denied coverage under an individual
180.23 health plan by a health plan company are eligible for coverage through a health plan
180.24 offered by the MCHA and may enroll in MCHA according to section 62E.14. Any
180.25 difference between the revenue and covered losses to the MCHA related to implementation
180.26 of this section shall be paid to the MCHA from the health care access fund.

180.27 Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers
180.28 and approvals necessary to implement coverage under this section for MinnesotaCare
180.29 enrollees eligible under section 256L.04, subdivision 1, with gross family incomes equal
180.30 to or greater than 133 percent of the federal poverty guidelines, while continuing to
180.31 receive federal matching funds.

180.32 Sec. 95. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

180.33 Subdivision 1. **Families with children.** (a) ~~Families with~~ Children with family
180.34 income equal to or less than 275 percent of the federal poverty guidelines for the
180.35 applicable family size and adults in families with children with family income equal to or

181.1 less than 200 percent of the federal poverty guidelines for the applicable family size, shall
181.2 be eligible for MinnesotaCare according to this section. All other provisions of sections
181.3 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section
181.4 256L.07, shall apply unless otherwise specified.

181.5 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
181.6 if the children are eligible. Children may be enrolled separately without enrollment by
181.7 parents. However, if one parent in the household enrolls, both parents must enroll, unless
181.8 other insurance is available. If one child from a family is enrolled, all children must
181.9 be enrolled, unless other insurance is available. If one spouse in a household enrolls,
181.10 the other spouse in the household must also enroll, unless other insurance is available.
181.11 Families cannot choose to enroll only certain uninsured members.

181.12 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies
181.13 to the MinnesotaCare program. These persons are no longer counted in the parental
181.14 household and may apply as a separate household.

181.15 (d) Beginning July 1, 2010, or upon federal approval, whichever is later, parents are
181.16 not eligible for MinnesotaCare if their gross income exceeds \$57,500.

181.17 ~~(e) Children formerly enrolled in medical assistance and automatically deemed~~
181.18 ~~eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt~~
181.19 ~~from the requirements of this section until renewal.~~

181.20 (f) [Reserved.]

181.21 **EFFECTIVE DATE.** This section is effective January 1, 2012, or upon federal
181.22 approval, whichever is later, and expires June 30, 2013, except that the amendment
181.23 striking paragraph (e) is effective retroactively from October 1, 2008, does not expire,
181.24 and federal approval is no longer necessary. The commissioner shall notify the revisor of
181.25 statutes when federal approval is obtained and publish a notice in the State Register.

181.26 Sec. 96. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

181.27 Subd. 7. **Single adults and households with no children.** (a) The definition of
181.28 eligible persons, through December 31, 2011, includes all individuals and households with
181.29 no children who have gross family incomes that are equal to or less than 200 percent
181.30 of the federal poverty guidelines.

181.31 (b) Effective ~~July 1, 2009~~ January 1, 2012, the definition of eligible persons includes
181.32 all individuals and households with no children who have gross family incomes that are
181.33 greater than 75 percent of the federal poverty guidelines and equal to or less than 250 200
181.34 percent of the federal poverty guidelines. Effective July 1, 2013, the maximum income
181.35 limit under this paragraph is increased to 250 percent of the federal poverty guidelines.

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

182.2 Sec. 97. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

182.3 Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall
182.4 use electronic verification as the primary method of income verification. If there is a
182.5 discrepancy between reported income and electronically verified income, an individual
182.6 may be required to submit additional verification. In addition, the commissioner shall
182.7 perform random audits to verify reported income and eligibility. The commissioner
182.8 may execute data sharing arrangements with the Department of Revenue and any other
182.9 governmental agency in order to perform income verification related to eligibility and
182.10 premium payment under the MinnesotaCare program.

182.11 (b) In determining eligibility for MinnesotaCare, the commissioner shall require
182.12 applicants and enrollees seeking renewal of eligibility to verify both earned and unearned
182.13 income. The commissioner shall also require applicants and enrollees to submit the
182.14 names of their employers and a contact name with a phone number for each employer
182.15 for purposes of verifying whether the applicant or enrollee, and any dependents, are
182.16 eligible for employer-subsidized coverage. Data collected is nonpublic data as defined
182.17 in section 13.02, subdivision 9.

182.18 Sec. 98. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

182.19 Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, ~~2007~~ 2011, an enrollee's
182.20 eligibility must be renewed every ~~12~~ six months. ~~The 12-month period begins in the~~
182.21 ~~month after the month the application is approved.~~

182.22 (b) The first six-month period of eligibility begins the month the application is
182.23 received by the commissioner. The effective date of coverage within the first six-month
182.24 period of eligibility is as provided in subdivision 3. Each new period of eligibility must
182.25 take into account any changes in circumstances that impact eligibility and premium
182.26 amount. An enrollee must provide all the information needed to redetermine eligibility
182.27 by the first day of the month that ends the eligibility period. If there is no change in
182.28 circumstances, the enrollee may renew eligibility at designated locations that include
182.29 community clinics and health care providers' offices. The designated sites shall forward
182.30 the renewal forms to the commissioner. The commissioner may establish criteria and
182.31 timelines for sites to forward applications to the commissioner or county agencies. The
182.32 premium for the new period of eligibility must be received as provided in section 256L.06
182.33 in order for eligibility to continue.

183.1 (c) An enrollee who fails to submit renewal forms and related documentation
183.2 necessary for verification of continued eligibility in a timely manner shall remain eligible
183.3 for one additional month beyond the end of the current eligibility period before being
183.4 disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the
183.5 additional month.

183.6 Sec. 99. Minnesota Statutes 2010, section 256L.05, subdivision 5, is amended to read:

183.7 Subd. 5. **Availability of private insurance.** The commissioner, in consultation with
183.8 the commissioners of health and commerce, shall provide information regarding the
183.9 availability of private health insurance coverage and the possibility of disenrollment
183.10 under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled
183.11 in the MinnesotaCare program ~~whose gross family income is equal to or more than 225~~
183.12 ~~percent of the federal poverty guidelines~~; and (2) single adults and households without
183.13 children enrolled in the MinnesotaCare program ~~whose gross family income is equal to~~
183.14 ~~or more than 165 percent of the federal poverty guidelines~~. This information must be
183.15 provided upon initial enrollment and annually thereafter. The commissioner shall also
183.16 include information regarding the availability of private health insurance coverage in the
183.17 notice of ineligibility provided to persons subject to disenrollment under section 256L.07,
183.18 subdivision 1, paragraphs (b) and (c).

183.19 **EFFECTIVE DATE.** This section is effective January 1, 2012, and expires June
183.20 30, 2013.

183.21 Sec. 100. Minnesota Statutes 2010, section 256L.05, is amended by adding a
183.22 subdivision to read:

183.23 Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants
183.24 for MinnesotaCare with incomes less than 133 percent of the federal poverty guidelines
183.25 who identify themselves as veterans are referred to a county veterans service officer for
183.26 assistance in applying to the United States Department of Veterans Affairs for any veterans
183.27 benefits for which they may be eligible.

183.28 Sec. 101. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

183.29 Subdivision 1. **General requirements.** (a) Children enrolled in the original
183.30 children's health plan as of September 30, 1992, children who enrolled in the
183.31 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
183.32 article 4, section 17, and children who have family gross incomes that are equal to or
183.33 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, are no longer eligible for the program and shall be disenrolled by the commissioner. ~~Beginning January 1, 2008,~~

(c) 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,~~ the limits described in section 256L.04, subdivision 7, 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 commissioner determines that the income of a family or individual exceeds program income limits.

~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in 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. 102. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

185.1 Subdivision 1. **General requirements.** (a) Children enrolled in the original
185.2 children's health plan as of September 30, 1992, children who enrolled in the
185.3 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
185.4 article 4, section 17, and children who have family gross incomes that are equal to or
185.5 less than 150 percent of the federal poverty guidelines are eligible without meeting
185.6 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
185.7 long as they maintain continuous coverage in the MinnesotaCare program or medical
185.8 assistance. Children who apply for MinnesotaCare on or after the implementation date
185.9 of the employer-subsidized health coverage program as described in Laws 1998, chapter
185.10 407, article 5, section 45, who have family gross incomes that are equal to or less than 150
185.11 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to
185.12 be eligible for MinnesotaCare.

185.13 (b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose
185.14 income increases above ~~275 percent of the federal poverty guidelines~~ the limits described
185.15 in section 256L.04, subdivision 1, are no longer eligible for the program and shall be
185.16 disenrolled by the commissioner.

185.17 (c) Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section
185.18 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty
185.19 guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no
185.20 longer eligible for the program and shall be disenrolled by the commissioner.

185.21 (d) For persons disenrolled under this subdivision, MinnesotaCare coverage
185.22 terminates the last day of the calendar month following the month in which the
185.23 commissioner determines that the income of a family or individual exceeds program
185.24 income limits.

185.25 ~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in
185.26 MinnesotaCare if ten percent of their gross individual or gross family income as defined in
185.27 section 256L.01, subdivision 4, is less than the annual premium for a policy with a \$500
185.28 deductible available through the Minnesota Comprehensive Health Association. Children
185.29 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month
185.30 notice period from the date that ineligibility is determined before disenrollment. The
185.31 premium for children remaining eligible under this clause shall be the maximum premium
185.32 determined under section 256L.15, subdivision 2, paragraph (b).

185.33 ~~(e)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for
185.34 MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period
185.35 of eligibility.

186.1 **EFFECTIVE DATE.** The amendment in paragraph (b) is effective January 1, 2012,
186.2 or upon federal approval whichever is later, and expires June 30, 2013. The commissioner
186.3 shall notify the revisor of statutes when federal approval is obtained and publish a notice
186.4 in the State Register.

186.5 Sec. 103. Minnesota Statutes 2010, section 256L.09, subdivision 4, is amended to read:

186.6 Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a
186.7 permanent Minnesota resident is a person who has demonstrated, through persuasive and
186.8 objective evidence, that the person is domiciled in the state and intends to live in the
186.9 state permanently.

186.10 (b) To be eligible as a permanent resident, an applicant must demonstrate the
186.11 requisite intent to live in the state permanently by:

186.12 (1) showing that the applicant maintains a residence at a verified address other than a
186.13 place of public accommodation, unless the place of public accommodation is the person's
186.14 primary or only residence, through the use of evidence of residence described in section
186.15 256D.02, subdivision 12a, paragraph (b), clause ~~(2)~~ (1);

186.16 (2) demonstrating that the applicant has been continuously domiciled in the state for
186.17 no less than 180 days immediately before the application; and

186.18 (3) signing an affidavit declaring that (A) the applicant currently resides in the state
186.19 and intends to reside in the state permanently; and (B) the applicant did not come to the
186.20 state for the primary purpose of obtaining medical coverage or treatment.

186.21 (c) A person who is temporarily absent from the state does not lose eligibility for
186.22 MinnesotaCare. "Temporarily absent from the state" means the person is out of the state
186.23 for a temporary purpose and intends to return when the purpose of the absence has been
186.24 accomplished. A person is not temporarily absent from the state if another state has
186.25 determined that the person is a resident for any purpose. If temporarily absent from the
186.26 state, the person must follow the requirements of the health plan in which the person is
186.27 enrolled to receive services.

186.28 Sec. 104. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

186.29 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
186.30 MinnesotaCare enrollees on or after ~~January 1, 2007~~, July 1, 2011, the commissioner shall
186.31 increase payment rates to dentists and dental clinics deemed by the commissioner to be
186.32 critical access providers under section 256B.76, subdivision 4, by ~~50~~ 30 percent above
186.33 the payment rate that would otherwise be paid to the provider. The commissioner shall
186.34 pay the prepaid health plans under contract with the commissioner amounts sufficient to

187.1 reflect this rate increase. The prepaid health plan must pass this rate increase to providers
187.2 who have been identified by the commissioner as critical access dental providers under
187.3 section 256B.76, subdivision 4.

187.4 Sec. 105. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

187.9 (b) For services rendered on or after January 1, 2004, the commissioner shall
187.10 withhold five percent of managed care plan payments and county-based purchasing
187.11 plan payments under this section pending completion of performance targets. Each
187.12 performance target must be quantifiable, objective, measurable, and reasonably attainable,
187.13 except in the case of a performance target based on a federal or state law or rule. Criteria
187.14 for assessment of each performance target must be outlined in writing prior to the
187.15 contract effective date. The managed care plan must demonstrate, to the commissioner's
187.16 satisfaction, that the data submitted regarding attainment of the performance target is
187.17 accurate. The commissioner shall periodically change the administrative measures used
187.18 as performance targets in order to improve plan performance across a broader range of
187.19 administrative services. The performance targets must include measurement of plan
187.20 efforts to contain spending on health care services and administrative activities. The
187.21 commissioner may adopt plan-specific performance targets that take into account factors
187.22 affecting only one plan, such as characteristics of the plan's enrollee population. The
187.23 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
187.24 following calendar year if performance targets in the contract are achieved.

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

187.30 (d) Effective for services rendered on or after January 1, 2011, the commissioner
187.31 shall include as part of the performance targets described in paragraph (b) a reduction in
187.32 the plan's emergency room utilization rate for state health care program enrollees by a
187.33 measurable rate of five percent from the plan's utilization rate for the previous calendar
187.34 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 described in this paragraph does not apply to county-based purchasing plans.

(e) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason for the hospitalization for state health care program enrollees by a measurable rate of five percent from the plan's hospitalization rate 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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization rate was achieved.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for state health care program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for state health care program enrollees for calendar year 2010. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must 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 utilizations less than the targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.

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

Sec. 106. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

- (1) payment by check;
- (2) payment by credit card;
- (3) payment by recurring automatic checking withdrawal;
- (4) payment by onetime electronic transfer of funds;
- (5) payment by wage withholding with the consent of the employer and the employee; or
- (6) payment by using state tax refund payments.

The commissioner shall include information about the payment options on each premium notice. At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the \$10 fee under section 270A.07, subdivision 1.

Sec. 107. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

Subd. 5. **Basic Health Care Grants**

(a) **MinnesotaCare Grants**

Health Care Access	-0-	(770,000)

Incentive Program and Outreach Grants.

Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

- (1) \$400,000 in fiscal year 2009 from the general fund and \$200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the

190.1 biennium beginning July 1, 2009, base level
190.2 funding for this activity shall be \$360,000
190.3 from the general fund and \$160,000 from the
190.4 health care access fund; and

190.5 (2) \$100,000 in fiscal year 2009 from the
190.6 general fund and \$50,000 in fiscal year 2009
190.7 from the health care access fund are for the
190.8 outreach grants under Minnesota Statutes,
190.9 section 256.962, subdivision 2. For the
190.10 biennium beginning July 1, 2009, base level
190.11 funding for this activity shall be \$90,000
190.12 from the general fund and \$40,000 from the
190.13 health care access fund.

190.14	(b) MA Basic Health Care Grants - Families		
190.15	and Children	-0-	(17,280,000)

190.16 **Third-Party Liability.** (a) During
190.17 fiscal year 2009, the commissioner shall
190.18 employ a contractor paid on a percentage
190.19 basis to improve third-party collections.
190.20 Improvement initiatives may include, but not
190.21 be limited to, efforts to improve postpayment
190.22 collection from nonresponsive claims and
190.23 efforts to uncover third-party payers the
190.24 commissioner has been unable to identify.

190.25 (b) In fiscal year 2009, the first \$1,098,000
190.26 of recoveries, after contract payments and
190.27 federal repayments, is appropriated to
190.28 the commissioner for technology-related
190.29 expenses.

190.30 **Administrative Costs.** (a) For contracts
190.31 effective on or after January 1, 2009,
190.32 the commissioner shall limit aggregate
190.33 administrative costs paid to managed care
190.34 plans under Minnesota Statutes, section
190.35 256B.69, and to county-based purchasing

191.1 plans under Minnesota Statutes, section
191.2 256B.692, to an overall average of ~~6.6~~ 6.1
191.3 percent of total contract payments under
191.4 Minnesota Statutes, sections 256B.69 and
191.5 256B.692, for each calendar year. For
191.6 purposes of this paragraph, administrative
191.7 costs do not include premium taxes paid
191.8 under Minnesota Statutes, section 297I.05,
191.9 subdivision 5, and provider surcharges paid
191.10 under Minnesota Statutes, section 256.9657,
191.11 subdivision 3.

191.12 (b) Notwithstanding any law to the contrary,
191.13 the commissioner may reduce or eliminate
191.14 administrative requirements to meet the
191.15 administrative target under paragraph (a).

191.16 (c) Notwithstanding any contrary provision
191.17 of this article, this rider shall not expire.

191.18 **Hospital Payment Delay.** Notwithstanding
191.19 Laws 2005, First Special Session chapter 4,
191.20 article 9, section 2, subdivision 6, payments
191.21 from the Medicaid Management Information
191.22 System that would otherwise have been made
191.23 for inpatient hospital services for medical
191.24 assistance enrollees are delayed as follows:
191.25 (1) for fiscal year 2008, June payments must
191.26 be included in the first payments in fiscal
191.27 year 2009; and (2) for fiscal year 2009,
191.28 June payments must be included in the first
191.29 payment of fiscal year 2010. The provisions
191.30 of Minnesota Statutes, section 16A.124,
191.31 do not apply to these delayed payments.
191.32 Notwithstanding any contrary provision in
191.33 this article, this paragraph expires on June
191.34 30, 2010.

191.35 **(c) MA Basic Health Care Grants - Elderly and**
191.36 **Disabled** (14,028,000) (9,368,000)

192.1 **Minnesota Disability Health Options Rate**
192.2 **Setting Methodology.** The commissioner
192.3 shall develop and implement a methodology
192.4 for risk adjusting payments for community
192.5 alternatives for disabled individuals (CADI)
192.6 and traumatic brain injury (TBI) home
192.7 and community-based waiver services
192.8 delivered under the Minnesota disability
192.9 health options program (MnDHO) effective
192.10 January 1, 2009. The commissioner shall
192.11 take into account the weighting system used
192.12 to determine county waiver allocations in
192.13 developing the new payment methodology.
192.14 Growth in the number of enrollees receiving
192.15 CADI or TBI waiver payments through
192.16 MnDHO is limited to an increase of 200
192.17 enrollees in each calendar year from January
192.18 2009 through December 2011. If those limits
192.19 are reached, additional members may be
192.20 enrolled in MnDHO for basic care services
192.21 only as defined under Minnesota Statutes,
192.22 section 256B.69, subdivision 28, and the
192.23 commissioner may establish a waiting list for
192.24 future access of MnDHO members to those
192.25 waiver services.

192.26 **MA Basic Elderly and Disabled**
192.27 **Adjustments.** For the fiscal year ending June
192.28 30, 2009, the commissioner may adjust the
192.29 rates for each service affected by rate changes
192.30 under this section in such a manner across
192.31 the fiscal year to achieve the necessary cost
192.32 savings and minimize disruption to service
192.33 providers, notwithstanding the requirements
192.34 of Laws 2007, chapter 147, article 7, section
192.35 71.

192.36 (d) **General Assistance Medical Care Grants** -0- (6,971,000)

193.1	(e) Other Health Care Grants	-0-	(17,000)

193.2 MinnesotaCare Outreach Grants Special

193.3 **Revenue Account.** The balance in the

193.4 MinnesotaCare outreach grants special

193.5 revenue account on July 1, 2009, estimated

193.6 to be \$900,000, must be transferred to the

193.7 general fund.

193.8 **Grants Reduction.** Effective July 1, 2008,

193.9 base level funding for nonforecast, general

193.10 fund health care grants issued under this

193.11 paragraph shall be reduced by 1.8 percent at

193.12 the allotment level.

193.13 Sec. 108. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision

193.14 6. is amended to read:

193.15 Subd. 6. Health Care Grants

193.16	(a) MinnesotaCare Grants	998,000	(13,376,000)

193.17 This appropriation is from the health care

193.18 access fund.

193.19 **Health Care Access Fund Transfer to**

193.20 **General Fund.** The commissioner of

193.21 management and budget shall transfer the

193.22 following amounts in the following years

193.23 from the health care access fund to the

193.24 general fund: ~~\$998,000~~ \$0 in fiscal year

193.25 2010; ~~\$176,704,000~~ \$59,901,000 in fiscal

193.26 year 2011; \$141,041,000 in fiscal year 2012;

193.27 and \$286,150,000 in fiscal year 2013. If at

193.28 any time the governor issues an executive

193.29 order not to participate in early medical

193.30 assistance expansion, no funds shall be

193.31 transferred from the health care access

193.32 fund to the general fund until early medical

193.33 assistance expansion takes effect. This

194.1 paragraph is effective the day following final
194.2 enactment.

194.3 **MinnesotaCare Ratable Reduction.**
194.4 Effective for services rendered on or after
194.5 July 1, 2010, to December 31, 2013,
194.6 MinnesotaCare payments to managed care
194.7 plans under Minnesota Statutes, section
194.8 256L.12, for single adults and households
194.9 without children whose income is greater
194.10 than 75 percent of federal poverty guidelines
194.11 shall be reduced by 15 percent. Effective
194.12 for services provided from July 1, 2010, to
194.13 June 30, 2011, this reduction shall apply to
194.14 all services. Effective for services provided
194.15 from July 1, 2011, to December 31, 2013, this
194.16 reduction shall apply to all services except
194.17 inpatient hospital services. Notwithstanding
194.18 any contrary provision of this article, this
194.19 paragraph shall expire on December 31,
194.20 2013.

194.21	(b) Medical Assistance Basic Health Care		
194.22	Grants - Families and Children	-0-	295,512,000

194.23 **Critical Access Dental.** Of the general
194.24 fund appropriation, \$731,000 in fiscal year
194.25 2011 is to the commissioner for critical
194.26 access dental provider reimbursement
194.27 payments under Minnesota Statutes, section
194.28 256B.76 subdivision 4. This is a onetime
194.29 appropriation.

194.30 **Nonadministrative Rate Reduction.** For
194.31 services rendered on or after July 1, 2010,
194.32 to December 31, 2013, the commissioner
194.33 shall reduce contract rates paid to managed
194.34 care plans under Minnesota Statutes,
194.35 sections 256B.69 and 256L.12, and to
194.36 county-based purchasing plans under

195.1	Minnesota Statutes, section 256B.692, by		
195.2	three percent of the contract rate attributable		
195.3	to nonadministrative services in effect on		
195.4	June 30, 2010. Notwithstanding any contrary		
195.5	provision in this article, this rider expires on		
195.6	December 31, 2013.		
195.7	(c) Medical Assistance Basic Health Care		
195.8	Grants - Elderly and Disabled	-0-	(30,265,000)
195.9			~~(75,389,000)~~
195.10	(d) General Assistance Medical Care Grants	-0-	<u>(59,583,000)</u>
195.11	<u>The reduction to general assistance medical</u>		
195.12	<u>care grants is contingent upon the effective</u>		
195.13	<u>date in Laws 2010, First Special Session</u>		
195.14	<u>chapter 1, article 16, section 48. The</u>		
195.15	<u>reduction shall be reestimated based upon</u>		
195.16	<u>the actual effective date of the law. The</u>		
195.17	<u>commissioner of management and budget</u>		
195.18	<u>shall make adjustments in fiscal year</u>		
195.19	<u>2011 to general assistance medical care</u>		
195.20	<u>appropriations to conform to the total</u>		
195.21	<u>expected expenditure reductions specified in</u>		
195.22	<u>this section.</u>		
195.23	(e) Other Health Care Grants	-0-	(7,000,000)
195.24	Cobra Carryforward. Unexpended funds		
195.25	appropriated in fiscal year 2010 for COBRA		
195.26	grants under Laws 2009, chapter 79, article		
195.27	5, section 78, do not cancel and are available		
195.28	to the commissioner for fiscal year 2011		
195.29	COBRA grant expenditures. Up to \$111,000		
195.30	of the fiscal year 2011 appropriation for		
195.31	COBRA grants provided in Laws 2009,		
195.32	chapter 79, article 13, section 3, subdivision		
195.33	6, may be used by the commissioner for costs		
195.34	related to administration of the COBRA		
195.35	grants.		

Sec. 109. **COMMISSIONER'S ACTIONS; REPEAL OF EARLY MEDICAL ASSISTANCE EXPANSION.**

Effective January 1, 2012, the commissioner of human services shall suspend implementation and administration of Minnesota Statutes 2010, sections 256B.055, subdivision 15; 256B.056, subdivision 3, paragraph (b); and 256B.056, subdivision 4, paragraph (d). The commissioner shall refer persons enrolled under these provisions, and applicants for coverage under these provisions, to the general assistance medical care program established under Minnesota Statutes, section 256D.031.

Sec. 110. **GENERAL ASSISTANCE MEDICAL CARE PROGRAM; PROVISIONS REVIVED.**

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 effective January 1, 2012:

(1) Minnesota Statutes 2010, section 256D.03, subdivisions 3, 3a, 6, 7, and 8;

(2) Minnesota Statutes 2010, section 256D.031, subdivisions 1, 2, 3, 4, 6, 7, and 10; and

(3) Laws 2010, chapter 200, article 1, section 18.

Sec. 111. **PLAN TO COORDINATE CARE FOR CHILDREN WITH HIGH-COST MENTAL HEALTH CONDITIONS.**

The commissioner of human services shall develop and submit to the legislature by December 15, 2011, a plan to provide care coordination to medical assistance and MinnesotaCare enrollees who are children with high-cost mental health conditions. For purposes of this section, a child has a "high-cost mental health condition" if mental health and medical expenses over the past year totalled \$100,000 or more. For purposes of this section, "care coordination" means collaboration between an advanced practice nurse and primary care physicians and specialists to manage care; development of mental health management plans for recurrent mental health issues; oversight and coordination of all aspects of care in partnership with families; organization of medical, treatment, and therapy information into a summary of critical information; coordination and appropriate sequencing of evaluations and multiple appointments; information and assistance with accessing resources; and telephone triage for behavior or other problems.

Sec. 112. **DATA ON CLAIMS AND UTILIZATION.**

197.1 The commissioner of human services, in consultation with the Health and Human
197.2 Services Reform Committee, shall develop and provide to the legislature by December 15,
197.3 2011, a methodology and any draft legislation necessary to allow for the release, upon
197.4 request, of summary data as defined in Minnesota Statutes, section 13.02, subdivision 19,
197.5 on claims and utilization for medical assistance, general assistance medical care, and
197.6 MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the
197.7 Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical
197.8 Systems Improvement, and other research institutions to conduct analyses of health care
197.9 outcomes and treatment effectiveness, provided the research institutions do not release
197.10 private or nonpublic data or data for which dissemination is prohibited by law.

197.11 Sec. 113. **REDUCTION OF STATE-MANDATED ADMINISTRATIVE**
197.12 **REPORTS.**

197.13 (a) The commissioner of management and budget shall convene a report reduction
197.14 working group of persons designated by the commissioners of health, human services, and
197.15 commerce to eliminate redundant, unnecessary, obsolete, and low-priority state-mandated
197.16 administrative reports required of health plans and county-based purchasing plans
197.17 that serve persons enrolled in Minnesota health care programs. The commissioner of
197.18 management and budget and the report reduction working group shall develop a plan to
197.19 oversee the report reduction activities of the individual state agencies and coordinate the
197.20 activities of multiple state agencies to consolidate reports or eliminate redundant reports
197.21 required by more than one state agency on the same or a similar topic.

197.22 (b) The commissioners of health, human services, and commerce shall reduce,
197.23 eliminate, or consolidate state-mandated reports according to the plan developed by the
197.24 commissioner of management and budget through the report reduction working group.
197.25 In addition to other report reduction actions the commissioners or the working group
197.26 may undertake, the commissioners shall:

197.27 (1) collect encounter data, including provider payment data if collected, in a
197.28 consolidated report provided to a single state agency, with the data collected by that state
197.29 agency to be shared with other state agencies who need the data;

197.30 (2) collect only one provider network report annually through a single state agency,
197.31 with the data collected by that state agency to be shared with other state agencies who
197.32 need the data;

197.33 (3) collect only one standard financial report through a single state agency, with
197.34 the data collected by that state agency to be shared with other state agencies who need
197.35 the data. Data collected must be of a nature and in a format to allow comparison of the

198.1 cost-effectiveness of fee-for-service payment systems and prepaid programs administered
198.2 by health plans and county-based purchasing plans;

198.3 (4) consolidate and simplify reports and documentation requirements relating to
198.4 member communications and marketing materials, and establish a single review process
198.5 for all programs, products, and agencies in order to ensure uniform and consistent
198.6 regulation of health plan contracts;

198.7 (5) consolidate state regulation and oversight of health plans and county-based
198.8 purchasing plans so that activities of multiple agencies are administered through an
198.9 efficient and uniform multiagency process of oversight and audits, with consistent
198.10 standards, measures, and definitions for state oversight of quality, utilization management,
198.11 care management, delegation accountability, access to care, appeals and grievances, and
198.12 financial management;

198.13 (6) establish uniform requirements and procedures for denial, termination, or
198.14 reduction of services and member appeals and grievances, and align state requirements
198.15 and procedures with federal requirements and procedures; and

198.16 (7) reform the state's performance improvement projects, requirements, and
198.17 procedures to be more flexible and efficient, and to place greater focus on measuring
198.18 improvement of outcomes and less on mandating detailed or prescriptive requirements for
198.19 specific performance improvement projects or activities.

198.20 (d) New reporting requirements or ad hoc report requests shall be established by a
198.21 state agency only:

198.22 (1) if required by a federal agency;

198.23 (2) if needed for a state regulatory audit or corrective action plan; or

198.24 (3) after the completion of a review and analysis, and the development of
198.25 recommendations by the commissioner of management and budget, in consultation
198.26 with the report reduction working group, regarding the necessity, importance, and
198.27 administrative cost of the new report, and after completing a review to determine
198.28 whether the information sought can be obtained through another available state or federal
198.29 report. The results of the review, analysis, and recommendations of the commissioner of
198.30 management and budget must be provided to health plans and county-based purchasing
198.31 plans for review and comment at least 60 days before a new report or requirement is
198.32 established.

198.33 (e) To the extent possible, all state agencies shall use the procedures, reports,
198.34 and audits of the Centers for Medicare and Medicaid Services instead of requiring an
198.35 additional state-mandated report on the same or a similar topic.

199.1 (f) By January 15, 2012, the commissioner of management and budget shall provide
199.2 a report on the activities and results of the report reduction project to the legislature.

199.3 The report must include:

199.4 (1) a timetable for report reduction actions already taken or planned by the
199.5 commissioners or the report reduction working group;

199.6 (2) the specific reports that have been or will be eliminated or consolidated;

199.7 (3) the amount of money that will be saved through reductions in administrative
199.8 costs of health plans and county-based purchasing plans as a result of the report reduction
199.9 project; and

199.10 (4) proposed legislation for changes to laws or rules that are needed to allow state
199.11 agencies to further reduce, consolidate, or eliminate reports when the changes cannot
199.12 be made administratively.

199.13 Sec. 114. **COMPETITIVE BIDDING PILOT.**

199.14 For managed care contracts effective January 1, 2012, the commissioner of
199.15 human services is required to establish a competitive price bidding pilot for nonelderly,
199.16 nondisabled adults and children in medical assistance and MinnesotaCare in the
199.17 seven-county metropolitan area. The pilot must allow a minimum of two managed care
199.18 organizations to serve the metropolitan area. The pilot shall expire after two full calendar
199.19 years on December 31, 2013. The commissioner of human service shall conduct an
199.20 evaluation of the pilot to determine the cost-effectiveness and impacts to provider access at
199.21 the end of the two-year period. The commissioner must consult with other states that have
199.22 experience implementing competitive bidding in their medical assistance population and
199.23 incorporate best practices from those states in designing this pilot. The commissioner, prior
199.24 to implementation, must also consult with stakeholders on the design and implementation
199.25 of the pilot, including providers, plans, advocacy groups, and other interested parties.

199.26 Sec. 115. **REQUEST FOR PROPOSAL; PROVIDER BILLING PATTERNS.**

199.27 (a) The commissioner of human services shall issue a request for proposal, using
199.28 existing resources, to identify abnormal provider billing patterns in order to prevent and
199.29 identify improper medical assistance payments.

199.30 (b) The request for proposal must include the following requirements for the
199.31 contractor:

199.32 (1) identification and reporting of improper claims, outlier claims, and improper
199.33 payments, both prior to and subsequent to reimbursement;

200.1 (2) utilization of fraud detection methods that maximize contemporary predictive
200.2 analytic tools, including but not limited to identity analytics, link analysis, and matching
200.3 capabilities;

200.4 (3) utilization of data analytics that improve fraud detection through the identification
200.5 of outlier reimbursement;

200.6 (4) reduction in state expenditures by reducing or eliminating payouts of improper
200.7 medical assistance claims; and

200.8 (5) demonstrated success with other states and state agencies using the specified
200.9 proposed solution, deployment, and implementation.

200.10 (c) The commissioner shall enter into a contract for the services in this section by
200.11 October 1, 2011. The contract must incorporate a performance-based vendor financing
200.12 mechanism under which the vendor shares in the risk of the project's success.

200.13 Sec. 116. **HEALTH SERVICES POLICY COMMITTEE STUDIES.**

200.14 (a) The commissioner of human services, through the health services policy
200.15 committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall
200.16 identify and review medical assistance services provided by health care professionals who
200.17 are not trained to provide the services in a high-quality manner. The commissioner shall
200.18 develop a process to limit payment for medical assistance services to providers who are
200.19 not appropriately trained to provide the service, and shall present recommendations and
200.20 draft legislation by January 15, 2012, to the legislature.

200.21 (b) The commissioner of human services, through the health services policy
200.22 committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall
200.23 study the effectiveness of new strategies for wound care treatment for medical assistance
200.24 and MinnesotaCare enrollees with diabetes, including but not limited to the use of new
200.25 wound care technologies, assessment tools, and reporting programs. The commissioner
200.26 shall present recommendations by December 15, 2011, to the legislature on whether these
200.27 new strategies for wound care treatment should be covered under medical assistance
200.28 and MinnesotaCare.

200.29 Sec. 117. **SPECIALIZED MAINTENANCE THERAPY.**

200.30 The commissioner of human services shall evaluate whether providing medical
200.31 assistance coverage for specialized maintenance therapy for enrollees with serious and
200.32 persistent mental illness who are at risk of hospitalization will improve the quality of
200.33 care and lower medical assistance spending by reducing rates of hospitalization. The
200.34 commissioner shall present findings and recommendations to the chairs and ranking

201.1 minority members of the legislative committees with jurisdiction over health and human
201.2 services finance and policy by December 15, 2011.

201.3 Sec. 118. **COVERAGE FOR LOWER-INCOME MINNESOTACARE**
201.4 **ENROLLEES.**

201.5 The commissioner of human services shall develop and present to the legislature,
201.6 by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees
201.7 eligible under Minnesota Statutes, section 256L.04, subdivisions 1 and 7, with incomes
201.8 less than 133 percent of the federal poverty guidelines. The plan must be designed to
201.9 improve continuity and quality of care, reduce unnecessary emergency room visits, and
201.10 reduce average per-enrollee costs. In developing the plan, the commissioner shall consider
201.11 innovative methods of service delivery, including but not limited to increasing the use
201.12 and choice of private sector health plan coverage and encouraging the use of community
201.13 health clinics, as defined in the federal Community Health Care Act of 1964, as health
201.14 care homes.

201.15 Sec. 119. **DIRECTION TO COMMISSIONER; FEDERAL WAIVERS.**

201.16 (a) The commissioner of human services shall apply to the Centers for Medicare
201.17 and Medicaid Services (CMS) for federal waivers to cover:

201.18 (1) families with children eligible under Minnesota Statutes, section 256L.04,
201.19 subdivision 1; and

201.20 (2) adults eligible under Minnesota Statutes, section 256L.04, subdivision 1,
201.21 under the MinnesotaCare healthy Minnesota contribution program established under
201.22 Minnesota Statutes, section 256L.031, by July 1, 2011. The commissioner shall report to
201.23 the legislative committees with jurisdiction over health and human services policy and
201.24 finance whether or not the federal waiver application was accepted within ten working
201.25 days of receipt of the decision.

201.26 (b) The commissioner of human services shall apply to the CMS for a section
201.27 1115(a) demonstration waiver, and any other necessary federal waivers and amendments,
201.28 including, but not limited to, a waiver of the appropriate sections of title XIX, United
201.29 States Code, title 42, section 1396a, and a waiver of any applicable federal maintenance of
201.30 effort provisions that would provide Minnesota with medical assistance program flexibility
201.31 in exchange for federal budget certainty. The commissioner shall seek federal approval to
201.32 enter into an agreement with CMS under which Minnesota would:

202.1 (1) accept an aggregate annual allotment for the medical assistance program, trended
202.2 forward at an agreed upon rate, with protections to cover medical inflation and projected
202.3 caseload growth; and

202.4 (2) receive federal waivers of Medicaid requirements related to: statewideness and
202.5 comparability of services; the amount, duration, and scope of services; freedom of choice;
202.6 cost-sharing; and other areas of program administration specified by the commissioner.

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

202.8 Sec. 120. **TRANSPARENCY AND QUALITY REPORTING FOR PUBLIC**
202.9 **HEALTH CARE PROGRAMS.**

202.10 When negotiating with external vendors to provide managed care services, the
202.11 commissioner of human services shall require use of an advanced request for information
202.12 tool. This tool must provide the department with an evidence-based assessment that
202.13 focuses on the cost control, quality, and information transparency of the health care
202.14 vendor. The assessment may include evidence-based performance measures that have
202.15 been shown to influence better health, better health care, and more cost-effective use of
202.16 resources including, but not limited to, areas that determine each plan's capabilities and
202.17 performance with respect to:

202.18 (1) consumer engagement, support, and incentives;

202.19 (2) processes and outcomes for closing gaps in care according to clinical guideline
202.20 expectations;

202.21 (3) provider management, including outcome and population-based reimbursement,
202.22 transparent measurement of provider performance, and support of physician practice
202.23 structures that lead to better care; and

202.24 (4) measures of clinical outcomes and waste approved by the National Quality
202.25 Forum.

202.26 Sec. 121. **RISK CORRIDORS.**

202.27 (a) Effective for services rendered on or after January 1, 2012, the commissioner
202.28 shall establish risk corridors for state public programs that are actuarially sound for each
202.29 managed care plan and each county-based purchasing plan. The risk corridors will be
202.30 calculated annually based on the calendar year's net underwriting gain or loss. If the
202.31 managed care plan or county-based purchasing plan has achieved a net underwriting gain
202.32 of greater than three percent of revenue, 80 percent of any excess must be repaid to the
202.33 commissioner by July 31 of the year following calculation of the risk corridor year, and
202.34 20 percent must be invested by the plan directly into programs for improving quality of

203.1 care or access to care for state public health care program enrollees. If the managed
203.2 care plan or county-based purchasing plan has incurred a net underwriting loss greater
203.3 than three percent of total revenue, 50 percent of any excess must be repaid to the plan
203.4 by the commissioner by July 31 of the year following calculation of the risk corridor
203.5 year. Determination of total revenues and net underwriting gain or loss must be based
203.6 on the Minnesota Supplement Report #1 which is filed on April 1 of the year following
203.7 calculation of the risk corridor and adjusted for the actual withhold calculation under
203.8 sections 256B.69, subdivision 5a, and 256L.12, subdivision 9. The report must be filed
203.9 with and publicly disclosed by the Department of Health.

203.10 (b) For purposes of this section, "state public programs" means those prepaid
203.11 medical assistance and MinnesotaCare programs for which a managed care plan or
203.12 county-based purchasing plan contracts with the commissioner to provide coverage under
203.13 sections 256B.69, 256B.692, and 256L.12. The risk corridors shall not apply to plans for
203.14 persons who are enrolled in integrated Medicare and medical assistance programs under
203.15 section 256B.69, subdivisions 23 and 28.

203.16 (c) This section expires January 1, 2014.

203.17 Sec. 122. **REPEALER.**

203.18 (a) Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, (**Legislative**
203.19 **Commission on Health Care Access) are repealed.**

203.20 (b) Laws 2009, chapter 79, article 5, section 64, (**256L.07, subdivision 2**) is repealed
203.21 retroactively from July 1, 2009, and federal approval is no longer necessary.

203.22 (c) Laws 2009, chapter 79, article 5, section 65, (**256L.07, subdivision 3**) is repealed
203.23 retroactively from July 1, 2009, and federal approval is no longer necessary.

203.24 (d) Laws 2009, chapter 79, article 5, section 68, (**256L.15, subdivision 2, exemption**
203.25 **of low-income children from MinnesotaCare premiums and insurance barriers) is**
203.26 **repealed retroactively from July 1, 2009, and federal approval is no longer necessary.**

203.27 (e) Minnesota Statutes 2010, section 256L.07, subdivision 7, (**exempting eligibility**
203.28 **for children formally under medical assistance, is repealed retroactively from October**
203.29 **1, 2008, and federal approval is no longer necessary.**

203.30 (f) The amendment in Laws 2009, chapter 79, article 5, section 55, as amended by
203.31 Laws 2009, chapter 173, article 1, section 36, (**256L.04, subdivision 1, children deemed**
203.32 **eligible are exempt from eligibility requirements) is repealed retroactively from January**
203.33 **1, 2009, and federal approval is no longer necessary.**

- 204.1 (g) Laws 2009, chapter 79, article 5, section 56, **(256L.04, subdivision 1b,**
204.2 **exemption from income limit for children)** is repealed retroactively from July 1, 2009,
204.3 and federal approval is no longer necessary.
- 204.4 (h) Laws 2009, chapter 79, article 5, section 60, **(256L.05, subdivision 1c, open**
204.5 **enrollment and streamlined application)** is repealed retroactively from July 1, 2009,
204.6 and federal approval is no longer necessary.
- 204.7 (i) Laws 2009, chapter 79, article 5, section 66, **(256L.07, subdivision 8, automatic**
204.8 **eligibility certain children)** is repealed retroactively from July 1, 2009, and federal
204.9 approval is no longer necessary.
- 204.10 (j) The amendment in Laws 2009, chapter 79, article 5, section 57, **(256L.04,**
204.11 **subdivision 7a, ineligibility for adults with certain income)** is repealed retroactively
204.12 from July 1, 2009, and federal approval is no longer necessary.
- 204.13 (k) The amendment in Laws 2009, chapter 79, article 5, section 61, **(256L.05,**
204.14 **subdivision 3, children eligibility following termination from foster care)** is repealed
204.15 retroactively from July 1, 2009, and federal approval is no longer necessary.
- 204.16 (l) The amendment in Laws 2009, chapter 79, article 5, section 62, **(256L.05,**
204.17 **subdivision 3a, exemption from cancellation for nonrenewal for children)** is repealed
204.18 retroactively from July 1, 2009, and federal approval is no longer necessary.
- 204.19 (m) The amendment in Laws 2009, chapter 79, article 5, section 63, **(256L.07,**
204.20 **subdivision 1, children whose gross family income is greater than 275 percent FPG**
204.21 **may remain enrolled)** is repealed retroactively from July 1, 2009, and federal approval is
204.22 no longer necessary.
- 204.23 (n) The amendment in Laws 2009, chapter 79, article 5, section 64, **(256L.07,**
204.24 **subdivision 2, exempts children from requirement not to have employer-subsidized**
204.25 **coverage)** is repealed retroactively from July 1, 2009, and federal approval is no longer
204.26 necessary.
- 204.27 (o) The amendment in Laws 2009, chapter 79, article 5, section 65, **(256L.07,**
204.28 **subdivision 3, requires children with family gross income over 200 percent of FPG**
204.29 **to have had no health coverage for four months prior to application)** is repealed
204.30 retroactively from July 1, 2009, and federal approval is no longer necessary.
- 204.31 (p) The amendment in Laws 2009, chapter 79, article 5, section 68, **(256L.15,**
204.32 **subdivision 2, children in families with income less than 200 percent FPG pay no**
204.33 **premium)** is repealed retroactively from July 1, 2009, and federal approval is no longer
204.34 necessary.
- 204.35 (q) The amendment in Laws 2009, chapter 79, article 5, section 69, **(256L.15,**
204.36 **subdivision 3, exempts children with family income below 200 percent FPG from**

205.1 sliding fee scale) is repealed retroactively from July 1, 2009, and federal approval is
205.2 no longer necessary.

205.3 (r) Laws 2009, chapter 79, article 5, section 79, (uncoded federal approval) is
205.4 repealed the day following final enactment.

205.5 (s) Minnesota Statutes 2010, section 256B.057, subdivision 2c, (extended medical
205.6 assistance for certain children) is repealed.

205.7 (t) The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9, (renewal
205.8 rolling month and premium grace month) are repealed.

205.9 Sec. 123. **REPEALER; EARLY MEDICAL ASSISTANCE EXPANSION.**

205.10 Minnesota Statutes 2010, section 256B.055, subdivision 15, is repealed January
205.11 1, 2012.

205.12 ARTICLE 6

205.13 CONTINUING CARE

205.14 Section 1. Minnesota Statutes 2010, section 144A.071, is amended by adding a
205.15 subdivision to read:

205.16 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health,
205.17 in consultation with the commissioner of human services, may approve a request for
205.18 consolidation of nursing facilities which includes the closure of one or more facilities
205.19 and the upgrading of the physical plant of the remaining nursing facility or facilities,
205.20 the costs of which exceed the threshold project limit under subdivision 2, clause (a).
205.21 The commissioners shall consider the criteria in this section, section 144A.073, and
205.22 section 256B.437, in approving or rejecting a consolidation proposal. In the event the
205.23 commissioners approve the request, the commissioner of human services shall calculate a
205.24 property rate adjustment according to clauses (1) to (3):

205.25 (1) the closure of beds shall not be eligible for a planned closure rate adjustment
205.26 under section 256B.437, subdivision 6;

205.27 (2) the construction project permitted in this clause shall not be eligible for a
205.28 threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium
205.29 exception adjustment under section 144A.073; and

205.30 (3) the property payment rate for a remaining facility or facilities shall be increased
205.31 by an amount equal to 65 percent of the projected net cost savings to the state calculated in
205.32 paragraph (b), divided by the state's medical assistance percentage of medical assistance
205.33 dollars, and then divided by estimated medical assistance resident days, as determined in
205.34 paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph.

206.1 (b) For purposes of calculating the net cost savings to the state, the commissioner
206.2 shall consider clauses (1) to (7):

206.3 (1) the annual savings from estimated medical assistance payments from the net
206.4 number of beds closed taking into consideration only beds that are in active service on the
206.5 date of the request and that have been in active service for at least three years;

206.6 (2) the estimated annual cost of increased case load of individuals receiving services
206.7 under the elderly waiver;

206.8 (3) the estimated annual cost of elderly waiver recipients receiving support under
206.9 group residential housing;

206.10 (4) the estimated annual cost of increased case load of individuals receiving services
206.11 under the alternative care program;

206.12 (5) the annual loss of license surcharge payments on closed beds;

206.13 (6) the savings from not paying planned closure rate adjustments that the facilities
206.14 would otherwise be eligible for under section 256B.437; and

206.15 (7) the savings from not paying property payment rate adjustments from submission
206.16 of renovation costs that would otherwise be eligible as threshold projects under section
206.17 256B.434, subdivision 4f.

206.18 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
206.19 assistance resident days of the remaining facility or facilities shall be computed assuming
206.20 95 percent occupancy multiplied by the historical percentage of medical assistance
206.21 resident days of the remaining facility or facilities, as reported on the facility's or facilities'
206.22 most recent nursing facility statistical and cost report filed before the plan of closure
206.23 is submitted, multiplied by 365.

206.24 (d) For purposes of net cost of savings to the state in paragraph (b), the average
206.25 occupancy percentages will be those reported on the facility's or facilities' most recent
206.26 nursing facility statistical and cost report filed before the plan of closure is submitted, and
206.27 the average payment rates shall be calculated based on the approved payment rates in
206.28 effect at the time the consolidation request is submitted.

206.29 (e) To qualify for the property payment rate adjustment under this provision, the
206.30 closing facilities shall:

206.31 (1) submit an application for closure according to section 256B.437, subdivision
206.32 3; and

206.33 (2) follow the resident relocation provisions of section 144A.161.

206.34 (f) The county or counties in which a facility or facilities are closed under this
206.35 subdivision shall not be eligible for designation as a hardship area under section 144A.071,
206.36 subdivision 3, for five years from the date of the approval of the proposed consolidation.

207.1 The applicant shall notify the county of this limitation and the county shall acknowledge
207.2 this in a letter of support.

207.3 Sec. 2. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

207.4 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
207.5 child, including a child determined eligible for medical assistance without consideration of
207.6 parental income, must contribute to the cost of services used by making monthly payments
207.7 on a sliding scale based on income, unless the child is married or has been married,
207.8 parental rights have been terminated, or the child's adoption is subsidized according to
207.9 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
207.10 is a partial or full payment for medical services provided for diagnostic, therapeutic,
207.11 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
207.12 defined in United States Code, title 26, section 213, needed by the child with a chronic
207.13 illness or disability.

207.14 (b) For households with adjusted gross income equal to or greater than 100 percent
207.15 of federal poverty guidelines, the parental contribution shall be computed by applying the
207.16 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

207.17 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
207.18 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
207.19 contribution is \$4 per month;

207.20 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
207.21 poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines,
207.22 the parental contribution shall be determined using a sliding fee scale established by the
207.23 commissioner of human services which begins at one percent of adjusted gross income at
207.24 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted
207.25 gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal
207.26 poverty guidelines;

207.27 (3) if the adjusted gross income is greater than ~~545~~ 525 percent of federal
207.28 poverty guidelines and less than 675 percent of federal poverty guidelines, the parental
207.29 contribution shall be ~~7.5~~ 9.5 percent of adjusted gross income;

207.30 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
207.31 poverty guidelines and less than ~~975~~ 900 percent of federal poverty guidelines, the parental
207.32 contribution shall be determined using a sliding fee scale established by the commissioner
207.33 of human services which begins at ~~7.5~~ 9.5 percent of adjusted gross income at 675 percent
207.34 of federal poverty guidelines and increases to ~~ten~~ 12 percent of adjusted gross income for
207.35 those with adjusted gross income up to ~~975~~ 900 percent of federal poverty guidelines; and

208.1 (5) if the adjusted gross income is equal to or greater than ~~975~~ 900 percent of
208.2 federal poverty guidelines, the parental contribution shall be ~~12.5~~ 13.5 percent of adjusted
208.3 gross income.

208.4 If the child lives with the parent, the annual adjusted gross income is reduced by
208.5 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
208.6 specified in section 256B.35, the parent is responsible for the personal needs allowance
208.7 specified under that section in addition to the parental contribution determined under this
208.8 section. The parental contribution is reduced by any amount required to be paid directly to
208.9 the child pursuant to a court order, but only if actually paid.

208.10 (c) The household size to be used in determining the amount of contribution under
208.11 paragraph (b) includes natural and adoptive parents and their dependents, including the
208.12 child receiving services. Adjustments in the contribution amount due to annual changes
208.13 in the federal poverty guidelines shall be implemented on the first day of July following
208.14 publication of the changes.

208.15 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
208.16 natural or adoptive parents determined according to the previous year's federal tax form,
208.17 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
208.18 have been used to purchase a home shall not be counted as income.

208.19 (e) The contribution shall be explained in writing to the parents at the time eligibility
208.20 for services is being determined. The contribution shall be made on a monthly basis
208.21 effective with the first month in which the child receives services. Annually upon
208.22 redetermination or at termination of eligibility, if the contribution exceeded the cost of
208.23 services provided, the local agency or the state shall reimburse that excess amount to
208.24 the parents, either by direct reimbursement if the parent is no longer required to pay a
208.25 contribution, or by a reduction in or waiver of parental fees until the excess amount is
208.26 exhausted. All reimbursements must include a notice that the amount reimbursed may be
208.27 taxable income if the parent paid for the parent's fees through an employer's health care
208.28 flexible spending account under the Internal Revenue Code, section 125, and that the
208.29 parent is responsible for paying the taxes owed on the amount reimbursed.

208.30 (f) The monthly contribution amount must be reviewed at least every 12 months;
208.31 when there is a change in household size; and when there is a loss of or gain in income
208.32 from one month to another in excess of ten percent. The local agency shall mail a written
208.33 notice 30 days in advance of the effective date of a change in the contribution amount.
208.34 A decrease in the contribution amount is effective in the month that the parent verifies a
208.35 reduction in income or change in household size.

209.1 (g) Parents of a minor child who do not live with each other shall each pay the
209.2 contribution required under paragraph (a). An amount equal to the annual court-ordered
209.3 child support payment actually paid on behalf of the child receiving services shall be
209.4 deducted from the adjusted gross income of the parent making the payment prior to
209.5 calculating the parental contribution under paragraph (b).

209.6 (h) The contribution under paragraph (b) shall be increased by an additional five
209.7 percent if the local agency determines that insurance coverage is available but not
209.8 obtained for the child. For purposes of this section, "available" means the insurance is a
209.9 benefit of employment for a family member at an annual cost of no more than five percent
209.10 of the family's annual income. For purposes of this section, "insurance" means health
209.11 and accident insurance coverage, enrollment in a nonprofit health service plan, health
209.12 maintenance organization, self-insured plan, or preferred provider organization.

209.13 Parents who have more than one child receiving services shall not be required
209.14 to pay more than the amount for the child with the highest expenditures. There shall
209.15 be no resource contribution from the parents. The parent shall not be required to pay
209.16 a contribution in excess of the cost of the services provided to the child, not counting
209.17 payments made to school districts for education-related services. Notice of an increase in
209.18 fee payment must be given at least 30 days before the increased fee is due.

209.19 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
209.20 in the 12 months prior to July 1:

209.21 (1) the parent applied for insurance for the child;

209.22 (2) the insurer denied insurance;

209.23 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
209.24 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
209.25 commerce, or litigated the complaint or appeal; and

209.26 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

209.27 For purposes of this section, "insurance" has the meaning given in paragraph (h).

209.28 A parent who has requested a reduction in the contribution amount under this
209.29 paragraph shall submit proof in the form and manner prescribed by the commissioner or
209.30 county agency, including, but not limited to, the insurer's denial of insurance, the written
209.31 letter or complaint of the parents, court documents, and the written response of the insurer
209.32 approving insurance. The determinations of the commissioner or county agency under this
209.33 paragraph are not rules subject to chapter 14.

209.34 ~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~
209.35 ~~2013, the parental contribution shall be computed by applying the following contribution~~
209.36 ~~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 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;

~~(1) provides~~ (2) provide information about state and federal eligibility requirements, benefits, and service options;

211.1 (3) provide benefits and options counseling;
211.2 ~~(2) makes~~ (4) make referrals to appropriate support entities;
211.3 ~~(3) delivers information and assistance based on national and state standards;~~
211.4 ~~(4) assists~~ (5) educate people to on their options so they can make well-informed
211.5 ~~decisions~~ choices; and
211.6 ~~(5) supports~~ (6) help support the timely resolution of service access and benefit
211.7 issues;
211.8 (7) inform people of their long-term community services and supports;
211.9 (8) provide necessary resources and supports that can lead to employment and
211.10 increased economic stability of people with disabilities; and
211.11 (9) serve as the technical assistance and help center for the Web-based tool,
211.12 Minnesota's Disability Benefits 101.org.

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

211.14 Sec. 4. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:

211.15 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
211.16 determinations of disability by the commissioner's state medical review team under
211.17 sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, ~~paragraph~~
211.18 ~~(f)~~, and 256B.055, subdivision 12, the commissioner shall review all medical evidence
211.19 submitted by county agencies with a referral and seek additional information from
211.20 providers, applicants, and enrollees to support the determination of disability where
211.21 necessary. Disability shall be determined according to the rules of title XVI and title
211.22 XIX of the Social Security Act and pertinent rules and policies of the Social Security
211.23 Administration.

211.24 (b) Prior to a denial or withdrawal of a requested determination of disability due
211.25 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
211.26 necessary and appropriate to a determination of disability, and (2) assist applicants and
211.27 enrollees to obtain the evidence, including, but not limited to, medical examinations
211.28 and electronic medical records.

211.29 (c) The commissioner shall provide the chairs of the legislative committees with
211.30 jurisdiction over health and human services finance and budget the following information
211.31 on the activities of the state medical review team by February 1 of each year:

211.32 (1) the number of applications to the state medical review team that were denied,
211.33 approved, or withdrawn;

211.34 (2) the average length of time from receipt of the application to a decision;

212.1 (3) the number of appeals, appeal results, and the length of time taken from the date
212.2 the person involved requested an appeal for a written decision to be made on each appeal;

212.3 (4) for applicants, their age, health coverage at the time of application, hospitalization
212.4 history within three months of application, and whether an application for Social Security
212.5 or Supplemental Security Income benefits is pending; and

212.6 (5) specific information on the medical certification, licensure, or other credentials
212.7 of the person or persons performing the medical review determinations and length of
212.8 time in that position.

212.9 (d) Any appeal made under section 256.045, subdivision 3, of a disability
212.10 determination made by the state medical review team must be decided according to the
212.11 timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is
212.12 not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the
212.13 appeal must be immediately reviewed by the chief appeals referee.

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

212.15 Sec. 5. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

212.16 Subd. 4a. **Case management appeals.** (a) Any recipient of case management
212.17 services pursuant to section 256B.0625 or 256B.092, personal care assistance services
212.18 under section 256B.0625, or other services who contests the county agency's action,
212.19 reduction, suspension, denial, or termination of services, or failure to act in the provision
212.20 of those services, other than a failure to act with reasonable promptness or a suspension,
212.21 reduction, denial, or termination of services, must submit a written request for a
212.22 conciliation conference with the recipient's case worker and the county social service
212.23 director or designee to the county agency prior to filing an appeal under this section.

212.24 (b) For purposes of this subdivision, a county agency's actions include actions by
212.25 the department with respect to these services. The request must be filed no later than 30
212.26 days from the date of a notice of action on personal care assistance services or ten days
212.27 from the date of a notice of agency action on case management or other services. The
212.28 county agency or the state may implement the action, reduction, suspension, denial, or
212.29 termination of services described in the notice of action unless the recipient includes a
212.30 request for continuation of services. The recipient may request a 30-day continuation of
212.31 personal care assistance services or ten-day continuation for case management or other
212.32 services. The county agency may hold the conference by telephone or by electronic media
212.33 unless the recipient requests the conference take place in person in their written request for
212.34 conference. The county agency shall have discretion to continue the conference.

213.1 (c) The county agency shall inform the commissioner of the receipt of a request
213.2 when it is submitted and shall schedule a ~~conciliation~~ conference to be held in person, by
213.3 telephone, or by electronic media within ten days of the receipt of the recipient's written
213.4 request. The county agency shall notify the recipient, the commissioner, and all interested
213.5 persons of the time, date, and location of the ~~conciliation~~ conference. ~~The commissioner~~
213.6 ~~may assist the county by providing mediation services or by identifying other resources~~
213.7 ~~that may assist in the mediation between the parties.~~ Within ~~30~~ 15 days after the conference
213.8 has been held, the county agency shall ~~conduct the conciliation conference and~~ inform the
213.9 recipient in writing of the action the county agency is going to take and when that action
213.10 will be taken and notify the recipient of the right to a hearing under this subdivision.

213.11 ~~The conciliation conference shall be conducted in a manner consistent with the~~
213.12 ~~commissioner's instructions.~~ (d) If the county fails to conduct the ~~conciliation~~ conference
213.13 and issue its report ~~within 30 days, or, at any time up to 90 days after the conciliation~~
213.14 ~~conference is held~~ as provided in paragraph (b) and the recipient disputes the county
213.15 agency's notice of its intended action, or if a recipient is otherwise entitled to a fair hearing
213.16 under subdivision 3a, a recipient may submit to the commissioner a written request for a
213.17 fair hearing ~~before a state human services referee to determine whether case management~~
213.18 ~~services have been provided in accordance with applicable laws and rules or whether the~~
213.19 ~~county agency has assured that the services identified in the recipient's individual service~~
213.20 ~~plan have been delivered in accordance with the laws and rules governing the provision of~~
213.21 ~~those services~~ under this section.

213.22 (e) Hearings involving claims the county agency failed to comply with the
213.23 requirement to schedule and hold a conference or to notify the recipient of its intended
213.24 action according to this subdivision shall be limited in scope to those issues only, and the
213.25 human services judge may recommend an order to the commissioner remanding the case
213.26 to the county agency with directions to schedule and hold the conference and to notify
213.27 the recipient of its intended action. The state human services referee shall recommend an
213.28 order to the commissioner, who shall, in accordance with the procedure in subdivision 5,
213.29 issue a final order within 60 days of the receipt of the request for a hearing involving case
213.30 management services only, unless the commissioner refuses to accept the recommended
213.31 order, in which event a final order shall issue within 90 days of the receipt of that request.
213.32 The order may direct the county agency to take those actions necessary to comply with
213.33 applicable laws or rules. The commissioner may issue a temporary order prohibiting the
213.34 demission of a recipient of case management services under section 256B.092, from
213.35 a residential or day habilitation program licensed under chapter 245A, while a county
213.36 agency review process or an appeal brought by a recipient under this subdivision is

214.1 pending, or for the period of time necessary for the county agency to implement the
214.2 commissioner's order. The commissioner shall not issue a final order staying the demission
214.3 of a recipient of case management services from a residential or day habilitation program
214.4 licensed under chapter 245A.

214.5 (f) Any recipient of case management services under section 256B.0625 or
214.6 256B.092, or personal care assistance services under section 256B.0625, must be informed
214.7 in writing at the time of application and at the time of any change in services that they
214.8 must submit a written request to the county agency for a conference with the case manager
214.9 and the county social service director before they can file an appeal under this section,
214.10 of their right to continue receiving services pending the outcome of the conference
214.11 and notice from the county agency, and that their time for requesting a hearing under
214.12 subdivision 3a and requesting continuation of services begins to run when they receive the
214.13 postconference notice of the county's intended actions. For purposes of this paragraph,
214.14 recipients are presumed to have received notice of the agency's intended actions three
214.15 business days after the date of the notice. Recipients have the burden of overcoming this
214.16 presumption by a preponderance of the evidence.

214.17 **EFFECTIVE DATE.** This section is effective for all notices of action dated on
214.18 or after January 1, 2012.

214.19 Sec. 6. Minnesota Statutes 2010, section 256.9657, subdivision 1, is amended to read:

214.20 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993,
214.21 each non-state-operated nursing home licensed under chapter 144A shall pay to the
214.22 commissioner an annual surcharge according to the schedule in subdivision 4. The
214.23 surcharge shall be calculated as \$620 per licensed bed. If the number of licensed beds
214.24 is reduced, the surcharge shall be based on the number of remaining licensed beds the
214.25 second month following the receipt of timely notice by the commissioner of human
214.26 services that beds have been delicensed. The nursing home must notify the commissioner
214.27 of health in writing when beds are delicensed. The commissioner of health must notify
214.28 the commissioner of human services within ten working days after receiving written
214.29 notification. If the notification is received by the commissioner of human services by
214.30 the 15th of the month, the invoice for the second following month must be reduced
214.31 to recognize the delicensing of beds. Beds on layaway status continue to be subject to
214.32 the surcharge. The commissioner of human services must acknowledge a medical care
214.33 surcharge appeal within 30 days of receipt of the written appeal from the provider.

214.34 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to \$625.

215.1 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased
215.2 to \$990.

215.3 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased
215.4 to \$2,815.

215.5 (e) Effective July 15, 2013, the surcharge under paragraph (d) shall apply only to
215.6 occupied, licensed nursing home beds that are not in layaway under section 144A.071,
215.7 subdivision 4b. Beginning January 1, 2013, nursing facilities may, on a quarterly basis,
215.8 report data on occupancy as a percent of capacity days, on a form and in a manner
215.9 prescribed by the commissioner. This data must be provided by the end of the month
215.10 following the calendar quarter. The commissioner shall use this data to adjust the
215.11 surcharge amount due for the calendar quarter following submission of the data. This
215.12 adjustment shall be allowed only for a nursing facility that provides complete and timely
215.13 data allowed in this paragraph. The commissioner shall apply a monthly surcharge
215.14 computed as the occupancy percentage as reported in this paragraph times the number of
215.15 licensed nursing home beds times \$2,815 divided by 12.

215.16 (f) The commissioner may reduce, and may subsequently restore, the surcharge
215.17 under paragraph (d) based on the commissioner's determination of a permissible surcharge.

215.18 ~~(f)~~ (g) Between April 1, 2002, and August 15, 2004, a facility governed by this
215.19 subdivision may elect to assume full participation in the medical assistance program
215.20 by agreeing to comply with all of the requirements of the medical assistance program,
215.21 including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and
215.22 all other requirements established in law or rule, and to begin intake of new medical
215.23 assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010
215.24 to 9549.0080. Notwithstanding section 256B.431, subdivision 27, paragraph (i), rate
215.25 calculations will be subject to limits as prescribed in rule and law. Other than the
215.26 adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3,
215.27 paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation
215.28 enacted prior to the finalization of rates, facilities assuming full participation in medical
215.29 assistance under this paragraph are not eligible for any rate adjustments until the July 1
215.30 following their settle-up period.

215.31 Sec. 7. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

215.32 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
215.33 medical assistance, a person must not individually own more than \$3,000 in assets, or if a
215.34 member of a household with two family members, husband and wife, or parent and child,
215.35 the household must not own more than \$6,000 in assets, plus \$200 for each additional

216.1 legal dependent. In addition to these maximum amounts, an eligible individual or family
216.2 may accrue interest on these amounts, but they must be reduced to the maximum at the
216.3 time of an eligibility redetermination. The accumulation of the clothing and personal
216.4 needs allowance according to section 256B.35 must also be reduced to the maximum at
216.5 the time of the eligibility redetermination. The value of assets that are not considered in
216.6 determining eligibility for medical assistance is the value of those assets excluded under
216.7 the supplemental security income program for aged, blind, and disabled persons, with
216.8 the following exceptions:

216.9 (1) household goods and personal effects are not considered;

216.10 (2) capital and operating assets of a trade or business that the local agency determines
216.11 are necessary to the person's ability to earn an income are not considered;

216.12 (3) motor vehicles are excluded to the same extent excluded by the supplemental
216.13 security income program;

216.14 (4) assets designated as burial expenses are excluded to the same extent excluded by
216.15 the supplemental security income program. Burial expenses funded by annuity contracts
216.16 or life insurance policies must irrevocably designate the individual's estate as contingent
216.17 beneficiary to the extent proceeds are not used for payment of selected burial expenses; and

216.18 (5) ~~effective upon federal approval~~, for a person who no longer qualifies as an
216.19 employed person with a disability due to loss of earnings, assets allowed while eligible
216.20 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
216.21 months, beginning with the first month of ineligibility as an employed person with a
216.22 disability, to the extent that the person's total assets remain within the allowed limits of
216.23 section 256B.057, subdivision 9, paragraph ~~(c)~~ (d).

216.24 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
216.25 15.

216.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

216.27 Sec. 8. Minnesota Statutes 2010, section 256B.056, is amended by adding a
216.28 subdivision to read:

216.29 **Subd. 5d. Spenddown adjustments.** When income is projected for a six-month
216.30 budget period, retroactive adjustments to income determined to be available to a person
216.31 under section 256B.0575 must be made at the end of each six-month budget period
216.32 based on changes occurring during the budget period. For changes occurring outside the
216.33 six-month budget period, such retroactive adjustments are limited to the six full calendar
216.34 months before the month the change is reported or discovered.

217.1 Sec. 9. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

217.2 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
217.3 for a person who is employed and who:

217.4 (1) but for excess earnings or assets, meets the definition of disabled under the
217.5 Supplemental Security Income program;

217.6 (2) is at least 16 but less than 65 years of age;

217.7 (3) meets the asset limits in paragraph ~~(c)~~ (d); and

217.8 (4) pays a premium and other obligations under paragraph (e).

217.9 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
217.10 for medical assistance under this subdivision, a person must have more than \$65 of earned
217.11 income. Earned income must have Medicare, Social Security, and applicable state and
217.12 federal taxes withheld. The person must document earned income tax withholding. Any
217.13 spousal income or assets shall be disregarded for purposes of eligibility and premium
217.14 determinations.

217.15 ~~(b)~~ (c) After the month of enrollment, a person enrolled in medical assistance under
217.16 this subdivision who:

217.17 (1) is temporarily unable to work and without receipt of earned income due to a
217.18 medical condition, as verified by a physician, ~~may retain eligibility for up to four calendar~~
217.19 ~~months;~~ or

217.20 (2) ~~effective January 1, 2004,~~ loses employment for reasons not attributable to the
217.21 enrollee, and is without receipt of earned income may retain eligibility for up to four
217.22 consecutive months after the month of job loss. To receive a four-month extension,
217.23 enrollees must verify the medical condition or provide notification of job loss. All other
217.24 eligibility requirements must be met and the enrollee must pay all calculated premium
217.25 costs for continued eligibility.

217.26 ~~(c)~~ (d) For purposes of determining eligibility under this subdivision, a person's
217.27 assets must not exceed \$20,000, excluding:

217.28 (1) all assets excluded under section 256B.056;

217.29 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
217.30 Keogh plans, and pension plans; ~~and~~

217.31 (3) medical expense accounts set up through the person's employer; and

217.32 (4) spousal assets, including spouse's share of jointly held assets.

217.33 ~~(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65~~
217.34 ~~earned income disregard. To be eligible, a person applying for medical assistance under~~
217.35 ~~this subdivision must have earned income above the disregard level.~~

218.1 ~~(2) Effective January 1, 2004, to be considered earned income, Medicare, Social~~
218.2 ~~Security, and applicable state and federal income taxes must be withheld. To be eligible,~~
218.3 ~~a person must document earned income tax withholding.~~

218.4 ~~(c)(1) A person whose earned and unearned income is equal to or greater than 100~~
218.5 ~~percent of federal poverty guidelines for the applicable family size must pay a premium~~
218.6 ~~to be eligible for medical assistance under this subdivision. (e) All enrollees must pay a~~
218.7 ~~premium to be eligible for medical assistance under this subdivision, except as provided~~
218.8 ~~under section 256.01, subdivision 18b.~~

218.9 (1) An enrollee must pay the greater of a \$65 premium or the premium shall be
218.10 calculated based on the person's gross earned and unearned income and the applicable
218.11 family size using a sliding fee scale established by the commissioner, which begins at
218.12 one percent of income at 100 percent of the federal poverty guidelines and increases
218.13 to 7.5 percent of income for those with incomes at or above 300 percent of the federal
218.14 poverty guidelines.

218.15 (2) Annual adjustments in the premium schedule based upon changes in the federal
218.16 poverty guidelines shall be effective for premiums due in July of each year.

218.17 ~~(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for~~
218.18 ~~medical assistance under this subdivision. An enrollee shall pay the greater of a \$35~~
218.19 ~~premium or the premium calculated in clause (1).~~

218.20 ~~(3) Effective November 1, 2003, All enrollees who receive unearned income must~~
218.21 ~~pay one-half of one five percent of unearned income in addition to the premium amount,~~
218.22 except as provided under section 256.01, subdivision 18b.

218.23 ~~(4) Effective November 1, 2003, for enrollees whose income does not exceed 200~~
218.24 ~~percent of the federal poverty guidelines and who are also enrolled in Medicare, the~~
218.25 ~~commissioner must reimburse the enrollee for Medicare Part B premiums under section~~
218.26 ~~256B.0625, subdivision 15, paragraph (a).~~

218.27 ~~(5) (4)~~ (4) Increases in benefits under title II of the Social Security Act shall not be
218.28 counted as income for purposes of this subdivision until July 1 of each year.

218.29 (f) A person's eligibility and premium shall be determined by the local county
218.30 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
218.31 the commissioner.

218.32 (g) Any required premium shall be determined at application and redetermined at
218.33 the enrollee's six-month income review or when a change in income or household size is
218.34 reported. Enrollees must report any change in income or household size within ten days
218.35 of when the change occurs. A decreased premium resulting from a reported change in
218.36 income or household size shall be effective the first day of the next available billing month

219.1 after the change is reported. Except for changes occurring from annual cost-of-living
219.2 increases, a change resulting in an increased premium shall not affect the premium amount
219.3 until the next six-month review.

219.4 (h) Premium payment is due upon notification from the commissioner of the
219.5 premium amount required. Premiums may be paid in installments at the discretion of
219.6 the commissioner.

219.7 (i) Nonpayment of the premium shall result in denial or termination of medical
219.8 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
219.9 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
219.10 D, are met. Except when an installment agreement is accepted by the commissioner,
219.11 all persons disenrolled for nonpayment of a premium must pay any past due premiums
219.12 as well as current premiums due prior to being reenrolled. Nonpayment shall include
219.13 payment with a returned, refused, or dishonored instrument. The commissioner may
219.14 require a guaranteed form of payment as the only means to replace a returned, refused,
219.15 or dishonored instrument.

219.16 (j) The commissioner shall notify enrollees annually beginning at least 24 months
219.17 before the person's 65th birthday of the medical assistance eligibility rules affecting
219.18 income, assets, and treatment of a spouse's income and assets that will be applied upon
219.19 reaching age 65.

219.20 (k) For enrollees whose income does not exceed 200 percent of the federal poverty
219.21 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
219.22 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
219.23 paragraph (a).

219.24 **EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or
219.25 older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

219.26 Sec. 10. Minnesota Statutes 2010, section 256B.0657, is amended to read:

219.27 **256B.0657 SELF-DIRECTED SUPPORTS ~~OPTION~~ OPTIONS.**

219.28 Subdivision 1. **Definition.** (a) "Lead agency" has the meaning given in section
219.29 256B.0911, subdivision 1a, paragraph (d).

219.30 (b) "Legal representative" means a legal guardian of a child or an adult, or parent of
219.31 a minor child.

219.32 (c) "Individual representative" means an individual who has been authorized, in
219.33 a written statement by the person or the person's legal representative, to speak on the
219.34 person's behalf and help the person understand and make informed choices in matters

220.1 related to identification of needs and choice of services and supports and assist the person
220.2 to implement an approved support plan and has no financial interest in the provision of any
220.3 services included in the individual's plan unless related by blood, adoption, or marriage.

220.4 (d) "Self-directed supports ~~option~~ options" means personal assistance, supports,
220.5 items, and related services purchased under an approved budget plan and budget by a
220.6 recipient.

220.7 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
220.8 who:

220.9 (1) is a recipient of medical assistance as determined under sections 256B.055,
220.10 256B.056, and 256B.057, subdivision 9;

220.11 (2) is eligible for personal care assistance services under section 256B.0659, or
220.12 for a home and community-based services waiver program under section 256B.0915,
220.13 256B.092, or 256B.49, or alternative care under section 256B.0913;

220.14 (3) lives in the person's own apartment or home, which is not owned, operated, or
220.15 controlled by a provider of services ~~not~~ except for services provided by those related by
220.16 blood ~~or~~, adoption, marriage, or family foster care consistent with the requirements of
220.17 section 256B.0651, subdivision 1, paragraph (e);

220.18 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
220.19 manage the individuals providing services, and to choose and obtain items, related
220.20 services, and supports as described in the participant's plan. If the recipient is not able
220.21 to carry out these functions but has a legal guardian, individual representative, or parent
220.22 to carry them out, the guardian, individual representative, or parent may fulfill these
220.23 functions on behalf of the recipient; and

220.24 (5) has not been excluded or disenrolled by the commissioner.

220.25 (b) The commissioner may disenroll ~~or~~ exclude, or require other measures such as
220.26 training, increased assistance, reporting, or oversight for recipients, including guardians
220.27 ~~and~~ parents, and individual representatives under the following circumstances:

220.28 (1) recipients who have been restricted by the ~~Primary Care Utilization Review~~
220.29 ~~Committee~~ Minnesota restricted recipient program may be excluded for a specified time
220.30 period;

220.31 (2) recipients who exit the self-directed supports option during the recipient's
220.32 service plan year shall not access the self-directed supports option for the remainder of
220.33 that service plan year; and

220.34 (3) when the department determines that the recipient cannot manage recipient
220.35 responsibilities under the program.

221.1 (c) For vendors or other self-directed service providers, the commissioner may
221.2 take any action authorized under surveillance and integrity review in Minnesota Rules,
221.3 parts 9505.2160 to 9505.2245.

221.4 Subd. 3. **Eligibility for other services.** Selection of the self-directed supports
221.5 option by a recipient shall not restrict access to other medically necessary care and
221.6 services furnished under the state plan medical assistance benefit, ~~including home care~~
221.7 ~~targeted case management~~, except that a person ~~receiving~~ choosing lead agency managed
221.8 home and community-based waiver services, agency-provided personal care assistance
221.9 services, a family support grant, or a consumer support grant is not eligible for funding
221.10 under the self-directed supports option.

221.11 Subd. 4. **Assessment requirements.** (a) The self-directed supports option
221.12 assessment must meet the following requirements:

221.13 (1) it shall be conducted ~~by the county public health nurse or a certified public health~~
221.14 ~~nurse under contract with the county~~ consistent with the requirements of personal care
221.15 assistance services under section 256B.0659, subdivision 3a; home and community-based
221.16 waiver services programs under section 256B.0915, 256B.092, or 256B.49; and the
221.17 alternative care program under section 256B.0913, until section 256B.0911, subdivision
221.18 3a, has been implemented;

221.19 (2) it shall be conducted face-to-face in the recipient's home initially, and at least
221.20 annually thereafter; when there is a significant change in the recipient's condition; and
221.21 when there is a change in the person's need for personal care assistance services under the
221.22 programs listed in subdivision 2, paragraph (a), clause (2). A recipient who is residing in a
221.23 facility may be assessed for the self-directed support option for the purpose of returning
221.24 to the community using this option; and

221.25 (3) it shall be completed using the format established by the commissioner.

221.26 (b) The results of the personal care assistance assessment and recommendations shall
221.27 be communicated to the commissioner and the recipient ~~by the county public health nurse~~
221.28 ~~or certified public health nurse under contract with the county~~ as required under section
221.29 256B.0659, subdivision 3a. The person's annual and monthly average authorization for
221.30 the self-directed budget amount shall be provided within 40 days after the personal care
221.31 assessment or reassessment, or within ten days after a request not related to an assessment.

221.32 (c) The lead agency responsible for administration of home and community-based
221.33 waiver services under section 256B.0915, 256B.092, or 256B.49, and alternative care
221.34 under section 256B.0913, shall provide annual and monthly average authorization for the
221.35 self-directed services budget amounts for all eligible persons within 40 days after an

222.1 initial assessment or annual review and within ten days if requested at a time unrelated to
222.2 the assessment or annual review.

222.3 Subd. 5. **Self-directed supports option plan requirements.** (a) The plan and
222.4 provider for the self-directed supports option must meet the following requirements:

222.5 (1) the plan must be completed using a person-centered process that:

222.6 (i) builds upon the recipient's capacity to engage in activities that promote
222.7 community life;

222.8 (ii) respects the recipient's preferences, choices, and abilities;

222.9 (iii) involves families, friends, and professionals in the planning or delivery of
222.10 services or supports as desired or required by the recipient; and

222.11 (iv) addresses the need for personal care assistance and other services and supports
222.12 identified in the recipient's self-directed supports option assessment;

222.13 (2) the plan shall be developed by the recipient, legal representative, ~~or by the~~
222.14 ~~guardian of an adult recipient or by a parent or guardian of a minor child,~~ individual
222.15 representative, and may be assisted by a provider who meets the requirements established
222.16 for using a person-centered planning process and shall be reviewed at least annually upon
222.17 reassessment or when there is a significant change in the recipient's condition; and

222.18 (3) the plan must include the total budget amount available divided into monthly
222.19 amounts that cover the number of months of personal care assistance services or home
222.20 and community-based waiver or alternative care authorization included in the budget.

222.21 A recipient may reserve funds monthly for the purchase of items that meet the standards
222.22 in subdivision 6, paragraph (a), clause (2), and are reflected in the support plan. The
222.23 amount used each month may vary, but additional funds shall not be provided above the
222.24 annual personal care assistance services authorized amount unless a change in condition
222.25 is documented.

222.26 (b) The commissioner or the commissioner's designee shall:

222.27 (1) ensure that outreach activities and information materials on self-directed options
222.28 are developed and provided across the state to persons who use or are seeking community
222.29 support services;

222.30 ~~(1) (2)~~ establish the format and criteria for the plan ~~as well as the requirements for~~
222.31 ~~providers who assist with plan development;~~

222.32 ~~(2) (3)~~ review the assessment and plan and, within 30 days after receiving the
222.33 assessment and plan, make a decision on approval of the plan;

222.34 ~~(3) (4)~~ notify the recipient, ~~parent, or guardian~~ legal representative, or individual
222.35 representative of approval or denial of the plan and provide notice of the right to appeal
222.36 under section 256.045; and

223.1 ~~(4)~~ (5) provide a copy of the plan to the fiscal support entity selected by the recipient
223.2 from among at least three certified entities.

223.3 (c) The commissioner shall:

223.4 (1) establish provider enrollment requirements for provision of fiscal support entity
223.5 services and person-centered support plan services, including benefits counseling to
223.6 support employment; and

223.7 (2) collect a fee to cover the costs of certifying providers for the services described
223.8 in this subdivision.

223.9 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
223.10 option include:

223.11 (1) personal care assistance services under section 256B.0659, and services under
223.12 the home and community-based waivers, except those provided in licensed or registered
223.13 residential settings unless the services are provided in a family foster care setting which
223.14 meets the requirements of section 256B.0651, subdivision 1, paragraph (e); and

223.15 (2) items, related services, and supports, including assistive technology, that increase
223.16 independence or substitute for human assistance to the extent expenditures would
223.17 otherwise be used for human assistance.

223.18 (b) Items, supports, and related services purchased under this option shall not be
223.19 considered home care services for the purposes of section 144A.43.

223.20 Subd. 7. **Noncovered services.** Services or supports that are not eligible for
223.21 payment under the self-directed supports option include:

223.22 (1) services, goods, or supports that do not benefit the recipient;

223.23 (2) any fees incurred by the recipient, such as Minnesota health care program fees
223.24 and co-pays, legal fees, or costs related to advocate agencies;

223.25 (3) insurance, except for insurance costs related to employee coverage or fiscal
223.26 support entity payments;

223.27 (4) room and board and personal items that are not related to the disability, except
223.28 that medically prescribed specialized diet items may be covered if they reduce the need for
223.29 human assistance;

223.30 (5) home modifications that add square footage, except those modifications that
223.31 configure a bathroom to accommodate a wheelchair;

223.32 (6) home modifications for a residence other than the primary residence of the
223.33 recipient, or in the event of a minor with parents not living together, the primary residences
223.34 of the parents;

224.1 (7) expenses for travel, lodging, or meals related to training the recipient, the
224.2 ~~parent or guardian of an adult recipient, or the parent or guardian of a minor child~~ legal
224.3 representative, or paid or unpaid caregivers that exceed \$500 in a 12-month period;

224.4 (8) experimental treatment;

224.5 (9) any service or item to the extent the service or item is covered by other medical
224.6 assistance state plan services, including prescription and over-the-counter medications,
224.7 compounds, and solutions and related fees, including premiums and co-payments;

224.8 (10) membership dues or costs, except when the service is necessary and appropriate
224.9 to treat a physical condition or to improve or maintain the recipient's physical condition.

224.10 The condition must be identified in the recipient's plan of care and monitored by a
224.11 Minnesota health care program enrolled physician;

224.12 (11) vacation expenses other than the cost of direct services;

224.13 (12) vehicle maintenance or modifications not related to the disability;

224.14 (13) tickets and related costs to attend sporting or other recreational events; and

224.15 (14) costs related to Internet access, except when necessary for operation of assistive
224.16 technology, to increase independence, or to substitute for human assistance.

224.17 Subd. 8. **Self-directed budget requirements.** (a) The budget for the provision of
224.18 the self-directed service option shall be established for persons eligible for personal care
224.19 assistance services under section 256B.0659 based on:

224.20 (1) assessed personal care assistance units, not to exceed the maximum number of
224.21 personal care assistance units available, as determined by section 256B.0659; and

224.22 (2) the personal care assistance unit rate:

224.23 (i) with a reduction to the unit rate to pay for a program administrator as defined in
224.24 subdivision 10; and

224.25 (ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for
224.26 the state.

224.27 (b) The budget for persons eligible for programs listed in subdivision 2, paragraph
224.28 (a), clause (2), is based on the approved budget methodologies for each program.

224.29 Subd. 9. **Quality assurance and risk management.** (a) The commissioner
224.30 shall establish quality assurance and risk management measures for use in developing
224.31 and implementing self-directed plans and budgets that (1) recognize the roles and
224.32 responsibilities involved in obtaining services in a self-directed manner, and (2) assure
224.33 the appropriateness of such plans and budgets based upon a recipient's resources and
224.34 capabilities. These measures must include (i) background studies, ~~and~~ (ii) backup and
224.35 emergency plans, including disaster planning, and (iii) for persons using home and

225.1 community-based waiver services, monitoring by the lead agency on quality assurance
225.2 measures and recipient health, safety, and welfare.

225.3 (b) The commissioner shall provide ongoing technical assistance and resource
225.4 and educational materials for families and recipients selecting the self-directed option,
225.5 including information on the quality assurance efforts.

225.6 (c) Performance assessments measures, such as of a recipient's functioning,
225.7 satisfaction with the services and supports, and ongoing monitoring of health and
225.8 well-being shall be identified in consultation with the stakeholder group.

225.9 Subd. 10. **Fiscal support entity.** (a) Each recipient or legal representative shall
225.10 choose a fiscal support entity provider certified by the commissioner to make payments
225.11 for services, items, supports, and administrative costs related to managing a self-directed
225.12 service plan authorized for payment in the approved plan and budget. ~~Recipients~~ The
225.13 recipient or legal representative shall also choose the payroll, agency with choice, or the
225.14 fiscal conduit model of financial and service management.

225.15 (b) The fiscal support entity:

225.16 (1) may not limit or restrict the recipient's choice of service or support providers,
225.17 including use of the payroll, agency with choice, or fiscal conduit model of financial
225.18 and service management;

225.19 (2) must have a written agreement with the recipient, individual representative, or
225.20 the recipient's legal representative that identifies the duties and responsibilities to be
225.21 performed and the specific related charges;

225.22 (3) must provide the recipient ~~and the home care targeted case manager~~, legal
225.23 representative, and individual representative with a monthly written summary of the
225.24 self-directed supports option services that were billed, including charges from the fiscal
225.25 support entity;

225.26 (4) must be knowledgeable of and comply with Internal Revenue Service
225.27 requirements necessary to process employer and employee deductions, provide appropriate
225.28 and timely submission of employer tax liabilities, and maintain documentation to support
225.29 medical assistance claims;

225.30 (5) must have current and adequate liability insurance and bonding and sufficient
225.31 cash flow and have on staff or under contract a certified public accountant or an individual
225.32 with a baccalaureate degree in accounting; and

225.33 (6) must maintain records to track all self-directed supports option services
225.34 expenditures, including time records of persons paid to provide supports and receipts for
225.35 any goods purchased. The records must be maintained for a minimum of five years from
225.36 the claim date and be available for audit or review upon request. Claims submitted by

226.1 the fiscal support entity must correspond with services, amounts, and time periods as
226.2 authorized in the recipient's self-directed supports option plan.

226.3 (c) The commissioner shall have authority to:

226.4 (1) set or negotiate rates with fiscal support entities;

226.5 (2) limit the number of fiscal support entities;

226.6 (3) identify a process to certify and recertify fiscal support entities and assure fiscal
226.7 support entities are available to recipients throughout the state; and

226.8 (4) establish a uniform format and protocol to be used by eligible fiscal support
226.9 entities.

226.10 Subd. 11. **Stakeholder consultation.** The commissioner shall consult with
226.11 a statewide ~~consumer-directed~~ self-directed services stakeholder group, including
226.12 representatives of all types of ~~consumer-directed~~ self-directed service users, advocacy
226.13 organizations, counties, and ~~consumer-directed~~ self-directed service providers. The
226.14 commissioner shall seek recommendations from this stakeholder group in developing,
226.15 monitoring, evaluating, and modifying:

226.16 (1) the self-directed plan format;

226.17 (2) requirements and guidelines for the person-centered plan assessment and
226.18 planning process;

226.19 (3) implementation of the option and the quality assurance and risk management
226.20 techniques; ~~and~~

226.21 (4) standards and requirements, including rates for the personal support plan
226.22 development provider and the fiscal support entity; policies; training; and implementation;
226.23 and

226.24 (5) the self-directed supports options available through the home and
226.25 community-based waivers under section 256B.0916 and the personal care assistance
226.26 program under section 256B.0659, including recommendations on possible ways to
226.27 increase participation, improve flexibility, and provide incentives for recipients to
226.28 participate in a life transition and crisis funding pool with others to save and contribute
226.29 part of their authorized budgets, which can be carried over year to year and used according
226.30 to priority standards under section 256B.092, subdivision 12, paragraph (a), clauses (1),
226.31 (3), (4), (5), and (6).

226.32 The stakeholder group shall provide recommendations on the repeal of the personal
226.33 care assistance choice option, transition issues, and whether the consumer support grant
226.34 program under section 256.476 should be modified. The stakeholder group shall meet
226.35 at least three times each year to provide advice on policy, implementation, and other
226.36 aspects of ~~consumer and~~ self-directed services.

227.1 Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports
227.2 option is available to current personal care assistance recipients upon annual personal
227.3 care assistance reassessment, with a maximum enrollment of ~~1,000~~ 2,000 people in the
227.4 first fiscal year of implementation and an additional ~~1,000~~ 3,000 people in the second
227.5 fiscal year. The commissioner shall evaluate the self-directed supports option during the
227.6 first two years of implementation and make any necessary changes ~~prior to the option~~
227.7 ~~becoming available statewide.~~

227.8 **EFFECTIVE DATE.** This section is effective July 1, 2012.

227.9 Sec. 11. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to
227.10 read:

227.11 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
227.12 must meet the following requirements:

227.13 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
227.14 of age with these additional requirements:

227.15 (i) supervision by a qualified professional every 60 days; and

227.16 (ii) employment by only one personal care assistance provider agency responsible
227.17 for compliance with current labor laws;

227.18 (2) be employed by a personal care assistance provider agency;

227.19 (3) enroll with the department as a personal care assistant after clearing a background
227.20 study. Except as provided in subdivision 11a, before a personal care assistant provides
227.21 services, the personal care assistance provider agency must initiate a background study on
227.22 the personal care assistant under chapter 245C, and the personal care assistance provider
227.23 agency must have received a notice from the commissioner that the personal care assistant
227.24 is:

227.25 (i) not disqualified under section 245C.14; or

227.26 (ii) is disqualified, but the personal care assistant has received a set aside of the
227.27 disqualification under section 245C.22;

227.28 (4) be able to effectively communicate with the recipient and personal care
227.29 assistance provider agency;

227.30 (5) be able to provide covered personal care assistance services according to the
227.31 recipient's personal care assistance care plan, respond appropriately to recipient needs,
227.32 and report changes in the recipient's condition to the supervising qualified professional
227.33 or physician;

227.34 (6) not be a consumer of personal care assistance services;

228.1 (7) maintain daily written records including, but not limited to, time sheets under
228.2 subdivision 12;

228.3 (8) effective January 1, 2010, complete standardized training as determined
228.4 by the commissioner before completing enrollment. The training must be available
228.5 in languages other than English and to those who need accommodations due to
228.6 disabilities. Personal care assistant training must include successful completion of the
228.7 following training components: basic first aid, vulnerable adult, child maltreatment,
228.8 OSHA universal precautions, basic roles and responsibilities of personal care assistants
228.9 including information about assistance with lifting and transfers for recipients, emergency
228.10 preparedness, orientation to positive behavioral practices, fraud issues, and completion of
228.11 time sheets. Upon completion of the training components, the personal care assistant must
228.12 demonstrate the competency to provide assistance to recipients;

228.13 (9) complete training and orientation on the needs of the recipient within the first
228.14 seven days after the services begin; and

228.15 (10) be limited to providing and being paid for up to 275 hours per month, except
228.16 that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,
228.17 2011, of personal care assistance services regardless of the number of recipients being
228.18 served or the number of personal care assistance provider agencies enrolled with. The
228.19 number of hours worked per day shall not be disallowed by the department unless in
228.20 violation of the law.

228.21 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
228.22 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

228.23 (c) Effective January 1, 2010, persons who do not qualify as a personal care assistant
228.24 include parents and stepparents of minors, spouses, paid legal guardians, family foster
228.25 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or
228.26 staff of a residential setting. When the personal care assistant is a relative of the recipient,
228.27 the commissioner shall pay 80 percent of the provider rate. For purposes of this section,
228.28 relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or
228.29 older, an adult child, a grandparent, or a grandchild.

228.30 Sec. 12. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to
228.31 read:

228.32 Subd. 28. **Personal care assistance provider agency; required documentation.**

228.33 (a) Required documentation must be completed and kept in the personal care assistance
228.34 provider agency file or the recipient's home residence. The required documentation
228.35 consists of:

- 229.1 (1) employee files, including:
- 229.2 (i) applications for employment;
- 229.3 (ii) background study requests and results;
- 229.4 (iii) orientation records about the agency policies;
- 229.5 (iv) trainings completed with demonstration of competence;
- 229.6 (v) supervisory visits;
- 229.7 (vi) evaluations of employment; and
- 229.8 (vii) signature on fraud statement;
- 229.9 (2) recipient files, including:
- 229.10 (i) demographics;
- 229.11 (ii) emergency contact information and emergency backup plan;
- 229.12 (iii) personal care assistance service plan;
- 229.13 (iv) personal care assistance care plan;
- 229.14 (v) month-to-month service use plan;
- 229.15 (vi) all communication records;
- 229.16 (vii) start of service information, including the written agreement with recipient; and
- 229.17 (viii) date the home care bill of rights was given to the recipient;
- 229.18 (3) agency policy manual, including:
- 229.19 (i) policies for employment and termination;
- 229.20 (ii) grievance policies with resolution of consumer grievances;
- 229.21 (iii) staff and consumer safety;
- 229.22 (iv) staff misconduct; and
- 229.23 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
- 229.24 resolution of consumer grievances;
- 229.25 (4) time sheets for each personal care assistant along with completed activity sheets
- 229.26 for each recipient served; ~~and~~
- 229.27 (5) agency marketing and advertising materials and documentation of marketing
- 229.28 activities and costs; and
- 229.29 (6) for each personal care assistant, whether or not the personal care assistant is
- 229.30 providing care to a relative as defined in subdivision 11.
- 229.31 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do
- 229.32 not consistently comply with the requirements of this subdivision.

229.33 Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to

229.34 read:

229.35 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

230.1 (a) "Long-term care consultation services" means:

230.2 (1) assistance in identifying services needed to maintain an individual in the most
230.3 inclusive environment;

230.4 (2) providing recommendations on cost-effective community services that are
230.5 available to the individual;

230.6 (3) development of an individual's person-centered community support plan;

230.7 (4) providing information regarding eligibility for Minnesota health care programs;

230.8 (5) face-to-face long-term care consultation assessments, which may be completed
230.9 in a hospital, nursing facility, intermediate care facility for persons with developmental
230.10 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
230.11 residence;

230.12 (6) federally mandated screening to determine the need for an institutional level of
230.13 care under subdivision 4a;

230.14 (7) determination of home and community-based waiver service eligibility
230.15 including level of care determination for individuals who need an institutional level of
230.16 care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility
230.17 including state plan home care services identified in sections 256B.0625, subdivisions
230.18 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support
230.19 plan development with appropriate referrals, including the option for ~~consumer-directed~~
230.20 ~~community~~ self-directed supports;

230.21 (8) providing recommendations for nursing facility placement when there are no
230.22 cost-effective community services available; ~~and~~

230.23 (9) assistance to transition people back to community settings after facility
230.24 admission; and

230.25 (10) providing notice to the individual or legal representative of the annual and
230.26 monthly average authorized amount for traditional agency services and self-directed
230.27 services under section 256B.0657 for which the recipient is found eligible.

230.28 (b) "Long-term care options counseling" means the services provided by the linkage
230.29 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
230.30 telephone assistance and follow up once a long-term care consultation assessment has
230.31 been completed.

230.32 (c) "Minnesota health care programs" means the medical assistance program under
230.33 chapter 256B and the alternative care program under section 256B.0913.

230.34 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
230.35 plans administering long-term care consultation assessment and support planning services.

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

231.1 Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to
231.2 read:

231.3 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
231.4 services planning, or other assistance intended to support community-based living,
231.5 including persons who need assessment in order to determine waiver or alternative
231.6 care program eligibility, must be visited by a long-term care consultation team within
231.7 ~~15 calendar~~ 20 calendar days after the date on which an assessment was requested or
231.8 recommended. After January 1, 2011, these requirements also apply to personal care
231.9 assistance services, private duty nursing, and home health agency services, on timelines
231.10 established in subdivision 5. Face-to-face assessments must be conducted according
231.11 to paragraphs (b) to (i).

231.12 (b) The county may utilize a team of either the social worker or public health nurse,
231.13 or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the
231.14 assessment in a face-to-face interview. The consultation team members must confer
231.15 regarding the most appropriate care for each individual screened or assessed.

231.16 (c) The assessment must be comprehensive and include a person-centered
231.17 assessment of the health, psychological, functional, environmental, and social needs of
231.18 referred individuals and provide information necessary to develop a support plan that
231.19 meets the consumers needs, using an assessment form provided by the commissioner.

231.20 (d) The assessment must be conducted in a face-to-face interview with the person
231.21 being assessed and the person's legal representative, as required by legally executed
231.22 documents, and other individuals as requested by the person, who can provide information
231.23 on the needs, strengths, and preferences of the person necessary to develop a support plan
231.24 that ensures the person's health and safety, but who is not a provider of service or has any
231.25 financial interest in the provision of services.

231.26 (e) The person, or the person's legal representative, must be provided with
231.27 written recommendations for community-based services, including ~~consumer-directed~~
231.28 self-directed options, or institutional care that include documentation that the most
231.29 cost-effective alternatives available were offered to the individual. For purposes of
231.30 this requirement, "cost-effective alternatives" means community services and living
231.31 arrangements that cost the same as or less than institutional care. For persons determined
231.32 eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the
231.33 community support plan must also include the estimated annual and monthly average
231.34 authorized budget amount for those services.

231.35 (f) If the person chooses to use community-based services, the person or the person's
231.36 legal representative must be provided with a written community support plan, regardless

232.1 of whether the individual is eligible for Minnesota health care programs. The written
232.2 community support plan must include:

232.3 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

232.4 (2) the individual's options and choices to meet identified needs, including all
232.5 available options for case management services and providers;

232.6 (3) identification of health and safety risks and how those risks will be addressed,
232.7 including personal risk management strategies;

232.8 (4) referral information; and

232.9 (5) informal caregiver supports, if applicable.

232.10 For persons determined eligible for services defined under subdivision 1a, paragraph
232.11 (a), clauses (7) to (10), the community support plan must also include:

232.12 (6) identification of individual goals;

232.13 (7) identification of short-term and long-term service outcomes. Short-term service
232.14 outcomes are defined as achievable within six months;

232.15 (8) a recommended schedule for case management visits. When achievement of
232.16 short-term service outcomes may affect the amount of service required, the schedule must
232.17 be at least every six months and must reflect evaluation and progress toward identified
232.18 short-term service outcomes; and

232.19 (9) the estimated annual and monthly budget amount for services.

232.20 In addition, for persons determined eligible for state plan home care under
232.21 subdivision 1a, paragraph (a), clause (8), the person or person's representative must also
232.22 receive a copy of the home care service plan developed by a certified assessor.

232.23 A person may request assistance in identifying community supports without
232.24 participating in a complete assessment. Upon a request for assistance identifying
232.25 community support, the person must be transferred or referred to the services available
232.26 under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone
232.27 assistance and follow up.

232.28 (g) The person has the right to make the final decision between institutional
232.29 placement and community placement after the recommendations have been provided,
232.30 except as provided in subdivision 4a, paragraph (c).

232.31 (h) The team must give the person receiving assessment or support planning, or
232.32 the person's legal representative, materials, and forms supplied by the commissioner
232.33 containing the following information:

232.34 (1) the need for and purpose of preadmission screening if the person selects nursing
232.35 facility placement;

233.1 (2) the role of the long-term care consultation assessment and support planning in
233.2 waiver and alternative care program eligibility determination;
233.3 (3) information about Minnesota health care programs;
233.4 (4) the person's freedom to accept or reject the recommendations of the team;
233.5 (5) the person's right to confidentiality under the Minnesota Government Data
233.6 Practices Act, chapter 13;
233.7 (6) the long-term care consultant's decision regarding the person's need for
233.8 institutional level of care as determined under criteria established in section 144.0724,
233.9 subdivision 11, or 256B.092; and
233.10 (7) the person's right to appeal the decision regarding the need for nursing facility
233.11 level of care or the county's final decisions regarding public programs eligibility according
233.12 to section 256.045, subdivision 3.
233.13 (i) Face-to-face assessment completed as part of eligibility determination for
233.14 the alternative care, elderly waiver, community alternatives for disabled individuals,
233.15 community alternative care, and traumatic brain injury waiver programs under sections
233.16 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
233.17 than 60 calendar days after the date of assessment. The effective eligibility start date
233.18 for these programs can never be prior to the date of assessment. If an assessment was
233.19 completed more than 60 days before the effective waiver or alternative care program
233.20 eligibility start date, assessment and support plan information must be updated ~~in a~~
233.21 ~~face-to-face visit~~ and documented in the department's Medicaid Management Information
233.22 System (MMIS). The updated assessment may be completed by face-to-face visit, written
233.23 communication, or telephone as determined by the commissioner to establish statewide
233.24 consistency. The effective date of program eligibility in this case cannot be prior to the
233.25 date the updated assessment is completed.

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

233.27 Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to
233.28 read:

233.29 Subd. 4a. **Preadmission screening activities related to nursing facility**
233.30 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
233.31 boarding care facilities, must be screened prior to admission regardless of income, assets,
233.32 or funding sources for nursing facility care, except as described in subdivision 4b. The
233.33 purpose of the screening is to determine the need for nursing facility level of care as
233.34 described in paragraph (d) and to complete activities required under federal law related to
233.35 mental illness and developmental disability as outlined in paragraph (b).

234.1 (b) A person who has a diagnosis or possible diagnosis of mental illness or
234.2 developmental disability must receive a preadmission screening before admission
234.3 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need
234.4 for further evaluation and specialized services, unless the admission prior to screening is
234.5 authorized by the local mental health authority or the local developmental disabilities case
234.6 manager, or unless authorized by the county agency according to Public Law 101-508.

234.7 The following criteria apply to the preadmission screening:

234.8 (1) the county must use forms and criteria developed by the commissioner to identify
234.9 persons who require referral for further evaluation and determination of the need for
234.10 specialized services; and

234.11 (2) the evaluation and determination of the need for specialized services must be
234.12 done by:

234.13 (i) a qualified independent mental health professional, for persons with a primary or
234.14 secondary diagnosis of a serious mental illness; or

234.15 (ii) a qualified developmental disability professional, for persons with a primary or
234.16 secondary diagnosis of developmental disability. For purposes of this requirement, a
234.17 qualified developmental disability professional must meet the standards for a qualified
234.18 developmental disability professional under Code of Federal Regulations, title 42, section
234.19 483.430.

234.20 (c) The local county mental health authority or the state developmental disability
234.21 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
234.22 nursing facility if the individual does not meet the nursing facility level of care criteria or
234.23 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
234.24 purposes of this section, "specialized services" for a person with developmental disability
234.25 means active treatment as that term is defined under Code of Federal Regulations, title
234.26 42, section 483.440 (a)(1).

234.27 (d) The determination of the need for nursing facility level of care must be made
234.28 according to criteria ~~established~~ developed by the commissioner, and in section 144.0724,
234.29 ~~subdivision 11, and 256B.092, using forms developed by the commissioner. Effective no~~
234.30 sooner than on or after January 1, 2014, for individuals age 21 and older, and on or after
234.31 October 1, 2019, for individuals under age 21, the determination of need for nursing
234.32 facility level of care shall be based on criteria in section 144.0724, subdivision 11. In
234.33 assessing a person's needs, consultation team members shall have a physician available for
234.34 consultation and shall consider the assessment of the individual's attending physician, if
234.35 any. The individual's physician must be included if the physician chooses to participate.
234.36 Other personnel may be included on the team as deemed appropriate by the county.

235.1 Sec. 16. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to
235.2 read:

235.3 Subd. 6. **Payment for long-term care consultation services.** (a) Seventy-five
235.4 percent of the total payment for each county must be paid monthly by certified nursing
235.5 facilities in the county. The monthly amount to be paid by each nursing facility for each
235.6 fiscal year must be determined by dividing the county's annual allocation for long-term
235.7 care consultation services by 12 to determine the monthly payment and allocating the
235.8 monthly payment to each nursing facility based on the number of licensed beds in the
235.9 nursing facility. Payments to counties in which there is no certified nursing facility must be
235.10 made by increasing the payment rate of the two facilities located nearest to the county seat.

235.11 (b) The commissioner shall include the total annual payment determined under
235.12 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
235.13 according to section 256B.431, subdivision 2b, paragraph (g).

235.14 (c) In the event of the layaway, delicensure and decertification, or removal from
235.15 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
235.16 the per diem payment amount in paragraph (b) and may adjust the monthly payment
235.17 amount in paragraph (a). The effective date of an adjustment made under this paragraph
235.18 shall be on or after the first day of the month following the effective date of the layaway,
235.19 delicensure and decertification, or removal from layaway.

235.20 (d) Payments for long-term care consultation services are available to the county
235.21 or counties to cover staff salaries and expenses to provide the services described in
235.22 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
235.23 the limits of available funding, sufficient personnel to provide long-term care consultation
235.24 services while meeting the state's long-term care outcomes and objectives as defined in
235.25 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
235.26 objectives as approved by the commissioner in the biennial home and community-based
235.27 services quality assurance plan on a form provided by the commissioner.

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

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

235.32 (g) The county may bill, as case management services, assessments, support
235.33 planning, and follow-along provided to persons determined to be eligible for case
235.34 management under Minnesota health care programs. ~~No individual or family member~~
235.35 ~~shall be charged for an initial assessment or initial support plan development provided~~
235.36 ~~under subdivision 3a or 3b.~~ Counties may set a fee schedule for initial assessments and

236.1 support plan development for individuals who are not financially eligible for medical
236.2 assistance or MinnesotaCare. The maximum fee must not be greater than the actual cost
236.3 of the initial assessment and support plan development.

236.4 (h) The commissioner shall develop an alternative payment methodology for
236.5 long-term care consultation services that includes the funding available under this
236.6 subdivision, and sections 256B.092 and 256B.0659. In developing the new payment
236.7 methodology, the commissioner shall consider the maximization of federal funding for
236.8 this activity.

236.9 Sec. 17. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to
236.10 read:

236.11 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

236.12 (a) Funding for services under the alternative care program is available to persons who
236.13 meet the following criteria:

236.14 (1) the person has been determined by a community assessment under section
236.15 256B.0911 to be a person who would require the level of care provided in a nursing
236.16 facility, as determined under section 256B.0911, subdivision 4a, paragraph (d), but for
236.17 the provision of services under the alternative care program. Effective January 1, 2011,
236.18 this determination must be made according to the criteria established in section 144.0724,
236.19 subdivision 11;

236.20 (2) the person is age 65 or older;

236.21 (3) the person would be eligible for medical assistance within 135 days of admission
236.22 to a nursing facility;

236.23 (4) the person is not ineligible for the payment of long-term care services by the
236.24 medical assistance program due to an asset transfer penalty under section 256B.0595 or
236.25 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

236.26 (5) the person needs long-term care services that are not funded through other
236.27 state or federal funding, or other health insurance or other third-party insurance such as
236.28 long-term care insurance;

236.29 (6) except for individuals described in clause (7), the monthly cost of the alternative
236.30 care services funded by the program for this person does not exceed 75 percent of the
236.31 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
236.32 does not prohibit the alternative care client from payment for additional services, but in no
236.33 case may the cost of additional services purchased under this section exceed the difference
236.34 between the client's monthly service limit defined under section 256B.0915, subdivision
236.35 3, and the alternative care program monthly service limit defined in this paragraph. If

237.1 care-related supplies and equipment or environmental modifications and adaptations are or
237.2 will be purchased for an alternative care services recipient, the costs may be prorated on a
237.3 monthly basis for up to 12 consecutive months beginning with the month of purchase.

237.4 If the monthly cost of a recipient's other alternative care services exceeds the monthly
237.5 limit established in this paragraph, the annual cost of the alternative care services shall be
237.6 determined. In this event, the annual cost of alternative care services shall not exceed 12
237.7 times the monthly limit described in this paragraph;

237.8 (7) for individuals assigned a case mix classification A as described under section
237.9 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
237.10 living, or (ii) only one dependency up to two dependencies in bathing, dressing, grooming,
237.11 ~~or walking, or (iii) a dependency score of less than three if eating is the only dependency~~
237.12 and eating when the dependency score in eating is three or greater as determined by
237.13 an assessment performed under section 256B.0911, the monthly cost of alternative
237.14 care services funded by the program cannot exceed ~~\$600~~ \$593 per month for all new
237.15 participants enrolled in the program on or after July 1, ~~2009~~ 2011. This monthly limit
237.16 shall be applied to all other participants who meet this criteria at reassessment. This
237.17 monthly limit shall be increased annually as described in section 256B.0915, subdivision
237.18 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from
237.19 payment for additional services, but in no case may the cost of additional services
237.20 purchased exceed the difference between the client's monthly service limit defined in this
237.21 clause and the limit described in clause (6) for case mix classification A; and

237.22 (8) the person is making timely payments of the assessed monthly fee.

237.23 A person is ineligible if payment of the fee is over 60 days past due, unless the person
237.24 agrees to:

237.25 (i) the appointment of a representative payee;

237.26 (ii) automatic payment from a financial account;

237.27 (iii) the establishment of greater family involvement in the financial management of
237.28 payments; or

237.29 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

237.30 The lead agency may extend the client's eligibility as necessary while making
237.31 arrangements to facilitate payment of past-due amounts and future premium payments.
237.32 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
237.33 reinstated for a period of 30 days.

237.34 (b) Alternative care funding under this subdivision is not available for a person
237.35 who is a medical assistance recipient or who would be eligible for medical assistance
237.36 without a spenddown or waiver obligation. A person whose initial application for medical

238.1 assistance and the elderly waiver program is being processed may be served under the
238.2 alternative care program for a period up to 60 days. If the individual is found to be eligible
238.3 for medical assistance, medical assistance must be billed for services payable under the
238.4 federally approved elderly waiver plan and delivered from the date the individual was
238.5 found eligible for the federally approved elderly waiver plan. Notwithstanding this
238.6 provision, alternative care funds may not be used to pay for any service the cost of which:
238.7 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
238.8 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
238.9 to participate in the federally approved elderly waiver program under the special income
238.10 standard provision.

238.11 (c) Alternative care funding is not available for a person who resides in a licensed
238.12 nursing home, certified boarding care home, hospital, or intermediate care facility, except
238.13 for case management services which are provided in support of the discharge planning
238.14 process for a nursing home resident or certified boarding care home resident to assist with
238.15 a relocation process to a community-based setting.

238.16 (d) Alternative care funding is not available for a person whose income is greater
238.17 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
238.18 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
238.19 year for which alternative care eligibility is determined, who would be eligible for the
238.20 elderly waiver with a waiver obligation.

238.21 Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to
238.22 read:

238.23 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
238.24 waived services to an individual elderly waiver client except for individuals described
238.25 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
238.26 mix resident class to which the elderly waiver client would be assigned under Minnesota
238.27 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
238.28 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
238.29 which the resident assessment system as described in section 256B.438 for nursing home
238.30 rate determination is implemented. Effective on the first day of the state fiscal year in
238.31 which the resident assessment system as described in section 256B.438 for nursing home
238.32 rate determination is implemented and the first day of each subsequent state fiscal year, the
238.33 monthly limit for the cost of waived services to an individual elderly waiver client shall
238.34 be the rate of the case mix resident class to which the waiver client would be assigned
238.35 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. 19. 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. 20. 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

241.1 shall use tools issued by the commissioner to develop and document customized living
241.2 service plans and rates.

241.3 (c) Component service rates must not exceed payment rates for comparable elderly
241.4 waiver or medical assistance services and must reflect economies of scale. Customized
241.5 living services must not include rent or raw food costs.

241.6 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
241.7 individualized monthly authorized payment for the customized living service plan shall
241.8 not exceed 50 percent of the greater of either the statewide or any of the geographic
241.9 groups' weighted average monthly nursing facility rate of the case mix resident class
241.10 to which the elderly waiver eligible client would be assigned under Minnesota Rules,
241.11 parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described
241.12 in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the
241.13 resident assessment system as described in section 256B.438 for nursing home rate
241.14 determination is implemented. Effective on July 1 of the state fiscal year in which
241.15 the resident assessment system as described in section 256B.438 for nursing home
241.16 rate determination is implemented and July 1 of each subsequent state fiscal year, the
241.17 individualized monthly authorized payment for the services described in this clause shall
241.18 not exceed the limit which was in effect on June 30 of the previous state fiscal year
241.19 updated annually based on legislatively adopted changes to all service rate maximums for
241.20 home and community-based service providers.

241.21 (e) Effective July 1, 2011, the individualized monthly payment for the customized
241.22 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
241.23 monthly authorized payment limit for customized living for individuals classified as case
241.24 mix A, reduced by 25 percent. This rate limit must be applied to all new participants
241.25 enrolled in the program on or after July 1, 2011, who meet the criteria described in
241.26 subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who
241.27 meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

241.28 ~~(e)~~ (f) Customized living services are delivered by a provider licensed by the
241.29 Department of Health as a class A or class F home care provider and provided in a
241.30 building that is registered as a housing with services establishment under chapter 144D.
241.31 Licensed home care providers are subject to section 256B.0651, subdivision 14.

241.32 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
241.33 family for additional units of any allowable component service beyond those available
241.34 under the service rate limits described in paragraph (d), nor for additional units of any
241.35 allowable component service beyond those approved in the service plan by the lead agency.

242.1 Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to
242.2 read:

242.3 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
242.4 payment rate for 24-hour customized living services is a monthly rate authorized by the
242.5 lead agency within the parameters established by the commissioner of human services.
242.6 The payment agreement must delineate the amount of each component service included in
242.7 each recipient's customized living service plan. The lead agency shall ensure that there is a
242.8 documented need within the parameters established by the commissioner for all component
242.9 customized living services authorized. The lead agency shall not authorize 24-hour
242.10 customized living services unless there is a documented need for 24-hour supervision.

242.11 (b) For purposes of this section, "24-hour supervision" means that the recipient
242.12 requires assistance due to needs related to one or more of the following:

242.13 (1) intermittent assistance with toileting, positioning, or transferring;

242.14 (2) cognitive or behavioral issues;

242.15 (3) a medical condition that requires clinical monitoring; or

242.16 (4) for all new participants enrolled in the program on or after ~~January~~ July 1, 2011,
242.17 and all other participants at their first reassessment after ~~January~~ July 1, 2011, dependency
242.18 in at least ~~two~~ three of the following activities of daily living as determined by assessment
242.19 under section 256B.0911: bathing; dressing; grooming; walking; or eating when the
242.20 dependency score in eating is three or greater; and needs medication management and at
242.21 least 50 hours of service per month. The lead agency shall ensure that the frequency and
242.22 mode of supervision of the recipient and the qualifications of staff providing supervision
242.23 are described and meet the needs of the recipient.

242.24 (c) The payment rate for 24-hour customized living services must be based on the
242.25 amount of component services to be provided utilizing component rates established by the
242.26 commissioner. Counties and tribes will use tools issued by the commissioner to develop
242.27 and document customized living plans and authorize rates.

242.28 (d) Component service rates must not exceed payment rates for comparable elderly
242.29 waiver or medical assistance services and must reflect economies of scale.

242.30 (e) The individually authorized 24-hour customized living payments, in combination
242.31 with the payment for other elderly waiver services, including case management, must not
242.32 exceed the recipient's community budget cap specified in subdivision 3a. Customized
242.33 living services must not include rent or raw food costs.

242.34 (f) The individually authorized 24-hour customized living payment rates shall not
242.35 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
242.36 living services in effect and in the Medicaid management information systems on March

243.1 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
243.2 to 9549.0059, to which elderly waiver service clients are assigned. When there are
243.3 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
243.4 shall multiply the calculated service payment rate maximum for the A classification by
243.5 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
243.6 9549.0059, to determine the applicable payment rate maximum. Service payment rate
243.7 maximums shall be updated annually based on legislatively adopted changes to all service
243.8 rates for home and community-based service providers.

243.9 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
243.10 may establish alternative payment rate systems for 24-hour customized living services in
243.11 housing with services establishments which are freestanding buildings with a capacity of
243.12 16 or fewer, by applying a single hourly rate for covered component services provided
243.13 in either:

243.14 (1) licensed corporate adult foster homes; or

243.15 (2) specialized dementia care units which meet the requirements of section 144D.065
243.16 and in which:

243.17 (i) each resident is offered the option of having their own apartment; or

243.18 (ii) the units are licensed as board and lodge establishments with maximum capacity
243.19 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
243.20 subparts 1, 2, 3, and 4, item A.

243.21 (h) A provider may not bill or otherwise charge an elderly waiver participant or their
243.22 family for additional units of any allowable component service beyond those available
243.23 under the service rate limits described in paragraph (e), nor for additional units of any
243.24 allowable component service beyond those approved in the service plan by the lead agency.

243.25 Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 5, is amended to
243.26 read:

243.27 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
243.28 shall receive an initial assessment of strengths, informal supports, and need for services
243.29 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
243.30 client served under the elderly waiver must be conducted at least every 12 months and
243.31 at other times when the case manager determines that there has been significant change
243.32 in the client's functioning. This may include instances where the client is discharged
243.33 from the hospital. There must be a determination that the client requires nursing facility
243.34 level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a,

244.1 paragraph (d), at initial and subsequent assessments to initiate and maintain participation
244.2 in the waiver program.

244.3 (b) Regardless of other assessments identified in section 144.0724, subdivision
244.4 4, as appropriate to determine nursing facility level of care for purposes of medical
244.5 assistance payment for nursing facility services, only face-to-face assessments conducted
244.6 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
244.7 level of care determination will be accepted for purposes of initial and ongoing access to
244.8 waiver service payment.

244.9 Sec. 23. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to
244.10 read:

244.11 Subd. 10. **Waiver payment rates; managed care organizations.** The
244.12 commissioner shall adjust the elderly waiver capitation payment rates for managed care
244.13 organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum
244.14 service rate limits for customized living services and 24-hour customized living services
244.15 under subdivisions 3e and 3h ~~for the contract period beginning October 1, 2009~~. Medical
244.16 assistance rates paid to customized living providers by managed care organizations under
244.17 this section shall not exceed the maximum service rate limits and component rates as
244.18 determined by the commissioner under subdivisions 3e and 3h.

244.19 Sec. 24. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to
244.20 read:

244.21 Subd. 6a. **Statewide availability of ~~consumer-directed community self-directed~~**
244.22 **support services.** (a) The commissioner shall submit to the federal Health Care Financing
244.23 Administration by August 1, 2001, an amendment to the home and community-based
244.24 waiver ~~for persons with developmental disabilities~~ under section 256B.092 and by April 1,
244.25 2005, for waivers under sections 256B.0915 and 256B.49, to make ~~consumer-directed~~
244.26 ~~community self-directed~~ support services available in every county of the state by January
244.27 1, 2002.

244.28 (b) Until the waiver amendment for self-directed community supports under
244.29 section 51 is effective, if a county declines to meet the requirements for provision of
244.30 ~~consumer-directed community self-directed~~ supports, the commissioner shall contract
244.31 with another county, a group of counties, or a private agency to plan for and administer
244.32 ~~consumer-directed community self-directed~~ supports in that county.

244.33 (c) The state of Minnesota, county agencies, tribal governments, or administrative
244.34 entities under contract to participate in the implementation and administration of the home

245.1 and community-based waiver for persons with developmental disabilities, shall not be
245.2 liable for damages, injuries, or liabilities sustained through the purchase of support by the
245.3 individual, the individual's family, legal representative, or the authorized representative
245.4 with funds received through the ~~consumer-directed community~~ self-directed support
245.5 service under this section. Liabilities include but are not limited to: workers' compensation
245.6 liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment
245.7 Tax Act (FUTA).

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

245.9 Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to
245.10 read:

245.11 Subd. 1a. **Case management ~~administration and services.~~** (a) ~~The administrative~~
245.12 ~~functions of case management provided to or arranged for a person include:~~

245.13 ~~(1) review of eligibility for services;~~

245.14 ~~(2) screening;~~

245.15 ~~(3) intake;~~

245.16 ~~(4) diagnosis;~~

245.17 ~~(5) the review and authorization of services based upon an individualized service~~
245.18 ~~plan; and~~

245.19 ~~(6) responding to requests for conciliation conferences and appeals according~~
245.20 ~~to section 256.045 made by the person, the person's legal guardian or conservator, or~~
245.21 ~~the parent if the person is a minor. Case management services must be provided by a~~

245.22 public or private agency that is enrolled as a medical assistance provider determined by
245.23 the commissioner to meet all of the requirements in the approved federal waiver plans.

245.24 Case management services cannot be provided to a recipient by a private agency that has
245.25 any financial interest in the provisions of any other services included in the recipient's
245.26 coordinated service and support plan.

245.27 (b) Case management ~~service activities provided to or arranged for a person include~~
245.28 services must be provided to each recipient of home and community-based waiver
245.29 services and available to those eligible for case management under sections 256B.0621
245.30 and 256B.0924, subdivision 4, who choose this service. Case management services for an
245.31 eligible person include:

245.32 (1) development of the ~~individual~~ coordinated service and support plan;

245.33 (2) informing the individual or the individual's legal guardian or conservator, or
245.34 parent if the person is a minor, of service options;

245.35 (3) consulting with relevant medical experts or service providers;

- 246.1 (4) assisting the person in the identification of potential providers;
- 246.2 (5) assisting the person to access services;
- 246.3 (6) coordination of services, including coordinating with the person's health care
- 246.4 home or health coordinator, if coordination of long-term care or community supports and
- 246.5 health care is not provided by another service provider;
- 246.6 (7) evaluation and monitoring of the services identified in the plan including at least
- 246.7 one face-to-face visit with each person annually by the case manager; and
- 246.8 (8) ~~annual reviews of service plans and services provided~~ providing the lead agency
- 246.9 with recommendations for service authorization based upon the individual's needs
- 246.10 identified in the support plan within ten working days after receiving the community
- 246.11 support plan from the certified assessor under section 256B.0911.
- 246.12 (c) Case management ~~administration and~~ service activities that are provided to the
- 246.13 person with a developmental disability shall be provided directly by ~~county agencies or~~
- 246.14 ~~under contract~~ a public or private agency that is enrolled as a medical assistance provider
- 246.15 determined by the commissioner to meet all of the requirements in section 256B.0621,
- 246.16 subdivision 5, paragraphs (a) and (b), clauses (1) to (5), and has no financial interest in the
- 246.17 provision of any other services to the person choosing case management service.
- 246.18 (d) ~~Case managers are responsible for the administrative duties and service~~
- 246.19 ~~provisions listed in paragraphs (a) and (b).~~ Case managers shall collaborate with
- 246.20 consumers, families, legal representatives, and relevant medical experts and service
- 246.21 providers in the development and annual review of the individualized service and
- 246.22 habilitation plans.
- 246.23 (e) The Department of Human Services shall offer ongoing education in case
- 246.24 management to case managers. Case managers shall receive no less than ten hours of case
- 246.25 management education and disability-related training each year.
- 246.26 (f) Persons eligible for home and community-based waiver services may choose a
- 246.27 case management service provider from among the public or private vendors enrolled
- 246.28 according to paragraph (d).
- 246.29 (g) For persons eligible for case management under section 256B.0924, and
- 246.30 Minnesota Rules, parts 9525.0004 to 9525.0036, the county or lead agency shall designate
- 246.31 the case management service provider.

246.32 **EFFECTIVE DATE.** This section is effective January 1, 2013, except subdivision

246.33 1a, paragraph (b), clause (6), is effective July 1, 2011.

246.34 Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to

246.35 read:

247.1 Subd. 1b. ~~Individual~~ Coordinated service and support plan. ~~The individual~~ Each
247.2 recipient of case management services and any legal representative shall be provided a
247.3 written copy of the coordinated service and support plan must, which:

247.4 (1) ~~include~~ is developed within ten working days after the case management service
247.5 receives the community support plan from the certified assessor under section 256B.0911;

247.6 (2) includes the results of the assessment information on the person's need for
247.7 service, including identification of service needs that will be or that are met by the person's
247.8 relatives, friends, and others, as well as community services used by the general public;

247.9 (3) reasonably assures the health, safety, and welfare of the recipient;

247.10 ~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person,
247.11 the person's legal guardian or conservator, or the parent if the person is a minor;

247.12 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
247.13 paragraph (o), of service and support providers;

247.14 ~~(3) identify~~ (6) identifies long- and short-range goals for the person;

247.15 ~~(4) identify~~ (7) identifies specific services and the amount and frequency of the
247.16 services to be provided to the person based on assessed needs, preferences, ~~and~~ available
247.17 resources. ~~The individual service plan shall also specify other services the person needs~~
247.18 ~~that are not available, and other services the person needs that are not available. The~~
247.19 individual coordinated service and support plan shall also specify service outcomes and
247.20 the provider's responsibility to monitor the achievement of the service outcomes;

247.21 ~~(5) identify~~ (8) identifies the need for an ~~individual program~~ individual's provider
247.22 plan to be developed by the provider according to the respective state and federal licensing
247.23 and certification standards, and additional assessments to be completed or arranged by the
247.24 provider after service initiation;

247.25 ~~(6) identify~~ (9) identifies provider responsibilities to implement and make
247.26 recommendations for modification to the ~~individual~~ coordinated service and support plan;

247.27 ~~(7) include~~ (10) includes notice of the right to have assessments completed and
247.28 service plans developed within specified time periods, the right to appeal action or
247.29 inaction, and the right to request a conciliation conference or a hearing, an appeal under
247.30 section 256.045;

247.31 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
247.32 or conservator, or the parent if the person is a minor, and the authorized county
247.33 representative; and

247.34 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
247.35 needs that impact the delivery of services.

248.1 ~~Service planning formats developed for interagency planning such as transition,~~
248.2 ~~vocational, and individual family service plans may be substituted for service planning~~
248.3 ~~formats developed by county agencies.~~

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

248.5 Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
248.6 read:

248.7 Subd. 1e. **Case management service monitoring, coordination, and evaluation;**
248.8 **and monitoring of services duties.** (a) If the ~~individual~~ coordinated service and support
248.9 plan identifies the need for individual ~~program~~ provider plans for authorized services,
248.10 the case ~~manager~~ management service provider shall assure that ~~individual program~~ the
248.11 individual provider plans are developed by the providers according to clauses (2) to (5).

248.12 The providers shall assure that the individual ~~program~~ provider plans:

248.13 (1) are developed according to the respective state and federal licensing and
248.14 certification requirements;

248.15 (2) are designed to achieve the goals of the individual service plan;

248.16 (3) are consistent with other aspects of the ~~individual~~ coordinated service and
248.17 support plan;

248.18 (4) assure the health and safety of the person; and

248.19 (5) are developed with consistent and coordinated approaches to services and service
248.20 outcomes among the various service providers.

248.21 (b) The case ~~manager~~ management service provider shall monitor the provision of
248.22 services:

248.23 (1) to assure that the individual service plan is being followed according to
248.24 paragraph (a);

248.25 (2) to identify any changes or modifications that might be needed in the individual
248.26 service plan, including changes resulting from recommendations of current service
248.27 providers;

248.28 (3) to determine if the person's legal rights are protected, and if not, notify the
248.29 person's legal guardian or conservator, or the parent if the person is a minor, protection
248.30 services, or licensing agencies as appropriate; and

248.31 (4) to determine if the person, the person's legal guardian or conservator, or the
248.32 parent if the person is a minor, is satisfied with the services provided.

248.33 (c) If the provider fails to develop or carry out the individual ~~program~~ provider plan
248.34 according to paragraph (a), the case manager shall notify the person's legal guardian or
248.35 conservator, or the parent if the person is a minor, the provider, the respective licensing

249.1 and certification agencies, and the county board where the services are being provided. In
249.2 addition, the case manager shall identify other steps needed to assure the person receives
249.3 the services identified in the ~~individual~~ coordinated service and support plan.

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

249.5 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to
249.6 read:

249.7 Subd. 1g. **Conditions not requiring development of ~~individual~~ a coordinated**
249.8 **service and support plan.** Unless otherwise required by federal law, the county agency is
249.9 not required to complete ~~an individual~~ a coordinated service and support plan as defined in
249.10 subdivision 1b for:

249.11 (1) persons whose families are requesting respite care for their family member who
249.12 resides with them, or whose families are requesting a family support grant and are not
249.13 requesting purchase or arrangement of habilitative services; and

249.14 (2) persons with developmental disabilities, living independently without authorized
249.15 services or receiving funding for services at a rehabilitation facility as defined in section
249.16 268A.01, subdivision 6, and not in need of or requesting additional services.

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

249.18 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

249.19 Subd. 3. **Authorization and termination of services.** ~~County agency case~~
249.20 ~~managers~~ Lead agencies, under rules of the commissioner, shall authorize and terminate
249.21 services of community and regional treatment center providers according to ~~individual~~
249.22 coordinated service and support plans. Services provided to persons with developmental
249.23 disabilities may only be authorized and terminated ~~by case managers~~ according to (1)
249.24 rules of the commissioner and (2) the ~~individual~~ coordinated service and support plan as
249.25 defined in subdivision 1b. Medical assistance services not needed shall not be authorized
249.26 by county agencies or funded by the commissioner. When purchasing or arranging for
249.27 unlicensed respite care services for persons with overriding health needs, the county
249.28 agency shall seek the advice of a health care professional in assessing provider staff
249.29 training needs and skills necessary to meet the medical needs of the person.

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

249.31 Sec. 30. 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 average authorized amount 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. 31. **[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

251.1 receiving disability services is enacted. This system is a partnership between the
251.2 Department of Human Services and the State Quality Council established under
251.3 subdivision 3.

251.4 (b) This system is a result of the recommendations from the Department of Human
251.5 Services' licensing and alternative quality assurance study mandated under Laws 2005,
251.6 First Special Session chapter 4, article 7, section 57, and presented to the legislature
251.7 in February 2007.

251.8 (c) The disability services eligible under this section include:

251.9 (1) the home and community-based services waiver programs for persons with
251.10 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
251.11 including traumatic brain injuries and services for those who qualify for nursing facility
251.12 level of care or hospital facility level of care;

251.13 (2) home care services under section 256B.0651;

251.14 (3) family support grants under section 252.32;

251.15 (4) consumer support grants under section 256.476;

251.16 (5) semi-independent living services under section 252.275; and

251.17 (6) services provided through an intermediate care facility for the developmentally
251.18 disabled.

251.19 (d) For purposes of this section, the following definitions apply:

251.20 (1) "commissioner" means the commissioner of human services;

251.21 (2) "council" means the State Quality Council under subdivision 3;

251.22 (3) "Quality Assurance Commission" means the commission under section
251.23 256B.0951; and

251.24 (4) "system" means the State Quality Assurance, Quality Improvement and
251.25 Licensing System under this section.

251.26 Subd. 2. **Duties of the commissioner of human services.** (a) The commissioner of
251.27 human services shall establish the State Quality Council under subdivision 3.

251.28 (b) The commissioner shall initially delegate authority to perform licensing
251.29 functions and activities according to section 245A.16 to a host county in Region 10. The
251.30 commissioner must not license or reimburse a participating facility, program, or service
251.31 located in Region 10 if the commissioner has received notification from the host county
251.32 that the facility, program, or service has failed to qualify for licensure.

251.33 (c) The commissioner may conduct random licensing inspections based on outcomes
251.34 adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services
251.35 eligible under this section. The role of the random inspections is to verify that the system

252.1 protects the safety and well-being of persons served and maintains the availability of
252.2 high-quality services for persons with disabilities.

252.3 (d) The commissioner shall ensure that the federal home and community-based
252.4 waiver requirements are met and that incidents that may have jeopardized safety and health
252.5 or violated services-related assurances, civil and human rights, and other protections
252.6 designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and
252.7 acted upon in a timely manner.

252.8 (e) The commissioner shall seek a federal waiver by July 1, 2012 to allow
252.9 intermediate care facilities for persons with developmental disabilities to participate in
252.10 this system.

252.11 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
252.12 Council which must define regional quality councils, and carry out a community-based,
252.13 person-directed quality review component, and a comprehensive system for effective
252.14 incident reporting, investigation, analysis, and follow-up.

252.15 (b) By August 1, 2011, the commissioner of human services shall appoint the
252.16 members of the initial State Quality Council. Members shall include representatives
252.17 from the following groups:

252.18 (1) disability service recipients and their family members;

252.19 (2) during the first two years of the State Quality Council, there must be at least three
252.20 members from the Region 10 stakeholders. As regional quality councils are formed under
252.21 subdivision 4, each regional quality council shall appoint one member;

252.22 (3) disability service providers;

252.23 (4) disability advocacy groups; and

252.24 (5) county human services agencies and staff from the Departments of Human
252.25 Services and Health, and Ombudsman for Mental Health and Developmental Disabilities.

252.26 (c) Members of the council who do not receive a salary or wages from an employer
252.27 for time spent on council duties may receive a per diem payment when performing council
252.28 duties and functions.

252.29 (d) The State Quality Council shall:

252.30 (1) assist the Departments of Human Services and Health in fulfilling federally
252.31 mandated obligations by monitoring disability service quality and quality assurance and
252.32 improvement practices in Minnesota; and

252.33 (2) establish state quality improvement priorities with methods for achieving results
252.34 and provide an annual report to the legislative committees with jurisdiction over policy
252.35 and funding of disability services on the outcomes, improvement priorities, and activities
252.36 undertaken by the commission during the previous state fiscal year.

- 253.1 (e) The State Quality Council, in partnership with the commissioner, shall:
253.2 (1) approve and direct implementation of the community-based, person-directed
253.3 system established in this section;
253.4 (2) recommend an appropriate method of funding this system, and determine the
253.5 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;
253.6 (3) approve measurable outcomes in the areas of health and safety, consumer
253.7 evaluation, education and training, providers, and systems;
253.8 (4) establish variable licensure periods not to exceed three years based on outcomes
253.9 achieved; and
253.10 (5) in cooperation with the Quality Assurance Commission, design a transition plan
253.11 for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.
253.12 (f) The State Quality Council shall notify the commissioner of human services that a
253.13 facility, program, or service has been reviewed by quality assurance team members under
253.14 subdivision 4, paragraph (b), clause (13), and qualifies for a license.
253.15 (g) The State Quality Council, in partnership with the commissioner, shall establish
253.16 an ongoing review process for the system. The review shall take into account the
253.17 comprehensive nature of the system which is designed to evaluate the broad spectrum of
253.18 licensed and unlicensed entities that provide services to persons with disabilities. The
253.19 review shall address efficiencies and effectiveness of the system.
253.20 (h) The State Quality Council may recommend to the commissioner certain
253.21 variances from the standards governing licensure of programs for persons with disabilities
253.22 in order to improve the quality of services so long as the recommended variances do
253.23 not adversely affect the health or safety of persons being served or compromise the
253.24 qualifications of staff to provide services.
253.25 (i) The safety standards, rights, or procedural protections referenced under
253.26 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
253.27 recommendations to the commissioner or to the legislature in the report required under
253.28 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
253.29 procedural protections referenced under subdivision 2, paragraph (c).
253.30 (j) The State Quality Council may hire staff to perform the duties assigned in this
253.31 subdivision.
253.32 **Subd. 4. Regional quality councils.** (a) The commissioner shall establish, as
253.33 selected by the State Quality Council, regional quality councils of key stakeholders,
253.34 including regional representatives of:
253.35 (1) disability service recipients and their family members;
253.36 (2) disability service providers;

254.1 (3) disability advocacy groups; and

254.2 (4) county human services agencies and staff from the Departments of Human

254.3 Services, and Health, and Ombudsman for Mental Health and Developmental Disabilities.

254.4 (b) Each regional quality council shall:

254.5 (1) direct and monitor the community-based, person-directed quality assurance

254.6 system in this section;

254.7 (2) approve a training program for quality assurance team members under clause

254.8 (13);

254.9 (3) review summary reports from quality assurance team reviews and make

254.10 recommendations to the State Quality Council regarding program licensure;

254.11 (4) make recommendations to the State Quality Council regarding the system;

254.12 (5) resolve complaints between the quality assurance teams, counties, providers,

254.13 persons receiving services, their families, and legal representatives;

254.14 (6) analyze and review quality outcomes and critical incident data reporting

254.15 incidents of life safety concerns immediately to the Department of Human Services

254.16 licensing division;

254.17 (7) provide information and training programs for persons with disabilities and their

254.18 families and legal representatives on service options and quality expectations;

254.19 (8) disseminate information and resources developed to other regional quality

254.20 councils;

254.21 (9) respond to state-level priorities;

254.22 (10) establish regional priorities for quality improvement;

254.23 (11) submit an annual report to the State Quality Council on the status, outcomes,

254.24 improvement priorities, and activities in the region;

254.25 (12) choose a representative to participate on the State Quality Council and assume

254.26 other responsibilities consistent with the priorities of the State Quality Council; and

254.27 (13) recruit, train, and assign duties to members of quality assurance teams, taking

254.28 into account the size of the service provider, the number of services to be reviewed,

254.29 the skills necessary for the team members to complete the process, and ensure that no

254.30 team member has a financial, personal, or family relationship with the facility, program,

254.31 or service being reviewed or with anyone served at the facility, program, or service.

254.32 Quality assurance teams must be comprised of county staff, persons receiving services

254.33 or the person's families, legal representatives, members of advocacy organizations,

254.34 providers, and other involved community members. Team members must complete

254.35 the training program approved by the regional quality council and must demonstrate

255.1 performance-based competency. Team members may be paid a per diem and reimbursed
255.2 for expenses related to their participation in the quality assurance process.

255.3 (c) The commissioner shall monitor the safety standards, rights, and procedural
255.4 protections for the monitoring of psychotropic medications and those identified under
255.5 sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2)
255.6 and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause
255.7 (7); 626.556; and 626.557.

255.8 (d) The regional quality councils may hire staff to perform the duties assigned in
255.9 this subdivision.

255.10 (e) The regional quality councils may charge fees for their services.

255.11 (f) The quality assurance process undertaken by a regional quality council consists of
255.12 an evaluation by a quality assurance team of the facility, program, or service. The process
255.13 must include an evaluation of a random sample of persons served. The sample must be
255.14 representative of each service provided. The sample size must be at least five percent but
255.15 not less than two persons served. All persons must be given the opportunity to be included
255.16 in the quality assurance process in addition to those chosen for the random sample.

255.17 (g) A facility, program, or service may contest a licensing decision of the regional
255.18 quality council as permitted under chapter 245A.

255.19 Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation
255.20 with the State Quality Council, shall conduct an annual independent statewide survey
255.21 of service recipients, randomly selected, to determine the effectiveness and quality
255.22 of disability services. The survey must be consistent with the system performance
255.23 expectations of the Centers for Medicare and Medicaid Services (CMS) Quality
255.24 Framework. The survey must analyze whether desired outcomes for persons with different
255.25 demographic, diagnostic, health, and functional needs, who are receiving different types
255.26 of services in different settings and with different costs, have been achieved. Annual
255.27 statewide and regional reports of the results must be published and used to assist regions,
255.28 counties, and providers to plan and measure the impact of quality improvement activities.

255.29 Subd. 6. **Mandated reporters.** Members of the State Quality Council under
255.30 subdivision 3, the regional quality councils under subdivision 4, and quality assurance
255.31 team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as
255.32 defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

255.33 **EFFECTIVE DATE.** (a) Subdivisions 1 to 6 are effective July 1, 2011.

255.34 (b) The jurisdictions of the regional quality councils in subdivision 4 must be
255.35 defined, with implementation dates, by July 1, 2012. During the biennium beginning July

256.1 1, 2011, the Quality Assurance Commission shall continue to implement the alternative
256.2 licensing system under this section.

256.3 Sec. 32. Minnesota Statutes 2010, section 256B.19, is amended by adding a
256.4 subdivision to read:

256.5 Subd. 2d. **Obligation of local agency to process medical assistance applications**
256.6 **within established timelines.** (a) Except as provided in paragraph (b), when an individual
256.7 submits an application for medical assistance and the applicant's eligibility is based on
256.8 disability or on being age 65 or older, the county must determine the applicant's eligibility
256.9 and mail a notice of its decision to the applicant within:

256.10 (1) 60 days from the date of the application for an individual whose eligibility
256.11 is based on disability; or

256.12 (2) 45 days from the date of the application for an individual whose eligibility is
256.13 based on being age 65 or older.

256.14 (b) The county must determine eligibility and mail a notice of its decision within the
256.15 time frames stated in paragraph (a), except in the following circumstances:

256.16 (1) the county cannot make a determination because, despite reasonable efforts by
256.17 the county to communicate what is required, the applicant or an examining physician
256.18 delays or fails to take a required action; or

256.19 (2) there is an administrative or other emergency beyond the county's control. For
256.20 purposes of this clause, a staffing shortage does not constitute an emergency beyond
256.21 the county's control.

256.22 For the events in either clause (1) or (2), the county must document in the applicant's
256.23 case record the reason for delaying beyond the established time frames.

256.24 (c) The county must not use the time frames established in paragraph (a) as a waiting
256.25 period before determining eligibility or as a reason for denying eligibility because it has
256.26 not determined eligibility within the established time frames.

256.27 (d) Effective July 1, 2011, unless one of the exceptions listed under paragraph (b)
256.28 applies, if a county fails to comply with paragraph (a) and the applicant ultimately is
256.29 determined to be eligible for medical assistance, the county is responsible for the entire
256.30 cost of medical assistance services provided to the applicant by a nursing facility and not
256.31 paid for by federal funds, from and including the first date of eligibility through the date
256.32 on which the county mails written notice of its decision on the application. The applicable
256.33 facility will bill and receive payment directly from the commissioner in customary
256.34 fashion, and the commissioner shall deduct any obligation incurred under this paragraph
256.35 from the amount due to the local agency under subdivision 1.

257.1 (e) This subdivision supersedes subdivision 1, clause (2), if both apply to an
257.2 applicant.

257.3 Sec. 33. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to
257.4 read:

257.5 Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the
257.6 commissioner shall limit payment for leave days in a nursing facility to 79 percent of that
257.7 nursing facility's total payment rate for the involved resident.

257.8 (b) For services rendered on or after July 1, 2003, for facilities reimbursed under this
257.9 section or section 256B.434, the commissioner shall limit payment for leave days in a
257.10 nursing facility to 60 percent of that nursing facility's total payment rate for the involved
257.11 resident.

257.12 (c) For services rendered on or after July 1, 2011, for facilities reimbursed under
257.13 this chapter, the commissioner shall limit payment for leave days in a nursing facility
257.14 to 30 percent of that nursing facility's total payment rate for the involved resident, and
257.15 shall allow this payment only when the occupancy of the nursing facility, inclusive of
257.16 bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules,
257.17 part 9505.0415.

257.18 Sec. 34. Minnesota Statutes 2010, section 256B.431, is amended by adding a
257.19 subdivision to read:

257.20 Subd. 44. **Property rate increase for a facility in Bloomington effective**
257.21 **November 1, 2010.** Notwithstanding any other law to the contrary, money available for
257.22 moratorium projects under section 144A.073, subdivision 11, shall be used, effective
257.23 November 1, 2010, to fund an approved moratorium exception project for a nursing
257.24 facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total
257.25 property rate adjustment of \$19.33.

257.26 Sec. 35. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

257.27 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
257.28 have their payment rates determined under this section rather than section 256B.431, the
257.29 commissioner shall establish a rate under this subdivision. The nursing facility must enter
257.30 into a written contract with the commissioner.

257.31 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
257.32 contract under this section is the payment rate the facility would have received under
257.33 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:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

259.1 (3) improved quality as measured in the Nursing Home Report Card;
259.2 (4) reduced acute care costs; and
259.3 (5) any additional outcomes proposed by a nursing facility that the commissioner
259.4 finds desirable.

259.5 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
259.6 take action to come into compliance with existing or pending requirements of the life
259.7 safety code provisions or federal regulations governing sprinkler systems must receive
259.8 reimbursement for the costs associated with compliance if all of the following conditions
259.9 are met:

259.10 (1) the expenses associated with compliance occurred on or after January 1, 2005,
259.11 and before December 31, 2008;

259.12 (2) the costs were not otherwise reimbursed under subdivision 4f or section
259.13 144A.071 or 144A.073; and

259.14 (3) the total allowable costs reported under this paragraph are less than the minimum
259.15 threshold established under section 256B.431, subdivision 15, paragraph (e), and
259.16 subdivision 16.

259.17 The commissioner shall use money appropriated for this purpose to provide to qualifying
259.18 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
259.19 2008. Nursing facilities that have spent money or anticipate the need to spend money
259.20 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
259.21 system or (2) replacing all or portions of an existing sprinkler system may submit to the
259.22 commissioner by June 30, 2007, on a form provided by the commissioner the actual
259.23 costs of a completed project or the estimated costs, based on a project bid, of a planned
259.24 project. The commissioner shall calculate a rate adjustment equal to the allowable
259.25 costs of the project divided by the resident days reported for the report year ending
259.26 September 30, 2006. If the costs from all projects exceed the appropriation for this
259.27 purpose, the commissioner shall allocate the money appropriated on a pro rata basis
259.28 to the qualifying facilities by reducing the rate adjustment determined for each facility
259.29 by an equal percentage. Facilities that used estimated costs when requesting the rate
259.30 adjustment shall report to the commissioner by January 31, 2009, on the use of this
259.31 money on a form provided by the commissioner. If the nursing facility fails to provide
259.32 the report, the commissioner shall recoup the money paid to the facility for this purpose.
259.33 If the facility reports expenditures allowable under this subdivision that are less than
259.34 the amount received in the facility's annualized rate adjustment, the commissioner shall
259.35 recoup the difference.

260.1 Sec. 36. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

260.2 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
260.3 services shall calculate the amount of the planned closure rate adjustment available under
260.4 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

260.5 (1) the amount available is the net reduction of nursing facility beds multiplied
260.6 by \$2,080;

260.7 (2) the total number of beds in the nursing facility or facilities receiving the planned
260.8 closure rate adjustment must be identified;

260.9 (3) capacity days are determined by multiplying the number determined under
260.10 clause (2) by 365; and

260.11 (4) the planned closure rate adjustment is the amount available in clause (1), divided
260.12 by capacity days determined under clause (3).

260.13 (b) A planned closure rate adjustment under this section is effective on the first day
260.14 of the month following completion of closure of the facility designated for closure in the
260.15 application and becomes part of the nursing facility's total operating payment rate.

260.16 (c) Applicants may use the planned closure rate adjustment to allow for a property
260.17 payment for a new nursing facility or an addition to an existing nursing facility or as an
260.18 operating payment rate adjustment. Applications approved under this subdivision are
260.19 exempt from other requirements for moratorium exceptions under section 144A.073,
260.20 subdivisions 2 and 3.

260.21 (d) Upon the request of a closing facility, the commissioner must allow the facility a
260.22 closure rate adjustment as provided under section 144A.161, subdivision 10.

260.23 (e) A facility that has received a planned closure rate adjustment may reassign it
260.24 to another facility that is under the same ownership at any time within three years of its
260.25 effective date. The amount of the adjustment shall be computed according to paragraph (a).

260.26 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
260.27 the commissioner shall recalculate planned closure rate adjustments for facilities that
260.28 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
260.29 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
260.30 from the date the per bed dollar amount is increased.

260.31 (g) For planned closures approved after June 30, 2009, the commissioner of human
260.32 services shall calculate the amount of the planned closure rate adjustment available under
260.33 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

260.34 (h) Beginning July 16, 2011, the commissioner shall no longer approve planned
260.35 closure rate adjustments under this subdivision.

261.1 Sec. 37. Minnesota Statutes 2010, section 256B.441, is amended by adding a
261.2 subdivision to read:

261.3 Subd. 60. **Rate increase for low-rate facilities.** (a) Effective October 1, 2011,
261.4 the commissioner shall adjust the operating payment rates of a nursing facility whose
261.5 operating payment rate on September 30, 2011, is greater than the 95th percentile of all
261.6 nursing facilities operating payment rates. The commissioner shall:

261.7 (1) array all operating payment rates in effect on September 30, 2011, at a case-mix
261.8 weight equal to 1.00 (DDF) from lowest to highest;

261.9 (2) remove from the array any nursing facility determined by the commissioner to
261.10 be providing specialized care, determined in accordance with criteria in subdivision 51a,
261.11 paragraph (b), and any facilities receiving a rate increase under paragraph (c), clause (1);

261.12 (3) determine the 95th percentile of the array in clause (1);

261.13 (4) compute a reduction amount not to exceed three percent, if a facility's amount
261.14 in clause (1) is greater than the amount computed in clause (3) by subtracting a facility's
261.15 DDF rate in clause (1) from the amount computed in clause (3);

261.16 (5) compute the portion of each facility's DDF operating payment rate that is the
261.17 direct care per diem based on the rates in effect on September 30, 2011; and

261.18 (6) determine the change for all other case-mix levels, by multiplying the amount in
261.19 clause (4) by the percentage in clause (5) and by the corresponding case-mix weight for
261.20 each care level. Add to this product the non-direct care per diem portion of the amount
261.21 in clause (4).

261.22 (b) The total amount to be saved by the rate reductions will be computed. The
261.23 commissioner shall:

261.24 (1) for each facility receiving a rate change in paragraph (a), multiply each case-mix
261.25 level's rate change in paragraph (a), clause (6), by the corresponding case-mix resident
261.26 days from the most recent cost report that has been desk audited; and

261.27 (2) sum all the products computed in clause (1).

261.28 (c) The amount of total payment reductions computed in paragraph (b) shall be
261.29 distributed to the facilities with the lowest DDF operating payment rates determined in
261.30 paragraph (a), clause (1). The commissioner shall:

261.31 (1) for nursing facilities located no more than one-quarter mile from a peer group
261.32 with higher limits under either subdivision 50 or 51, give an operating rate adjustment.
261.33 The operating payment rates of a lower-limit peer group facility must be adjusted to be
261.34 equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate
261.35 with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are

262.1 those defined in subdivision 30. The nearest facility must be determined by the most
262.2 direct driving route;

262.3 (2) start with the facility or facilities with the lowest DDF operating payment rate
262.4 and compute the amount of a rate adjustment needed to make the DDF rate equal to the
262.5 DDF of the facility directly below it in the array;

262.6 (3) compute the rate increases for the other case-mix levels using the amount
262.7 computed in clause (2), and the process stated in paragraph (a), clauses (5) and (6);

262.8 (4) compute the total amount the lowest facilities will receive using the process
262.9 described in paragraph (b);

262.10 (5) compute the running total to be spent at all facilities receiving an increase under
262.11 this paragraph by summing each facility's amount computed in clause (4); and

262.12 (6) repeat the process in clauses (2) to (5) as long as the amount in clause (5) does
262.13 not exceed the amount in paragraph (b), clause (2). In no case shall the DDF operating
262.14 payment rate increase determined in clauses (2) to (6) exceed two percent.

262.15 Sec. 38. Minnesota Statutes 2010, section 256B.48, subdivision 1, is amended to read:

262.16 Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive
262.17 medical assistance payments unless it refrains from all of the following:

262.18 (a) Charging private paying residents rates for similar services which exceed those
262.19 which are approved by the state agency for medical assistance recipients as determined by
262.20 the prospective desk audit rate, except under the following circumstances:

262.21 (1) the nursing facility may;

262.22 ~~(1)~~ (i) charge private paying residents a higher rate for a private room; and

262.23 ~~(2)~~ (ii) charge for special services which are not included in the daily rate if medical
262.24 assistance residents are charged separately at the same rate for the same services in
262.25 addition to the daily rate paid by the commissioner;

262.26 (2) effective July 1, 2011, through September 30, 2012, nursing facilities may charge
262.27 private paying residents rates up to two percent higher than the allowable payment rate
262.28 determined by the commissioner for the RUGS group currently assigned to the resident;

262.29 (3) effective October 1, 2012, through September 30, 2013, nursing facilities
262.30 may charge private paying residents rates up to four percent higher than the allowable
262.31 payment rate determined by the commissioner for the RUGS group currently assigned
262.32 to the resident;

262.33 (4) effective October 1, 2013, through September 30, 2014, nursing facilities may
262.34 charge private paying residents rates up to six percent higher than the allowable payment

263.1 rate determined by the commissioner for the RUGS group currently assigned to the
263.2 resident;

263.3 (5) effective October 1, 2014, nursing facilities may charge private paying
263.4 residents up to eight percent higher than the allowable payment rate determined by the
263.5 commissioner for the RUGS group currently assigned to the resident; and

263.6 (6) the higher private pay charges allowed in this paragraph shall be limited to actual
263.7 costs per resident day, as determined by the commissioner, based on data provided in the
263.8 statistical and cost report in section 256B.441.

263.9 Nothing in this section precludes a nursing facility from charging a rate allowable
263.10 under the facility's single room election option under Minnesota Rules, part 9549.0060,
263.11 subpart 11. Services covered by the payment rate must be the same regardless of payment
263.12 source. Special services, if offered, must be available to all residents in all areas of the
263.13 nursing facility and charged separately at the same rate. Residents are free to select
263.14 or decline special services. Special services must not include services which must be
263.15 provided by the nursing facility in order to comply with licensure or certification standards
263.16 and that if not provided would result in a deficiency or violation by the nursing facility.
263.17 Services beyond those required to comply with licensure or certification standards must
263.18 not be charged separately as a special service if they were included in the payment rate for
263.19 the previous reporting year. A nursing facility that charges a private paying resident a rate
263.20 in violation of this clause is subject to an action by the state of Minnesota or any of its
263.21 subdivisions or agencies for civil damages. A private paying resident or the resident's legal
263.22 representative has a cause of action for civil damages against a nursing facility that charges
263.23 the resident rates in violation of this clause. The damages awarded shall include three
263.24 times the payments that result from the violation, together with costs and disbursements,
263.25 including reasonable attorneys' fees or their equivalent. A private paying resident or the
263.26 resident's legal representative, the state, subdivision or agency, or a nursing facility may
263.27 request a hearing to determine the allowed rate or rates at issue in the cause of action.
263.28 Within 15 calendar days after receiving a request for such a hearing, the commissioner
263.29 shall request assignment of an administrative law judge under sections 14.48 to 14.56 to
263.30 conduct the hearing as soon as possible or according to agreement by the parties. The
263.31 administrative law judge shall issue a report within 15 calendar days following the close
263.32 of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed
263.33 as boarding care facilities which are not certified as skilled or intermediate care facilities
263.34 level I or II for reimbursement through medical assistance.

263.35 (b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission
263.36 to the facility, or from anyone acting in behalf of the applicant, as a condition of

264.1 admission, expediting the admission, or as a requirement for the individual's continued
264.2 stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required
264.3 as payment under the state plan. For residents on medical assistance, medical assistance
264.4 payment according to the state plan must be accepted as payment in full for continued
264.5 stay, except where otherwise provided for under statute;

264.6 (2) requiring an individual, or anyone acting in behalf of the individual, to loan
264.7 any money to the nursing facility;

264.8 (3) requiring an individual, or anyone acting in behalf of the individual, to promise
264.9 to leave all or part of the individual's estate to the facility; or

264.10 (4) requiring a third-party guarantee of payment to the facility as a condition of
264.11 admission, expedited admission, or continued stay in the facility.

264.12 Nothing in this paragraph would prohibit discharge for nonpayment of services in
264.13 accordance with state and federal regulations.

264.14 (c) Requiring any resident of the nursing facility to utilize a vendor of health care
264.15 services chosen by the nursing facility. A nursing facility may require a resident to use
264.16 pharmacies that utilize unit dose packing systems approved by the Minnesota Board of
264.17 Pharmacy, and may require a resident to use pharmacies that are able to meet the federal
264.18 regulations for safe and timely administration of medications such as systems with specific
264.19 number of doses, prompt delivery of medications, or access to medications on a 24-hour
264.20 basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict
264.21 a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit
264.22 dose drug packing.

264.23 (d) Providing differential treatment on the basis of status with regard to public
264.24 assistance.

264.25 (e) Discriminating in admissions, services offered, or room assignment on the
264.26 basis of status with regard to public assistance ~~or refusal to purchase special services.~~

264.27 Discrimination in admissions discrimination, services offered, or room assignment shall
264.28 include, but is not limited to:

264.29 (1) basing admissions decisions upon ~~assurance by the applicant to the nursing~~
264.30 ~~facility, or the applicant's guardian or conservator, that the applicant is neither eligible for~~
264.31 ~~nor will seek~~ information or assurances regarding current or future eligibility for public
264.32 assistance for payment of nursing facility care costs; and

264.33 (2) engaging in preferential selection from waiting lists based on an applicant's
264.34 ability to pay privately or an applicant's refusal to pay for a special service.

264.35 The collection and use by a nursing facility of financial information of any applicant
264.36 pursuant to a preadmission screening program established by law shall not raise an

265.1 inference that the nursing facility is utilizing that information for any purpose prohibited
265.2 by this paragraph.

265.3 (f) Requiring any vendor of medical care as defined by section 256B.02, subdivision
265.4 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any
265.5 amount based on utilization or service levels or any portion of the vendor's fee to the
265.6 nursing facility except as payment for renting or leasing space or equipment or purchasing
265.7 support services from the nursing facility as limited by section 256B.433. All agreements
265.8 must be disclosed to the commissioner upon request of the commissioner. Nursing
265.9 facilities and vendors of ancillary services that are found to be in violation of this provision
265.10 shall each be subject to an action by the state of Minnesota or any of its subdivisions or
265.11 agencies for treble civil damages on the portion of the fee in excess of that allowed by
265.12 this provision and section 256B.433. Damages awarded must include three times the
265.13 excess payments together with costs and disbursements including reasonable attorney's
265.14 fees or their equivalent.

265.15 (g) Refusing, for more than 24 hours, to accept a resident returning to the same
265.16 bed or a bed certified for the same level of care, in accordance with a physician's order
265.17 authorizing transfer, after receiving inpatient hospital services.

265.18 (h) For a period not to exceed 180 days, the commissioner may continue to make
265.19 medical assistance payments to a nursing facility or boarding care home which is in
265.20 violation of this section if extreme hardship to the residents would result. In these cases
265.21 the commissioner shall issue an order requiring the nursing facility to correct the violation.
265.22 The nursing facility shall have 20 days from its receipt of the order to correct the violation.
265.23 If the violation is not corrected within the 20-day period the commissioner may reduce
265.24 the payment rate to the nursing facility by up to 20 percent. The amount of the payment
265.25 rate reduction shall be related to the severity of the violation and shall remain in effect
265.26 until the violation is corrected. The nursing facility or boarding care home may appeal the
265.27 commissioner's action pursuant to the provisions of chapter 14 pertaining to contested
265.28 cases. An appeal shall be considered timely if written notice of appeal is received by the
265.29 commissioner within 20 days of notice of the commissioner's proposed action.

265.30 In the event that the commissioner determines that a nursing facility is not eligible
265.31 for reimbursement for a resident who is eligible for medical assistance, the commissioner
265.32 may authorize the nursing facility to receive reimbursement on a temporary basis until the
265.33 resident can be relocated to a participating nursing facility.

265.34 Certified beds in facilities which do not allow medical assistance intake on July 1,
265.35 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

266.1 Sec. 39. Minnesota Statutes 2010, section 256B.49, subdivision 12, is amended to read:

266.2 Subd. 12. **Informed choice.** Persons who are determined likely to require the
266.3 level of care provided in a nursing facility as determined under ~~sections 144.0724,~~
266.4 ~~subdivision 11, and section 256B.0911;~~ or a hospital shall be informed of the home and
266.5 community-based support alternatives to the provision of inpatient hospital services or
266.6 nursing facility services. Each person must be given the choice of either institutional or
266.7 home and community-based services using the provisions described in section 256B.77,
266.8 subdivision 2, paragraph (p).

266.9 Sec. 40. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

266.10 Subd. 13. **Case management.** ~~(a) Each recipient of a home and community-based~~
266.11 ~~waiver under this section shall be provided case management services according to~~
266.12 ~~section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the~~
266.13 ~~federally approved waiver application. The case management service activities provided~~
266.14 ~~will include:~~

266.15 ~~(1) assessing the needs of the individual within 20 working days of a recipient's~~
266.16 ~~request;~~

266.17 ~~(2) developing the written individual service plan within ten working days after the~~
266.18 ~~assessment is completed;~~

266.19 ~~(3) informing the recipient or the recipient's legal guardian or conservator of service~~
266.20 ~~options;~~

266.21 ~~(4) assisting the recipient in the identification of potential service providers;~~

266.22 ~~(5) assisting the recipient to access services;~~

266.23 ~~(6) coordinating, evaluating, and monitoring of the services identified in the service~~
266.24 ~~plan;~~

266.25 ~~(7) completing the annual reviews of the service plan; and~~

266.26 ~~(8) informing the recipient or legal representative of the right to have assessments~~
266.27 ~~completed and service plans developed within specified time periods, and to appeal county~~
266.28 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~
266.29 ~~nursing facility level of care.~~

266.30 ~~(b) The case manager may delegate certain aspects of the case management service~~
266.31 ~~activities to another individual provided there is oversight by the case manager. The case~~
266.32 ~~manager may not delegate those aspects which require professional judgment including~~
266.33 ~~assessments, reassessments, and care plan development.~~

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

267.1 Sec. 41. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

267.2 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
267.3 strengths, informal support systems, and need for services shall be completed within 20
267.4 working days of the recipient's request as provided in section 256B.0911. Reassessment
267.5 of each recipient's strengths, support systems, and need for services shall be conducted
267.6 at least every 12 months and at other times when there has been a significant change in
267.7 the recipient's functioning.

267.8 (b) There must be a determination that the client requires a hospital level of care or a
267.9 nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911,
267.10 subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and
267.11 maintain participation in the waiver program.

267.12 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
267.13 appropriate to determine nursing facility level of care for purposes of medical assistance
267.14 payment for nursing facility services, only face-to-face assessments conducted according
267.15 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
267.16 determination or a nursing facility level of care determination must be accepted for
267.17 purposes of initial and ongoing access to waiver services payment.

267.18 (d) Persons with developmental disabilities who apply for services under the nursing
267.19 facility level waiver programs shall be screened for the appropriate level of care according
267.20 to section 256B.092.

267.21 (e) Recipients who are found eligible for home and community-based services under
267.22 this section before their 65th birthday may remain eligible for these services after their
267.23 65th birthday if they continue to meet all other eligibility factors.

267.24 (f) The commissioner shall develop criteria to identify individuals whose level of
267.25 functioning is reasonably expected to improve and reassess these individuals every six
267.26 months. Individuals who meet these criteria must have a comprehensive transitional
267.27 service plan developed under subdivision 15, paragraphs (b) and (c). Counties, case
267.28 managers, and service providers are responsible for conducting these reassessments and
267.29 shall complete the reassessments out of existing funds.

267.30 **EFFECTIVE DATE.** This section is effective January 1, 2012, except for paragraph
267.31 (f), which is effective July 1, 2013.

267.32 Sec. 42. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

267.33 Subd. 15. **Individualized Coordinated service and support plan; comprehensive**
267.34 **transitional service plan; maintenance service plan.** (a) Each recipient of home and
267.35 community-based waived services shall be provided a copy of the written coordinated

268.1 service and support plan ~~which~~ that complies with the requirements of section 256B.092,
268.2 subdivisions 1b and 1e.

268.3 ~~(1) is developed and signed by the recipient within ten working days of the~~
268.4 ~~completion of the assessment;~~

268.5 ~~(2) meets the assessed needs of the recipient;~~

268.6 ~~(3) reasonably ensures the health and safety of the recipient;~~

268.7 ~~(4) promotes independence;~~

268.8 ~~(5) allows for services to be provided in the most integrated settings; and~~

268.9 ~~(6) provides for an informed choice, as defined in section 256B.77, subdivision 2,~~
268.10 ~~paragraph (p), of service and support providers.~~

268.11 (b) In developing the comprehensive transitional service plan, the individual
268.12 receiving services, the case manager, and the guardian, if applicable, will identify
268.13 the transitional service plan fundamental service outcome and anticipated timeline to
268.14 achieve this outcome. Within the first 20 days following a recipient's request for an
268.15 assessment or reassessment, the transitional service planning team must be identified. A
268.16 team leader must be identified who will be responsible for assigning responsibility and
268.17 communicating with team members to ensure implementation of the transition plan and
268.18 ongoing assessment and communication process. The team leader should be an individual,
268.19 such as the case manager or guardian, who has the opportunity to follow the individual to
268.20 the next level of service.

268.21 Within ten days following an assessment, a comprehensive transitional service plan
268.22 must be developed incorporating elements of a comprehensive functional assessment and
268.23 including short-term measurable outcomes and timelines for achievement of and reporting
268.24 on these outcomes. Functional milestones must also be identified and reported according
268.25 to the timelines agreed upon by the transitional service planning team. In addition, the
268.26 comprehensive transitional service plan must identify additional supports that may assist
268.27 in the achievement of the fundamental service outcome such as the development of greater
268.28 natural community support, increased collaboration among agencies, and technological
268.29 supports.

268.30 The timelines for reporting on functional milestones will prompt a reassessment of
268.31 services provided, the units of services, rates, and appropriate service providers. It is
268.32 the responsibility of the transitional service planning team leader to review functional
268.33 milestone reporting to determine if the milestones are consistent with observable skills
268.34 and that milestone achievement prompts any needed changes to the comprehensive
268.35 transitional service plan.

269.1 For those whose fundamental transitional service outcome involves the need to
269.2 procure housing, a plan for the individual to seek the resources necessary to secure
269.3 the least restrictive housing possible should be incorporated into the plan, including
269.4 employment and public supports such as housing access and shelter needy funding.

269.5 (c) Counties and other agencies responsible for funding community placement and
269.6 ongoing community supportive services are responsible for the implementation of the
269.7 comprehensive transitional service plans. Oversight responsibilities include both ensuring
269.8 effective transitional service delivery and efficient utilization of funding resources.

269.9 (d) Following one year of transitional services, the transitional services planning
269.10 team will make a determination as to whether or not the individual receiving services
269.11 requires the current level of continuous and consistent support in order to maintain the
269.12 individual's current level of functioning. Individuals who move from a transitional to a
269.13 maintenance service plan must be reassessed to determine if the individual would benefit
269.14 from a transitional service plan on at least an annual basis. This assessment should
269.15 consider any changes to technological or natural community supports.

269.16 ~~(b)~~ (e) When a county is evaluating denials, reductions, or terminations of home
269.17 and community-based services under section 256B.49 for an individual, the case manager
269.18 shall offer to meet with the individual or the individual's guardian in order to discuss the
269.19 prioritization of service needs within the individualized service plan, comprehensive
269.20 transitional service plan, or maintenance service plan. The reduction in the authorized
269.21 services for an individual due to changes in funding for waived services may not exceed
269.22 the amount needed to ensure medically necessary services to meet the individual's health,
269.23 safety, and welfare.

269.24 **EFFECTIVE DATE.** This section is effective January 1, 2012, except for
269.25 paragraphs (b), (c), and (d), which are effective July 1, 2013.

269.26 Sec. 43. Minnesota Statutes 2010, section 256B.5012, is amended by adding a
269.27 subdivision to read:

269.28 Subd. 9. **ICF/MR rate increase.** Effective July 1, 2011, the commissioner shall
269.29 increase the daily rate to \$138.23 at an intermediate care facility for the developmentally
269.30 disabled located in Clearwater County and classified as a class A facility with 15 beds.

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

269.32 Sec. 44. Minnesota Statutes 2010, section 256B.5012, is amended by adding a
269.33 subdivision to read:

270.1 Subd. 10. **ICF/MR rate adjustment.** For each facility reimbursed under this
270.2 section, except for a facility located in Clearwater County and classified as a class A
270.3 facility with 15 beds, the commissioner shall decrease operating payment rates equal to ...
270.4 percent of the operating payment rates in effect on June 30, 2011. For each facility, the
270.5 commissioner shall apply the rate reduction, based on occupied beds, using the percentage
270.6 specified in this subdivision multiplied by the total payment rate, including the variable rate
270.7 but excluding the property-related payment rate, in effect on the preceding date. The total
270.8 rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

270.9 Sec. 45. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

270.10 Subd. 6. **Excluded time.** "Excluded time" means:

270.11 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
270.12 other than an emergency shelter, halfway house, foster home, semi-independent living
270.13 domicile or services program, residential facility offering care, board and lodging facility
270.14 or other institution for the hospitalization or care of human beings, as defined in section
270.15 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
270.16 or correctional facility; or any facility based on an emergency hold under sections
270.17 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

270.18 (b) any period an applicant spends on a placement basis in a training and habilitation
270.19 program, including a rehabilitation facility or work or employment program as defined
270.20 in section 268A.01; ~~or receiving personal care assistance services pursuant to section~~
270.21 ~~256B.0659~~; semi-independent living services provided under section 252.275, and
270.22 Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs
270.23 and assisted living services; and

270.24 (c) any placement for a person with an indeterminate commitment, including
270.25 independent living.

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

270.27 Sec. 46. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by
270.28 Laws 2010, First Special Session chapter 1, article 24, section 12, is amended to read:

270.29 **EFFECTIVE DATE.** ~~The~~ This section is effective ~~July 1, 2011~~ on or after January
270.30 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals
270.31 under age 21.

271.1 Sec. 47. Laws 2009, chapter 79, article 8, section 51, the effective date, as amended by
271.2 Laws 2010, First Special Session chapter 1, article 17, section 14, is amended to read:

271.3 **EFFECTIVE DATE.** This section is effective ~~July 1, 2011~~ January 1, 2014.

271.4 Sec. 48. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
271.5 Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special
271.6 Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

271.7 Subd. 8. **Continuing Care Grants**

271.8 The amounts that may be spent from the
271.9 appropriation for each purpose are as follows:

271.10	(a) Aging and Adult Services Grants	13,499,000	15,805,000

271.11 **Base Adjustment.** The general fund base is
271.12 increased by \$5,751,000 in fiscal year 2012
271.13 and \$6,705,000 in fiscal year 2013.

271.14 **Information and Assistance**

271.15 **Reimbursement.** Federal administrative
271.16 reimbursement obtained from information
271.17 and assistance services provided by the
271.18 Senior LinkAge or Disability Linkage lines
271.19 to people who are identified as eligible for
271.20 medical assistance shall be appropriated to
271.21 the commissioner for this activity.

271.22 **Community Service Development Grant**

271.23 **Reduction.** Funding for community service
271.24 development grants must be reduced by
271.25 \$260,000 for fiscal year 2010; \$284,000 in
271.26 fiscal year 2011; \$43,000 in fiscal year 2012;
271.27 and \$43,000 in fiscal year 2013. Base level
271.28 funding shall be restored in fiscal year 2014.

271.29 **Community Service Development Grant**

271.30 **Community Initiative.** Funding for
271.31 community service development grants shall
271.32 be used to offset the cost of aging support

272.1 grants. Base level funding shall be restored
272.2 in fiscal year 2014.

272.3 **Senior Nutrition Use of Federal Funds.**
272.4 For fiscal year 2010, general fund grants
272.5 for home-delivered meals and congregate
272.6 dining shall be reduced by \$500,000. The
272.7 commissioner must replace these general
272.8 fund reductions with equal amounts from
272.9 federal funding for senior nutrition from the
272.10 American Recovery and Reinvestment Act
272.11 of 2009.

272.12	(b) Alternative Care Grants	50,234,000	48,576,000

272.13 **Base Adjustment.** The general fund base is
272.14 decreased by \$3,598,000 in fiscal year 2012
272.15 and \$3,470,000 in fiscal year 2013.

272.16 **Alternative Care Transfer.** Any money
272.17 allocated to the alternative care program that
272.18 is not spent for the purposes indicated does
272.19 not cancel but must be transferred to the
272.20 medical assistance account.

272.21	(c) Medical Assistance Grants; Long-Term		
272.22	Care Facilities.	367,444,000	419,749,000

272.23	(d) Medical Assistance Long-Term Care		
272.24	Waivers and Home Care Grants	853,567,000	1,039,517,000

272.25 **Manage Growth in TBI and CADI**
272.26 **Waivers.** During the fiscal years beginning
272.27 on July 1, 2009, and July 1, 2010, the
272.28 commissioner shall allocate money for home
272.29 and community-based waiver programs
272.30 under Minnesota Statutes, section 256B.49,
272.31 to ensure a reduction in state spending that is
272.32 equivalent to limiting the caseload growth of
272.33 the TBI waiver to 12.5 allocations per month
272.34 each year of the biennium and the CADI
272.35 waiver to 95 allocations per month each year

273.1 of the biennium. Limits do not apply: (1)
273.2 when there is an approved plan for nursing
273.3 facility bed closures for individuals under
273.4 age 65 who require relocation due to the
273.5 bed closure; (2) to fiscal year 2009 waiver
273.6 allocations delayed due to unallotment; or (3)
273.7 to transfers authorized by the commissioner
273.8 from the personal care assistance program
273.9 of individuals having a home care rating
273.10 of "CS," "MT," or "HL." Priorities for the
273.11 allocation of funds must be for individuals
273.12 anticipated to be discharged from institutional
273.13 settings or who are at imminent risk of a
273.14 placement in an institutional setting.

273.15 **Manage Growth in DD Waiver.** The
273.16 commissioner shall manage the growth in
273.17 the DD waiver by limiting the allocations
273.18 included in the February 2009 forecast to 15
273.19 additional diversion allocations each month
273.20 for the calendar years that begin on January
273.21 1, 2010, and January 1, 2011. Additional
273.22 allocations must be made available for
273.23 transfers authorized by the commissioner
273.24 from the personal care program of individuals
273.25 having a home care rating of "CS," "MT,"
273.26 or "HL."

273.27 **Adjustment to Lead Agency Waiver**
273.28 **Allocations.** Prior to the availability of the
273.29 alternative license defined in Minnesota
273.30 Statutes, section 245A.11, subdivision 8,
273.31 the commissioner shall reduce lead agency
273.32 waiver allocations for the purposes of
273.33 implementing a moratorium on corporate
273.34 foster care.

~~Alternatives to Personal Care Assistance Services. Base level funding of \$3,237,000 in fiscal year 2012 and \$4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.~~

(e) Mental Health Grants

Appropriations by Fund			
General	77,739,000	77,739,000	
Health Care Access	750,000	750,000	
Lottery Prize	1,508,000	1,508,000	

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000

(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

Payments for Substance Abuse Treatment.
For placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:
(1) rates charged for these services on January 1, 2009; or

275.1 (2) 160 percent of the average rate on January
275.2 1, 2009, for each group of vendors with
275.3 similar attributes.

275.4 Rates for fiscal years 2010 and 2011 must
275.5 not exceed 160 percent of the average rate on
275.6 January 1, 2009, for each group of vendors
275.7 with similar attributes.

275.8 Effective July 1, 2010, rates that were above
275.9 the average rate on January 1, 2009, are
275.10 reduced by five percent from the rates in
275.11 effect on June 1, 2010. Rates below the
275.12 average rate on January 1, 2009, are reduced
275.13 by 1.8 percent from the rates in effect on
275.14 June 1, 2010. Services provided under
275.15 this section by state-operated services are
275.16 exempt from the rate reduction. For services
275.17 provided in fiscal years 2012 and 2013, the
275.18 statewide aggregate payment under the new
275.19 rate methodology to be developed under
275.20 Minnesota Statutes, section 254B.12, must
275.21 not exceed the projected aggregate payment
275.22 under the rates in effect for fiscal year 2011
275.23 excluding the rate reduction for rates that
275.24 were below the average on January 1, 2009,
275.25 plus a state share increase of \$3,787,000 for
275.26 fiscal year 2012 and \$5,023,000 for fiscal
275.27 year 2013. Notwithstanding any provision
275.28 to the contrary in this article, this provision
275.29 expires on June 30, 2013.

275.30 **Chemical Dependency Special Revenue**
275.31 **Account.** For fiscal year 2010, \$750,000
275.32 must be transferred from the consolidated
275.33 chemical dependency treatment fund
275.34 administrative account and deposited into the
275.35 general fund.

276.1 **County CD Share of MA Costs for**
276.2 **ARRA Compliance.** Notwithstanding the
276.3 provisions of Minnesota Statutes, chapter
276.4 254B, for chemical dependency services
276.5 provided during the period October 1, 2008,
276.6 to December 31, 2010, and reimbursed by
276.7 medical assistance at the enhanced federal
276.8 matching rate provided under the American
276.9 Recovery and Reinvestment Act of 2009, the
276.10 county share is 30 percent of the nonfederal
276.11 share. This provision is effective the day
276.12 following final enactment.

276.13	(h) Chemical Dependency Nonentitlement		
276.14	Grants	1,729,000	1,729,000
276.15	(i) Other Continuing Care Grants	19,201,000	17,528,000

276.16 **Base Adjustment.** The general fund base is
276.17 increased by \$2,639,000 in fiscal year 2012
276.18 and increased by \$3,854,000 in fiscal year
276.19 2013.

276.20 **Technology Grants.** \$650,000 in fiscal
276.21 year 2010 and \$1,000,000 in fiscal year
276.22 2011 are for technology grants, case
276.23 consultation, evaluation, and consumer
276.24 information grants related to developing and
276.25 supporting alternatives to shift-staff foster
276.26 care residential service models.

276.27 **Other Continuing Care Grants; HIV**
276.28 **Grants.** Money appropriated for the HIV
276.29 drug and insurance grant program in fiscal
276.30 year 2010 may be used in either year of the
276.31 biennium.

276.32 **Quality Assurance Commission.** Effective
276.33 July 1, 2009, state funding for the quality
276.34 assurance commission under Minnesota
276.35 Statutes, section 256B.0951, is canceled.

277.1 Sec. 49. **DIRECTIONS TO COMMISSIONER.**

277.2 Subdivision 1. Co-payments for home and community-based services. Upon
277.3 federal approval, the commissioner of human services shall develop and implement a
277.4 co-payment schedule for individuals receiving home and community-based services under
277.5 Minnesota Statutes, chapter 256B.

277.6 Subd. 2. Federal waiver amendment. The commissioner shall seek an amendment
277.7 to the 1915c home and community-based waivers under Minnesota Statutes, sections
277.8 256B.092 and 256B.49, to allow properly licensed residential programs under Minnesota
277.9 Statutes, section 245A.02, subdivision 14, to provide residential services to up to eight
277.10 individuals with physical or developmental disabilities, chronic illnesses, or traumatic
277.11 brain injuries. A facility licensed for five to eight people must be an existing residential
277.12 building, such as a duplex, that is owned by the same company and meets all other
277.13 licensing requirements.

277.14 Subd. 3. Recommendations for personal care assistance service changes. The
277.15 commissioner shall consult with stakeholder groups, including counties, advocates,
277.16 persons receiving personal care assistance services, and personal care assistance providers,
277.17 and make recommendations to the legislature by February 1, 2014, on changes that could
277.18 be made to the program to improve oversight, program efficiency, and cost-effectiveness.

277.19 Subd. 4. Nursing facility pay-for-performance reimbursement system.
277.20 The commissioner of human services shall report to the legislative committees with
277.21 jurisdiction over nursing facility policy and finance with recommendations for developing
277.22 and implementing a pay-for-performance reimbursement system with a quality add-on by
277.23 January 15, 2012.

277.24 Subd. 5. ICF/MR transition plan. The commissioner of human services shall
277.25 work with stakeholders to develop and implement a plan by June 30, 2013, to transition
277.26 individuals currently residing in intermediate care facilities for persons with developmental
277.27 disabilities into the least restrictive community settings possible. The plan must include a
277.28 requirement for a cooperative planning process between the counties and providers for
277.29 the downsizing or closure of intermediate care facilities for persons with developmental
277.30 disabilities, with funding from the bed closures converting to home and community-based
277.31 waiver funding to fund services for those leaving the intermediate care facilities for
277.32 persons with developmental disabilities based on a plan approved by the commissioner. In
277.33 order to facilitate this process, the commissioner shall provide information to facilities and
277.34 counties about the number of people in facilities who have requested to move to home and
277.35 community-based services. Individuals residing in intermediate care facilities for persons
277.36 with developmental disabilities who choose to remain there or whose health or safety

278.1 would be put at risk in a less restrictive setting may continue to reside in intermediate care
278.2 facilities for persons with developmental disabilities.

278.3 Subd. 6. **Representative payee.** The commissioner of human services shall make
278.4 recommendations to the legislative committees with jurisdiction over health and human
278.5 services policy and finance by January 15, 2012, on ways to better manage funds for
278.6 persons who rely on a representative payee.

278.7 Subd. 7. **Autism treatment.** The commissioner of human services shall review
278.8 autism treatment benefits under the TEFRA option and make recommendations to the
278.9 legislative committees with jurisdiction over health and human services policy and finance
278.10 by January 1, 2012, to extend the same autism treatment benefits to MA managed care and
278.11 county-based purchasing.

278.12 Sec. 50. **STATE PLAN AMENDMENT TO IMPLEMENT SELF-DIRECTED**
278.13 **PERSONAL SUPPORTS.**

278.14 By July 15, 2011, the commissioner shall submit a state plan amendment to
278.15 implement Minnesota Statutes, section 256B.0657, as soon as possible upon federal
278.16 approval.

278.17 Sec. 51. **AMENDMENT FOR SELF-DIRECTED COMMUNITY SUPPORTS.**

278.18 By September 1, 2011, the commissioner shall submit an amendment to the home
278.19 and community-based waiver programs consistent with implementing the self-directed
278.20 option under Minnesota Statutes, section 256B.0657, through statewide enrolled providers
278.21 contracted to provide outreach information, training, and fiscal support entity services to
278.22 all eligible recipients choosing this option and with shared care in some types of services.
278.23 The waiver amendment shall be consistent with changes in case management services
278.24 under Minnesota Statutes, section 256B.092.

278.25 Sec. 52. **ESTABLISHMENT OF RATES FOR SHARED HOME AND**
278.26 **COMMUNITY-BASED WAIVER SERVICES.**

278.27 By January 1, 2012, the commissioner shall establish rates to begin paying for
278.28 in-home services and personal supports under all of the home and community-based
278.29 waiver services programs consistent with the standards in Minnesota Statutes, section
278.30 256B.4912, subdivision 2.

278.31 Sec. 53. **ESTABLISHMENT OF RATE FOR CASE MANAGEMENT**
278.32 **SERVICES.**

279.1 By July 1, 2012, the commissioner shall establish the rate to be paid for case
279.2 management services under Minnesota Statutes, sections 256B.0621, subdivision 2, clause
279.3 (4), 256B.092, and 256B.49, consistent with the standards in Minnesota Statutes, section
279.4 256B.4912, subdivision 2.

279.5 Sec. 54. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**
279.6 **REDESIGN.**

279.7 By February 1, 2012, the commissioner of human services shall develop a legislative
279.8 report with specific recommendations and language for proposed legislation to be effective
279.9 July 1, 2012, for the following:

279.10 (1) definitions of service and consolidation of standards and rates to the extent
279.11 appropriate for all types of medical assistance case management services, including
279.12 targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625,
279.13 subdivision 20; and 256B.0924; mental health case management services for children
279.14 and adults, all types of home and community-based waiver case management, and case
279.15 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be
279.16 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

279.17 (2) recommendations on county of financial responsibility requirements and quality
279.18 assurance measures for case management;

279.19 (3) identification of county administrative functions that may remain entwined in
279.20 case management service delivery models; and

279.21 (4) implementation of a methodology to fully fund county case management
279.22 administrative functions.

279.23 Sec. 55. **MY LIFE, MY CHOICES TASK FORCE.**

279.24 Subdivision 1. **Establishment.** The My Life, My Choices Task Force is established
279.25 to create a system of supports and services for people with disabilities governed by the
279.26 following principles:

279.27 (1) freedom to act as a consumer of services in the marketplace;

279.28 (2) freedom to choose to take as much risk as any other citizen;

279.29 (3) more choices in levels of service that may vary throughout life;

279.30 (4) opportunity to work with a trusted partner and fiscal support entity to manage a
279.31 personal budget and to be accountable for reporting spending and personal outcomes;

279.32 (5) opportunity to live with minimal constraints instead of minimal freedoms; and

279.33 (6) ability to consolidate funding streams into an individualized budget.

280.1 Subd. 2. **Membership.** The My Life, My Choices Task Force shall consist of the
280.2 lieutenant governor; the commissioner of human services, or designee; a representative of
280.3 the Minnesota Chamber of Commerce; and the following to be appointed by the governor:
280.4 one administrative law judge, one labor representative, two family members of people
280.5 with disabilities, and one individual with disabilities. In addition, the following shall be
280.6 appointed jointly by the speaker of the house and the senate Subcommittee on Committees
280.7 of the Committee on Rules and Administration, a representative of a disability advocacy
280.8 organization; a representative of a disability legal services advocacy organization;
280.9 representatives of two nonprofit organizations, one of which serves all 87 counties; and
280.10 a representative of a philanthropic organization. Appointed nongovernmental members
280.11 of the task force shall serve as staff for the task force and take on the responsibilities of
280.12 coordinating meetings, reporting on committee recommendations, and providing other
280.13 staff support as needed to meet the responsibilities of the task force as described in
280.14 subdivision 3. Legislative appointment of nongovernmental members of the task force
280.15 shall be conditioned upon agreement from the appointees to provide staff assistance to
280.16 execute the work of the task force. The chairs and ranking minority members of the
280.17 legislative committees with jurisdiction over health and human services policy and finance
280.18 shall serve as ex officio members.

280.19 Subd. 3. **Duties.** The task force shall make recommendations, including proposed
280.20 legislation, and report to the legislative committees with jurisdiction over health and
280.21 human services policy and finance by November 15, 2011, on creating a system of
280.22 supports and services for people with disabilities by July 1, 2012, as governed by the
280.23 principles under subdivision 1. In making recommendations and proposed legislation, the
280.24 council shall work in conjunction with the Consumer-Directed Community Supports Task
280.25 Force and shall include self-directed planning, individual budgeting, choice of trusted
280.26 partner, self-directed purchasing of services and supports, reporting of outcomes, ability
280.27 to share in any savings, and any additional rules or laws that may need to be waived.
280.28 Recommendations from the task force shall be fully implemented by July 1, 2013.

280.29 Subd. 4. **Expense reimbursement.** The members of the task force shall not be
280.30 reimbursed for expenses related to the duties of the task force. The task force shall be
280.31 independently staffed and coordinated by nongovernmental appointees who serve on the
280.32 task force, and no state funding shall be appropriated for expenses related to the task
280.33 force under this section.

280.34 Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

ARTICLE 7

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;

282.1 (3) have a substantial number of children for whom determinations of maltreatment
282.2 have occurred;

282.3 (4) have capacity to respond to reports of abuse and neglect under section 626.556;
282.4 (5) provide a wide range of services to families in need of child welfare services; and
282.5 (6) have a tribal-state title IV-E agreement in effect.

282.6 (d) Grants awarded under this section may be used for the nonfederal costs of
282.7 providing child welfare services to American Indian children on the tribe's reservation,
282.8 including costs associated with:

282.9 (1) assessment and prevention of child abuse and neglect;
282.10 (2) family preservation;
282.11 (3) facilitative, supportive, and reunification services;
282.12 (4) out-of-home placement for children removed from the home for child protective
282.13 purposes; and
282.14 (5) other activities and services approved by the commissioner that further the goals
282.15 of providing safety, permanency, and well-being of American Indian children.

282.16 (e) When a tribe has initiated a project and has been approved by the commissioner
282.17 to assume child welfare responsibilities for American Indian children of that tribe under
282.18 this section, the affected county social service agency is relieved of responsibility for
282.19 responding to reports of abuse and neglect under section 626.556 for those children
282.20 during the time within which the tribal project is in effect and funded. The commissioner
282.21 shall work with tribes and affected counties to develop procedures for data collection,
282.22 evaluation, and clarification of ongoing role and financial responsibilities of the county
282.23 and tribe for child welfare services prior to initiation of the project. Children who have not
282.24 been identified by the tribe as participating in the project shall remain the responsibility
282.25 of the county. Nothing in this section shall alter responsibilities of the county for law
282.26 enforcement or court services.

282.27 (f) Participating tribes may conduct children's mental health screenings under section
282.28 245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the
282.29 initiative and living on the reservation and who meet one of the following criteria:

282.30 (1) the child must be receiving child protective services;
282.31 (2) the child must be in foster care; or
282.32 (3) the child's parents must have had parental rights suspended or terminated.

282.33 Tribes may access reimbursement from available state funds for conducting the screenings.
282.34 Nothing in this section shall alter responsibilities of the county for providing services
282.35 under section 245.487.

283.1 (g) Participating tribes may establish a local child mortality review panel. In
283.2 establishing a local child mortality review panel, the tribe agrees to conduct local child
283.3 mortality reviews for child deaths or near-fatalities occurring on the reservation under
283.4 subdivision 12. Tribes with established child mortality review panels shall have access
283.5 to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c)
283.6 to (e). The tribe shall provide written notice to the commissioner and affected counties
283.7 when a local child mortality review panel has been established and shall provide data upon
283.8 request of the commissioner for purposes of sharing nonpublic data with members of the
283.9 state child mortality review panel in connection to an individual case.

283.10 (h) The commissioner shall collect information on outcomes relating to child safety,
283.11 permanency, and well-being of American Indian children who are served in the projects.
283.12 Participating tribes must provide information to the state in a format and completeness
283.13 deemed acceptable by the state to meet state and federal reporting requirements.

283.14 (i) In consultation with the White Earth Band, the commissioner shall develop
283.15 and submit to the chairs and ranking minority members of the legislative committees
283.16 with jurisdiction over health and human services a plan to transfer legal responsibility
283.17 for providing child protective services to White Earth Band member children residing in
283.18 Hennepin County to the White Earth Band. The plan shall include a financing proposal,
283.19 definitions of key terms, statutory amendments required, and other provisions required to
283.20 implement the plan. The commissioner shall submit the plan by January 15, 2012.

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

283.23 Subd. 14c. **American Indian child welfare, social, and human services project;**
283.24 **White Earth Band of Ojibwe.** (a) The commissioner of human services shall enter into a
283.25 contractual agreement as authorized under subdivision 2, paragraph (a), clause (7), with
283.26 the White Earth Band of Ojibwe Indians for the tribe to provide all human services and
283.27 public assistance programs that are under the supervision of the commissioner to tribal
283.28 members who reside on the reservation. Grants may be issued to the White Earth Band
283.29 of Ojibwe Indians to support the project. The commissioner may waive existing rules to
283.30 support this project. The commissioner shall seek any federal approvals necessary to carry
283.31 out the project as well as seek and use any funds available to the commissioner, including
283.32 use of federal funds, foundation funds, existing grant funds, and other funds. The
283.33 commissioner is authorized to advance state funds as necessary to operate the projects.
283.34 Federal reimbursement applicable to the projects is appropriated to the commissioner for
283.35 purposes of the project.

284.1 (b) The commissioner shall redirect all funds provided to Mahnomen County for
284.2 these services, including administrative expenses, to the White Earth Band of Ojibwe
284.3 Indians.

284.4 (c) The commissioner, in consultation with the tribe, is authorized to determine: (1)
284.5 which programs not currently provided by the White Earth Band of Ojibwe Indians will be
284.6 transferred to the tribe; and (2) the process by which the new programs will be transferred.
284.7 In the case of a dispute, a two-thirds vote of the tribal council to transfer a program to
284.8 the tribe must overrule the decision of the commissioner.

284.9 (d) When the commissioner approves transfer of programs and the tribe assumes
284.10 responsibility under this section, Mahnomen County is relieved of responsibility for
284.11 providing program services to tribal members who live on the reservation while the tribal
284.12 project is in effect and funded. The commissioner shall seek and use any funds available,
284.13 including federal funds, foundation funds, existing grant funds, and other state funds as
284.14 available.

284.15 (e) The tribe shall comply with all reporting and record keeping requirements under
284.16 state and federal laws and rules.

284.17 Sec. 4. **[256.0145] COMPUTER SYSTEM SIMPLIFICATION.**

284.18 Subdivision 1. **Reprogram MAXIS.** The commissioner of human services, as part
284.19 of the enterprise architecture project, shall reprogram the MAXIS computer system to
284.20 automatically apply child support payments entered into the PRISM computer system to
284.21 a MAXIS case file.

284.22 Subd. 2. **Program the social service information system.** The commissioner of
284.23 human services shall require all prepaid health plans to accept a billing format identical to
284.24 the MMIS billing format for payment to county agencies for mental health targeted case
284.25 management claims, elderly waiver claims, and other claim categories as added to the
284.26 benefit set. The commissioner shall make any necessary changes to the SSIS system to
284.27 bill prepaid health plans for those claims.

284.28 Sec. 5. **[256.0147] COUNTY ELECTRONIC VERIFICATION TO DETERMINE**
284.29 **ELIGIBILITY.**

284.30 County agencies are authorized to use all automated databases containing
284.31 information regarding recipients' or applicants' income in order to determine eligibility
284.32 for child support enforcement, general assistance, Minnesota supplemental aid, and
284.33 programs, services, and supports under chapter 256J. The information is sufficient to
284.34 determine eligibility. State and county caseworkers shall not be cited in error, as part of

285.1 any audit and quality review, for an incorrect eligibility determination based on current but
285.2 inaccurate information received through a state-approved electronic data source. If there
285.3 is a potential error, the reviewer must forward a corrective action notice to the caseworker
285.4 for proper and immediate correction. If the state or county caseworker has data available
285.5 through client reporting, or other means, that are more accurate than state-approved
285.6 electronic data, the caseworker should use the more accurate information in making the
285.7 eligibility determination.

285.8 Sec. 6. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
285.9 to read:

285.10 Subd. 30. **Provision of required materials in alternative formats.** (a) For the
285.11 purposes of this subdivision, "alternative format" means a medium other than paper and
285.12 "prepaid health plan" means managed care plans and county-based purchasing plans.

285.13 (b) A prepaid health plan may provide in an alternative format a provider directory
285.14 and certificate of coverage, or materials otherwise required to be available in writing
285.15 under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's
285.16 contract with the prepaid health plan, if the following conditions are met:

285.17 (1) the prepaid health plan, local agency, or commissioner, as applicable, informs the
285.18 enrollee that:

285.19 (i) provision in an alternative format is available and the enrollee affirmatively
285.20 requests of the prepaid health plan that the provider directory, certificate of coverage,
285.21 or materials otherwise required under Code of Federal Regulations, title 42, section
285.22 438.10, or under the commissioner's contract with the prepaid health plan be provided in
285.23 an alternative format; and

285.24 (ii) a record of the enrollee request is retained by the prepaid health plan in the
285.25 form of written direction from the enrollee or a documented telephone call followed by a
285.26 confirmation letter to the enrollee from the prepaid health plan that explains that the
285.27 enrollee may change the request at any time;

285.28 (2) the materials are sent to a secured mailbox and are made available at a
285.29 password-protected secured Web site or on a data storage device if the materials contain
285.30 enrollee data that is individually identifiable;

285.31 (3) the enrollee is provided a customer service number on the enrollee's membership
285.32 card that may be called to request a paper version of the materials provided in an
285.33 alternative format; and

285.34 (4) the materials provided in an alternative format meet all other requirements of
285.35 the commissioner regarding content, size of typeface, and any required time frames for

286.1 distribution. "Required time frames for distribution" must permit sufficient time for
286.2 prepaid health plans to distribute materials in alternative formats upon receipt of enrollees'
286.3 requests for the materials.

286.4 (c) A prepaid health plan may provide in an alternative format its primary care
286.5 network list to the commissioner and to local agencies within its service area. The
286.6 commissioner or local agency, as applicable, shall inform a potential enrollee of the
286.7 availability of a prepaid health plan's primary care network list in an alternative format. If
286.8 the potential enrollee requests an alternative format of the prepaid health plan's primary
286.9 care network list, a record of that request shall be retained by the commissioner or local
286.10 agency. The potential enrollee is permitted to withdraw the request at any time.

286.11 The prepaid health plan shall submit sufficient paper versions of the primary
286.12 care network list to the commissioner and to local agencies within its service area to
286.13 accommodate potential enrollee requests for paper versions of the primary care network
286.14 list.

286.15 (d) A prepaid health plan may provide in an alternative format materials otherwise
286.16 required to be available in writing under Code of Federal Regulations, title 42, section
286.17 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions
286.18 of paragraphs (b), (c), and (e), are met for persons who are:

286.19 (1) enrolled in integrated Medicare and Medicaid programs under subdivisions
286.20 23 and 28;

286.21 (2) enrolled in managed care long-term care programs under subdivision 6b;

286.22 (3) dually eligible for Medicare and medical assistance; or

286.23 (4) in the waiting period for Medicare.

286.24 (e) The commissioner shall seek any federal Medicaid waivers within 90 days after
286.25 the effective date of this subdivision that are necessary to provide alternative formats of
286.26 required material to enrollees of prepaid health plans as authorized under this subdivision.

286.27 (f) The commissioner shall consult with managed care plans, county-based
286.28 purchasing plans, counties, and other interested parties to determine how materials
286.29 required to be made available to enrollees under Code of Federal Regulations, title 42,
286.30 section 438.10, or under the commissioner's contract with a prepaid health plan may
286.31 be provided in an alternative format on the basis that the enrollee has not opted in to
286.32 receive the alternative format. The commissioner shall consult with managed care
286.33 plans, county-based purchasing plans, counties, and other interested parties to develop
286.34 recommendations relating to the conditions that must be met for an opt-out process
286.35 to be granted.

287.1 Sec. 7. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:

287.2 Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or
287.3 family general assistance is paid to a recipient in excess of the payment due, it shall be
287.4 recoverable by the county agency. The agency shall give written notice to the recipient of
287.5 its intention to recover the overpayment.

287.6 (b) Except as provided for interim assistance in section 256D.06, subdivision
287.7 5, when an overpayment occurs, the county agency shall recover the overpayment
287.8 from a current recipient by reducing the amount of aid payable to the assistance unit of
287.9 which the recipient is a member, for one or more monthly assistance payments, until
287.10 the overpayment is repaid. All county agencies in the state shall reduce the assistance
287.11 payment by three percent of the assistance unit's standard of need in nonfraud cases and
287.12 ten percent where fraud has occurred, or the amount of the monthly payment, whichever is
287.13 less, for all overpayments.

287.14 (c) In cases when there is both an overpayment and underpayment, the county
287.15 agency shall offset one against the other in correcting the payment.

287.16 (d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
287.17 in addition to the aid reductions provided in this subdivision, to include further voluntary
287.18 reductions in the grant level agreed to in writing by the individual, until the total amount
287.19 of the overpayment is repaid.

287.20 (e) The county agency shall make reasonable efforts to recover overpayments to
287.21 persons no longer on assistance under standards adopted in rule by the commissioner
287.22 of human services. The county agency need not attempt to recover overpayments of
287.23 less than \$35 paid to an individual no longer on assistance if the individual does not
287.24 receive assistance again within three years, unless the individual has been convicted of
287.25 violating section 256.98.

287.26 (f) Establishment of an overpayment is limited to 12 months prior to the month of
287.27 discovery due to agency error and six years prior to the month of discovery due to client
287.28 error or an intentional program violation determined under section 256.046.

287.29 Sec. 8. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

287.30 Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When
287.31 the county agency determines that an overpayment of the recipient's monthly payment
287.32 of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment
287.33 to the recipient. If the person is no longer receiving Minnesota supplemental aid, the
287.34 county agency may request voluntary repayment or pursue civil recovery. If the person is
287.35 receiving Minnesota supplemental aid, the county agency shall recover the overpayment

by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date 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.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of ~~nursing homes, regional treatment centers, and~~ licensed residential facilities with negotiated rates shall not have overpayments recovered from their personal needs allowance.

Sec. 9. Minnesota Statutes 2010, section 256J.38, subdivision 1, is amended to read:

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

- (1) reconstruct each affected budget month and corresponding payment month;
- (2) use the policies and procedures that were in effect for the payment month; and
- (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) 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.

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

Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local social services agency shall establish and administer the food stamp program according to rules of the commissioner of human services, the supervision of the commissioner as specified in section 256.01, and all federal laws and regulations. The commissioner of human services shall monitor food stamp program delivery on an ongoing basis to ensure that each county complies with federal laws and regulations. Program requirements to be monitored include, but are not limited to, number of applications, number of approvals,

289.1 number of cases pending, length of time required to process each application and deliver
289.2 benefits, number of applicants eligible for expedited issuance, length of time required
289.3 to process and deliver expedited issuance, number of terminations and reasons for
289.4 terminations, client profiles by age, household composition and income level and sources,
289.5 and the use of phone certification and home visits. The commissioner shall determine the
289.6 county-by-county and statewide participation rate.

289.7 (b) On July 1 of each year, the commissioner of human services shall determine a
289.8 statewide and county-by-county food stamp program participation rate. The commissioner
289.9 may designate a different agency to administer the food stamp program in a county if the
289.10 agency administering the program fails to increase the food stamp program participation
289.11 rate among families or eligible individuals, or comply with all federal laws and regulations
289.12 governing the food stamp program. The commissioner shall review agency performance
289.13 annually to determine compliance with this paragraph.

289.14 (c) A person who commits any of the following acts has violated section 256.98 or
289.15 609.821, or both, and is subject to both the criminal and civil penalties provided under
289.16 those sections:

289.17 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
289.18 willful statement or misrepresentation, or intentional concealment of a material fact, food
289.19 stamps or vouchers issued according to sections 145.891 to 145.897 to which the person
289.20 is not entitled or in an amount greater than that to which that person is entitled or which
289.21 specify nutritional supplements to which that person is not entitled; or

289.22 (2) presents or causes to be presented, coupons or vouchers issued according to
289.23 sections 145.891 to 145.897 for payment or redemption knowing them to have been
289.24 received, transferred or used in a manner contrary to existing state or federal law; or

289.25 (3) willfully uses, possesses, or transfers food stamp coupons, authorization to
289.26 purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner
289.27 contrary to existing state or federal law, rules, or regulations; or

289.28 (4) buys or sells food stamp coupons, authorization to purchase cards, other
289.29 assistance transaction devices, vouchers issued according to sections 145.891 to 145.897,
289.30 or any food obtained through the redemption of vouchers issued according to sections
289.31 145.891 to 145.897 for cash or consideration other than eligible food.

289.32 (d) A peace officer or welfare fraud investigator may confiscate food stamps,
289.33 authorization to purchase cards, or other assistance transaction devices found in the
289.34 possession of any person who is neither a recipient of the food stamp program nor
289.35 otherwise authorized to possess and use such materials. Confiscated property shall be
289.36 disposed of as the commissioner may direct and consistent with state and federal food

290.1 stamp law. The confiscated property must be retained for a period of not less than 30 days
290.2 to allow any affected person to appeal the confiscation under section 256.045.

290.3 ~~(e) Food stamp overpayment claims which are due in whole or in part to client error~~
290.4 ~~shall be established by the county agency for a period of six years from the date of any~~
290.5 ~~resultant overpayment~~ Establishment of an overpayment is limited to 12 months prior to
290.6 the month of discovery due to agency error and six years prior to the month of discovery
290.7 due to client error or an intentional program violation determined under section 256.046.

290.8 (f) With regard to the federal tax revenue offset program only, recovery incentives
290.9 authorized by the federal food and consumer service shall be retained at the rate of 50
290.10 percent by the state agency and 50 percent by the certifying county agency.

290.11 (g) A peace officer, welfare fraud investigator, federal law enforcement official,
290.12 or the commissioner of health may confiscate vouchers found in the possession of any
290.13 person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise
290.14 authorized to possess and use such vouchers. Confiscated property shall be disposed of
290.15 as the commissioner of health may direct and consistent with state and federal law. The
290.16 confiscated property must be retained for a period of not less than 30 days.

290.17 (h) The commissioner of human services may seek a waiver from the United States
290.18 Department of Agriculture to allow the state to specify foods that may and may not be
290.19 purchased in Minnesota with benefits funded by the federal Food Stamp Program. The
290.20 commissioner shall consult with the members of the house of representatives and senate
290.21 policy committees having jurisdiction over food support issues in developing the waiver.
290.22 The commissioner, in consultation with the commissioners of health and education, shall
290.23 develop a broad public health policy related to improved nutrition and health status. The
290.24 commissioner must seek legislative approval prior to implementing the waiver.

290.25 Sec. 11. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

290.26 Subd. 4. **Essential human services or essential services.** "Essential human
290.27 services" or "essential services" means assistance and services to recipients or potential
290.28 recipients of public welfare and other services delivered by counties or tribes that are
290.29 mandated in federal and state law that are to be available in all counties of the state.

290.30 Sec. 12. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

290.31 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
290.32 county, or group consortium of counties operating by execution of a joint powers
290.33 agreement under section 471.59 or other contractual agreement, that has voluntarily
290.34 chosen by resolution of the county board of commissioners to participate in the redesign

291.1 under this chapter or has been assigned by the commissioner pursuant to section 402A.18.
291.2 A service delivery authority includes an Indian tribe or group of tribes that have voluntarily
291.3 chosen by resolution of tribal government to participate in redesign under this chapter.

291.4 Sec. 13. Minnesota Statutes 2010, section 402A.15, is amended to read:

291.5 **402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME**
291.6 **REFORMS.**

291.7 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome
291.8 Reforms shall develop a uniform process to establish and review performance and outcome
291.9 standards for all essential human services based on the current level of resources available,
291.10 and ~~to~~ shall develop appropriate reporting measures and a uniform accountability process
291.11 for responding to a county's or ~~human~~ service delivery authority's failure to make adequate
291.12 progress on achieving performance measures. The accountability process shall focus on
291.13 the performance measures rather than inflexible implementation requirements.

291.14 (b) The steering committee shall:

291.15 (1) by November 1, 2009, establish an agreed-upon list of essential services;

291.16 (2) by February 15, 2010, develop and recommend to the legislature a uniform,
291.17 graduated process, in addition to the remedies identified in section 402A.18, for responding
291.18 to a county's failure to make adequate progress on achieving performance measures; and

291.19 (3) by December 15, 2012, for each essential service, make recommendations
291.20 to the legislature regarding ~~(1)~~ (i) performance measures and goals based on those
291.21 measures for each essential service, ~~(2)~~ and (ii) a system for reporting on the performance
291.22 measures and goals, ~~and (3) appropriate resources, including funding, needed to achieve~~
291.23 ~~those performance measures and goals. The resource recommendations shall take into~~
291.24 ~~consideration program demand and the unique differences of local areas in geography and~~
291.25 ~~the populations served. Priority shall be given to services with the greatest variation in~~
291.26 ~~availability and greatest administrative demands.~~ By January 15 of each year starting
291.27 January 15, 2011, the steering committee shall report its recommendations to the governor
291.28 and legislative committees with jurisdiction over health and human services. As part of its
291.29 report, the steering committee shall, as appropriate, recommend statutory provisions, rules
291.30 and requirements, and reports that should be repealed or eliminated.

291.31 (c) As far as possible, the performance measures, reporting system, and funding
291.32 shall be consistent across program areas. The development of performance measures shall
291.33 consider the manner in which data will be collected and performance will be reported.
291.34 The steering committee shall consider state and local administrative costs related to
291.35 collecting data and reporting outcomes when developing performance measures. ~~The~~

292.1 ~~steering committee shall correlate the performance measures and goals to available levels~~
292.2 ~~of resources, including state and local funding. The steering committee shall also identify~~
292.3 ~~and incorporate federal performance measures in its recommendations for those program~~
292.4 ~~areas where federal funding is contingent on meeting federal performance standards. The~~
292.5 steering committee shall take into consideration that the goal of implementing changes
292.6 to program monitoring and reporting the progress toward achieving outcomes is to
292.7 significantly minimize the cost of administrative requirements and to allow funds freed
292.8 by reduced administrative expenditures to be used to provide additional services, allow
292.9 flexibility in service design and management, and focus energies on achieving program
292.10 and client outcomes.

292.11 (d) In making its recommendations, the steering committee shall consider input from
292.12 the council established in section 402A.20. ~~The steering committee shall review the~~
292.13 ~~measurable goals established in a memorandum of understanding entered into under~~
292.14 ~~section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied~~
292.15 ~~as statewide performance outcomes.~~

292.16 (e) The steering committee shall form work groups that include persons who provide
292.17 or receive essential services and representatives of organizations who advocate on behalf
292.18 of those persons.

292.19 (f) By December 15, 2009, the steering committee shall establish a three-year
292.20 schedule for completion of its work. The schedule shall be published on the Department of
292.21 Human Services Web site and reported to the legislative committees with jurisdiction over
292.22 health and human services. In addition, the commissioner shall post quarterly updates on
292.23 the progress of the steering committee on the Department of Human Services Web site.

292.24 Subd. 2. **Composition.** (a) The steering committee shall include:

292.25 (1) the commissioner of human services, or designee, and two additional
292.26 representatives of the department;

292.27 (2) two county commissioners, representative of rural and urban counties, selected
292.28 by the Association of Minnesota Counties;

292.29 (3) two county directors of human services, representative of rural and urban
292.30 counties, selected by the Minnesota Association of County Social Service Administrators;
292.31 and

292.32 (4) three clients or client advocates representing different populations receiving
292.33 services from the Department of Human Services, who are appointed by the commissioner.

292.34 (b) The commissioner, or designee, and a county commissioner shall serve as
292.35 cochair of the committee. The committee shall be convened within 60 days of May
292.36 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. 14. 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;

294.1 (2) mandatory incorporation of the administration and operation of ~~the specific~~
294.2 essential ~~service~~ services with an existing service delivery authority or another county.

294.3 A service delivery authority or county incorporating an underperforming county shall
294.4 not be financially liable for the costs associated with remedying performance outcome
294.5 deficiencies; or

294.6 (3) transfer of authority for program administration and operation of ~~the specific~~
294.7 essential ~~service~~ services to the commissioner.

294.8 Subd. 2a. **Financial responsibility of underperforming county.** A county subject
294.9 to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of
294.10 the essential service or essential services the amount of nonfederal and nonstate funding
294.11 needed to remedy performance outcome deficiencies.

294.12 Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may
294.13 impose the remedies authorized under this section, the following conditions must be met:

294.14 (1) the county or service delivery authority determined by the commissioner
294.15 to be deficient in achieving minimum performance outcomes has the opportunity, in
294.16 coordination with the council, to develop a program outcome improvement plan. The
294.17 program outcome improvement plan must be developed no later than six months from the
294.18 date of the deficiency determination; and

294.19 (2) the council has conducted an assessment of the program outcome improvement
294.20 plan to determine if the county or service delivery authority has made satisfactory
294.21 progress toward performance outcomes and has made a recommendation about remedies
294.22 to the commissioner. The ~~review~~ assessment and recommendation must be made to the
294.23 commissioner within 12 months from the date of the deficiency determination.

294.24 Sec. 15. Minnesota Statutes 2010, section 402A.20, is amended to read:

294.25 **402A.20 COUNCIL.**

294.26 Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service
294.27 Delivery Redesign Council is established. Appointed council members must be appointed
294.28 by their respective agencies, associations, or governmental units by November 1, 2009.
294.29 The council shall be cochaired by the commissioner of human services, or designee, and a
294.30 county representative from paragraph (b), clause (4) or (5), appointed by the Association
294.31 of Minnesota Counties. Recommendations of the council must be approved by a majority
294.32 of the voting council members. The provisions of section 15.059 do not apply to this
294.33 council, and this council does not expire.

294.34 (b) The council must consist of the following members:

295.1 (1) two legislators appointed by the speaker of the house, one from the minority
295.2 and one from the majority;

295.3 (2) two legislators appointed by the Senate Rules Committee, one from the majority
295.4 and one from the minority;

295.5 (3) the commissioner of human services, or designee, and three employees from
295.6 the department;

295.7 (4) two county commissioners appointed by the Association of Minnesota Counties;

295.8 (5) two county representatives appointed by the Minnesota Association of County
295.9 Social Service Administrators;

295.10 (6) one representative appointed by AFSCME as a nonvoting member; and

295.11 (7) one representative appointed by the Teamsters as a nonvoting member.

295.12 (c) Administrative support to the council may be provided by the Association of
295.13 Minnesota Counties and affiliates.

295.14 (d) Member agencies and associations are responsible for initial and subsequent
295.15 appointments to the council.

295.16 Subd. 2. **Council duties.** The council shall:

295.17 (1) provide review of the service delivery redesign process, including proposed
295.18 memoranda of understanding to establish a service delivery authority to conduct and
295.19 administer experimental projects to test new methods and procedures of delivering
295.20 services;

295.21 ~~(2) certify, in accordance with section 402A.30, subdivision 4, the formation of~~
295.22 ~~a service delivery authority, including the memorandum of understanding in section~~
295.23 ~~402A.30, subdivision 2, paragraph (b);~~

295.24 ~~(3) ensure the consistency of the memorandum of understanding entered into~~
295.25 ~~under section 402A.30, subdivision 2, paragraph (b), with the performance standards~~
295.26 ~~recommended by the steering committee and enacted by the legislature;~~

295.27 ~~(4)~~ (2) ensure the consistency of the memorandum of understanding, to the extent
295.28 appropriate, ~~or~~ with other memorandum of understanding entered into by other service
295.29 delivery authorities;

295.30 (3) review and make recommendations on applications from a service delivery
295.31 authority for waivers of statutory or rule program requirements that are needed for
295.32 flexibility to determine the most cost-effective means of achieving specified measurable
295.33 goals in a redesign of human services delivery;

295.34 ~~(5)~~ (4) establish a process to take public input on the ~~service delivery framework~~
295.35 ~~specified in the memorandum of understanding in section 402A.30, subdivision 2,~~

296.1 ~~paragraph (b)~~ scope of essential services over which a service delivery authority has
296.2 jurisdiction;

296.3 ~~(6)~~ (5) form work groups as necessary to carry out the duties of the council under the
296.4 redesign;

296.5 ~~(7)~~ (6) serve as a forum for resolving conflicts among participating counties and
296.6 tribes or between participating counties or tribes and the commissioner of human services,
296.7 provided nothing in this section is intended to create a formal binding legal process;

296.8 ~~(8)~~ (7) engage in the program improvement process established in section 402A.18,
296.9 subdivision 3; and

296.10 ~~(9)~~ (8) identify and recommend incentives for counties and tribes to participate in
296.11 ~~human services~~ service delivery authorities.

296.12 Subd. 3. **Program evaluation.** By December 15, 2014, the council shall request
296.13 consideration by the legislative auditor for a reevaluation under section 3.971, subdivision
296.14 7, of those aspects of the program evaluation of human services administration reported
296.15 in January 2007 affected by this chapter.

296.16 Sec. 16. **[402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

296.17 Subdivision 1. **Requirements for establishing a service delivery authority.**

296.18 (a) A county, tribe, or consortium of counties is eligible to establish a service delivery
296.19 authority if:

296.20 (1) the county, tribe, or consortium of counties is:

296.21 (i) a single county with a population of 55,000 or more;

296.22 (ii) a consortium of counties with a total combined population of 55,000 or more;

296.23 (iii) a consortium of four or more counties in reasonable geographic proximity
296.24 without regard to population; or

296.25 (iv) one or more tribes with a total combined population of 25,000 or more.

296.26 The council may recommend that the commissioner of human services exempt a
296.27 single county, tribe, or consortium of counties from the minimum population standard if
296.28 the county, tribe, or consortium of counties can demonstrate that it can otherwise meet
296.29 the requirements of this chapter.

296.30 (b) A service delivery authority shall:

296.31 (1) comply with current state and federal law, including any existing federal or state
296.32 performance measures and performance measures under section 402A.15 when they are
296.33 enacted into law, except where waivers are approved by the commissioner. Nothing
296.34 in this subdivision requires the establishment of performance measures under section

297.1 402A.15 prior to a service delivery authority participating in the service delivery redesign
297.2 under this chapter;

297.3 (2) define the scope of essential services over which the service delivery authority
297.4 has jurisdiction;

297.5 (3) designate a single administrative structure to oversee the delivery of those
297.6 services included in a proposal for a redesigned service or services and identify a single
297.7 administrative agent for purposes of contact and communication with the department;

297.8 (4) identify the waivers from statutory or rule program requirements that are needed
297.9 to ensure greater local control and flexibility to determine the most cost-effective means of
297.10 achieving specified measurable goals that the participating service delivery authority is
297.11 expected to achieve;

297.12 (5) set forth a reasonable level of targeted reductions in overhead and administrative
297.13 costs for each service delivery authority participating in the service delivery redesign; and

297.14 (6) set forth the terms under which a county, tribe, or consortium of counties may
297.15 withdraw from participation.

297.16 (c) Once a county, tribe, or consortium of counties establishes a service delivery
297.17 authority, no county, tribe, or consortium of counties that is a member of the service
297.18 delivery authority may participate as a member of any other service delivery authority.
297.19 The service delivery authority may allow an additional county, a tribe, or a consortium of
297.20 counties to join the service delivery authority subject to the approval of the council and
297.21 the commissioner.

297.22 (d) Nothing in this chapter precludes local governments from using sections 465.81
297.23 and 465.82 to establish procedures for local governments to merge, with the consent
297.24 of the voters. Nothing in this chapter limits the authority of a county board or tribal
297.25 council to enter into contractual agreements for services not covered by the provisions
297.26 of a memorandum of understanding establishing a service delivery authority with other
297.27 agencies or with other units of government.

297.28 Subd. 2. **Relief from statutory requirements.** (a) Unless otherwise identified in
297.29 the memorandum of understanding, any county, tribe, or consortium of counties forming a
297.30 service delivery authority is exempt from the provisions of sections 245.465; 245.4835;
297.31 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph
297.32 (b); and 256M.30.

297.33 (b) This subdivision does not preclude any county, tribe, or consortium of counties
297.34 forming a service delivery authority from requesting additional waivers from statutory and
297.35 rule requirements to ensure greater local control and flexibility.

297.36 Subd. 3. **Duties.** The service delivery authority shall:

298.1 (1) within the scope of essential services set forth in the memorandum of
298.2 understanding establishing the authority, carry out the responsibilities required of local
298.3 agencies under chapter 393 and human services boards under chapter 402;
298.4 (2) manage the public resources devoted to human services and other public services
298.5 delivered or purchased by the counties or tribes that are subsidized or regulated by the
298.6 Department of Human Services under chapters 245 to 261;
298.7 (3) employ staff to assist in carrying out its duties;
298.8 (4) develop and maintain a continuity of operations plan to ensure the continued
298.9 operation or resumption of essential human services functions in the event of any business
298.10 interruption according to local, state, and federal emergency planning requirements;
298.11 (5) receive and expend funds received for the redesign process under the
298.12 memorandum of understanding;
298.13 (6) plan and deliver services directly or through contract with other governmental,
298.14 tribal, or nongovernmental providers;
298.15 (7) rent, purchase, sell, and otherwise dispose of real and personal property as
298.16 necessary to carry out the redesign; and
298.17 (8) carry out any other service designated as a responsibility of a county.
298.18 Subd. 4. **Process for establishing a service delivery authority.** (a) The county,
298.19 tribe, or consortium of counties meeting the requirements of section 402A.30 and
298.20 proposing to establish a service delivery authority shall present to the council:
298.21 (1) in conjunction with the commissioner, a proposed memorandum of understanding
298.22 meeting the requirements of subdivision 1, paragraph (b), and outlining:
298.23 (i) the details of the proposal;
298.24 (ii) the state, tribal, and local resources, which may include, but are not limited to,
298.25 funding, administrative and technology support, and other requirements necessary for
298.26 the service delivery authority; and
298.27 (iii) the relief available to the service delivery authority if the resource commitments
298.28 identified in item (ii) are not met; and
298.29 (2) a board resolution from the board of commissioners of each participating county
298.30 stating the county's intent to participate, or in the case of a tribe, a resolution from tribal
298.31 government, stating the tribe's intent to participate.
298.32 (b) After the council has considered and recommended approval of a proposed
298.33 memorandum of understanding, the commissioner may finalize and execute the
298.34 memorandum of understanding.
298.35 Subd. 5. **Commissioner authority to seek waivers.** The commissioner may use the
298.36 authority under section 256.01, subdivision 2, paragraph (1), to grant waivers identified as

299.1 part of a proposed service delivery authority under subdivision 1, paragraph (b), clause
299.2 (4), except that waivers granted under this section must be approved by the council under
299.3 section 402A.20 rather than the Legislative Advisory Committee.

299.4 Sec. 17. **ALIGNMENT OF VERIFICATION AND REDETERMINATION**
299.5 **POLICIES.**

299.6 The commissioner of human services shall develop recommendations to align
299.7 eligibility verification procedures for all health care, economic assistance, food support,
299.8 child support enforcement, and child care programs. The commissioner shall report back
299.9 to the chairs of the legislative committees with jurisdiction over these issues by January
299.10 15, 2012, with recommendations and draft legislation to implement the alignment of
299.11 eligibility verifications.

299.12 Sec. 18. **ALTERNATIVE STRATEGIES FOR CERTAIN**
299.13 **REDETERMINATIONS.**

299.14 The commissioner of human services shall develop and implement by January 15,
299.15 2012, a simplified process to redetermine eligibility for recipient populations in the medical
299.16 assistance, Minnesota supplemental aid, food support, and group residential housing
299.17 programs who are eligible based upon disability, age, or chronic medical conditions, and
299.18 who are expected to experience minimal change in income or assets from month to month.
299.19 The commissioner shall apply for any federal waivers needed to implement this section.

299.20 Sec. 19. **SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT**
299.21 **PROCESS.**

299.22 Subdivision 1. **Request for proposal.** (a) The commissioner of human services
299.23 shall issue a request for proposals for a contract to create an implementation plan for
299.24 an integrated service delivery framework including, at a minimum, all service delivery
299.25 components specified in paragraph (f). The implementation plan shall include proposed
299.26 implementation phasing with implementation timelines, estimated costs and savings
299.27 associated with each implementation phase, tasks related to obtaining federal financial
299.28 participation, and a draft of the first implementation request for proposals that will be
299.29 issued. The first implementation request for proposals shall be for implementation of a
299.30 phased-in integrated online eligibility and application portal for health care programs,
299.31 food support, cash assistance, and child care. The implementation request for proposals
299.32 may incorporate a performance-based vendor financing option in which the vendor shares
299.33 the risk of the project's success. The health care portal must be developed in phases with

300.1 the capacity to integrate food support, cash assistance, and child care programs as funds
300.2 are available. The request for proposals must require that the system recommended and
300.3 implemented by the contractor:

300.4 (1) streamline eligibility determinations and case processing to support statewide
300.5 eligibility processing. Responses to the request for proposals must specify components of
300.6 the service delivery framework the proposal addresses and the expected administrative
300.7 savings;

300.8 (2) enable interested persons to determine eligibility for each program, and to apply
300.9 for programs online in a manner that the applicant will be asked only those questions
300.10 relevant to the programs for which the person is applying;

300.11 (3) leverage technology that has been operational in other state environments with
300.12 similar requirements; and

300.13 (4) include Web-based application, worker application processing support, and the
300.14 opportunity for expansion. Responses to the request for proposals must indicate how
300.15 future expansion can include remaining service delivery components as specified in
300.16 paragraph (f).

300.17 (b) The commissioner shall issue a final report, including the implementation
300.18 plan and first implementation request for proposals, to the chairs and ranking minority
300.19 members of the legislative committees with jurisdiction over health and human services
300.20 no later than April 30, 2012.

300.21 (c) The commissioner shall partner with counties, a service delivery authority
300.22 established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology,
300.23 other state agencies, and service partners to develop an integrated service delivery
300.24 framework which will simplify and streamline human services eligibility and enrollment
300.25 processes. The primary objectives for the simplification effort include significantly
300.26 improved eligibility processing productivity resulting in reduced time for eligibility
300.27 determination and enrollment, increased customer service for applicants and recipients of
300.28 services, increased program integrity, and greater administrative flexibility.

300.29 (d) The commissioner shall develop a service-oriented business architecture
300.30 for a fully automated medical, cash support, food support, and child care eligibility
300.31 and enrollment process that aligns with, and supports, the business processes. The
300.32 commissioner shall use the eligibility and enrollment business architecture to create an
300.33 integrated and collaborative service delivery framework for evolving or maintaining
300.34 existing information technology and acquiring new information technology. The agency's
300.35 plan and program for creating the business architecture and integrated service delivery
300.36 framework shall include counties, service delivery authorities, collaborative partners,

301.1 the Office of Enterprise Technology, and end-users in the delivery of human services.

301.2 An Enterprise Architecture Board shall govern these efforts and shall be chaired by the
301.3 commissioner.

301.4 (e) The commissioner will ensure agency compliance with the prompt, efficient, and
301.5 effective implementation of these governance provisions and specific service delivery
301.6 components. The commissioner, along with a county representative appointed by the
301.7 Association of Minnesota Counties, shall report specific implementation progress to the
301.8 legislature every six months beginning January 15, 2012.

301.9 (f) The commissioner shall work with the Minnesota Association of County Social
301.10 Service Administrators and the Office of Enterprise Technology to develop collaborative
301.11 task forces, as necessary, to support implementation of these service delivery components.
301.12 The commissioner must develop and include, as part of the integrated eligibility and
301.13 enrollment service delivery framework, the following:

301.14 (1) screening tools for applicants to determine potential eligibility as part of an
301.15 online application process;

301.16 (2) the capacity to use databases to electronically verify application and renewal
301.17 data as required by law;

301.18 (3) online accounts accessible by applicants, enrollees, and third parties acting on
301.19 behalf of applicants and enrollees. At a minimum, online accounts must contain date of
301.20 application, application data, status of eligibility determination, premium and spenddown
301.21 amounts and due dates, recertification dates, required verifications, and supplemental
301.22 information. These accounts must be a component of a self-service Web site that includes
301.23 the capacity for online application and renewal;

301.24 (4) recertification forms prepopulated with name, case number, eligibility data,
301.25 and a bar code for use statewide;

301.26 (5) an Interactive Voice Response system, available statewide, that provides case
301.27 information for applicants, enrollees, and authorized third parties;

301.28 (6) a statewide electronic document management system that provides seamless
301.29 electronic transfer of all documents required for eligibility and enrollment processes. All
301.30 entities processing eligibility and enrollment within the state shall use the electronic
301.31 document management system to accept and transfer any eligibility and enrollment
301.32 documents. Processing entities include the state, counties, service delivery authorities
301.33 established under Minnesota Statutes, chapter 402A, and authorized third parties.

301.34 The electronic document management system must interface with existing document
301.35 management systems and automated eligibility systems. Agency produced documents will
301.36 contain bar codes that must be used by all eligibility processing entities; and

302.1 (7) a centralized customer contact center that applicants, enrollees, and authorized
302.2 third parties can use statewide to receive program information, application assistance, and
302.3 case information; to report changes; to make cost-sharing payments; and conduct other
302.4 eligibility and enrollment transactions.

302.5 (g) All provisions in paragraph (f) must be fully integrated as part of any automated
302.6 eligibility systems. The commissioner must seek federal financial participation to fund
302.7 system development.

302.8 Subd. 2. **Appropriation.** \$200,000 is appropriated to the commissioner from the
302.9 general fund for implementation of this section.

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

302.11 Sec. 20. **REPEALER.**

302.12 (a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.

302.13 (b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

302.14 **ARTICLE 8**

302.15 **CHEMICAL AND MENTAL HEALTH**

302.16 Section 1. Minnesota Statutes 2010, section 245.50, is amended to read:

302.17 **245.50 INTERSTATE CONTRACTS, MENTAL HEALTH, CHEMICAL**
302.18 **HEALTH, DETOXIFICATION SERVICES.**

302.19 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
302.20 the meanings given them.

302.21 (a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

302.22 (b) "Receiving agency" means a public or private hospital, mental health center,
302.23 chemical health treatment facility, detoxification facility, or other person or organization
302.24 which provides mental health ~~or~~, chemical health, or detoxification services under this
302.25 section to individuals from a state other than the state in which the agency is located.

302.26 (c) "Receiving state" means the state in which a receiving agency is located.

302.27 (d) "Sending agency" means a state or county agency which sends an individual to a
302.28 bordering state for treatment or detoxification under this section.

302.29 (e) "Sending state" means the state in which the sending agency is located.

302.30 Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable
302.31 appropriate treatment or detoxification services to be provided to individuals, across state
302.32 lines from the individual's state of residence, in qualified facilities that are closer to the
302.33 homes of individuals than are facilities available in the individual's home state.

303.1 (b) Unless prohibited by another law and subject to the exceptions listed in
303.2 subdivision 3, a county board or the commissioner of human services may contract
303.3 with an agency or facility in a bordering state for mental health ~~or~~, chemical health, or
303.4 detoxification services for residents of Minnesota, and a Minnesota mental health ~~or~~,
303.5 chemical health, or detoxification agency or facility may contract to provide services to
303.6 residents of bordering states. Except as provided in subdivision 5, a person who receives
303.7 services in another state under this section is subject to the laws of the state in which
303.8 services are provided. A person who will receive services in another state under this
303.9 section must be informed of the consequences of receiving services in another state,
303.10 including the implications of the differences in state laws, to the extent the individual will
303.11 be subject to the laws of the receiving state.

303.12 Subd. 3. **Exceptions.** A contract may not be entered into under this section for
303.13 services to persons who:

- 303.14 (1) are serving a sentence after conviction of a criminal offense;
303.15 (2) are on probation or parole;
303.16 (3) are the subject of a presentence investigation; or
303.17 (4) have been committed involuntarily in Minnesota under chapter 253B for
303.18 treatment of mental illness or chemical dependency, except as provided under subdivision
303.19 5.

303.20 Subd. 4. **Contracts.** Contracts entered into under this section must, at a minimum:

- 303.21 (1) describe the services to be provided;
303.22 (2) establish responsibility for the costs of services;
303.23 (3) establish responsibility for the costs of transporting individuals receiving
303.24 services under this section;
303.25 (4) specify the duration of the contract;
303.26 (5) specify the means of terminating the contract;
303.27 (6) specify the terms and conditions for refusal to admit or retain an individual; and
303.28 (7) identify the goals to be accomplished by the placement of an individual under
303.29 this section.

303.30 Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained,
303.31 committed, or placed on an involuntary basis under chapter 253B may be confined or
303.32 treated in a bordering state pursuant to a contract under this section. An individual
303.33 who is detained, committed, or placed on an involuntary basis under the civil law of a
303.34 bordering state may be confined or treated in Minnesota pursuant to a contract under
303.35 this section. A peace or health officer who is acting under the authority of the sending
303.36 state may transport an individual to a receiving agency that provides services pursuant to

304.1 a contract under this section and may transport the individual back to the sending state
304.2 under the laws of the sending state. Court orders valid under the law of the sending state
304.3 are granted recognition and reciprocity in the receiving state for individuals covered by
304.4 a contract under this section to the extent that the court orders relate to confinement for
304.5 treatment or care of mental illness ~~or~~, chemical dependency, or detoxification. Such
304.6 treatment or care may address other conditions that may be co-occurring with the mental
304.7 illness or chemical dependency. These court orders are not subject to legal challenge in
304.8 the courts of the receiving state. Individuals who are detained, committed, or placed under
304.9 the law of a sending state and who are transferred to a receiving state under this section
304.10 continue to be in the legal custody of the authority responsible for them under the law
304.11 of the sending state. Except in emergencies, those individuals may not be transferred,
304.12 removed, or furloughed from a receiving agency without the specific approval of the
304.13 authority responsible for them under the law of the sending state.

304.14 (b) While in the receiving state pursuant to a contract under this section, an
304.15 individual shall be subject to the sending state's laws and rules relating to length of
304.16 confinement, reexaminations, and extensions of confinement. No individual may be sent
304.17 to another state pursuant to a contract under this section until the receiving state has
304.18 enacted a law recognizing the validity and applicability of this section.

304.19 (c) If an individual receiving services pursuant to a contract under this section leaves
304.20 the receiving agency without permission and the individual is subject to involuntary
304.21 confinement under the law of the sending state, the receiving agency shall use all
304.22 reasonable means to return the individual to the receiving agency. The receiving agency
304.23 shall immediately report the absence to the sending agency. The receiving state has the
304.24 primary responsibility for, and the authority to direct, the return of these individuals
304.25 within its borders and is liable for the cost of the action to the extent that it would be
304.26 liable for costs of its own resident.

304.27 (d) Responsibility for payment for the cost of care remains with the sending agency.

304.28 (e) This subdivision also applies to county contracts under subdivision 2 which
304.29 include emergency care and treatment provided to a county resident in a bordering state.

304.30 (f) If a Minnesota resident is admitted to a facility in a bordering state under this
304.31 chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or
304.32 an advance practice registered nurse certified in mental health, who is licensed in the
304.33 bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092,
304.34 253B.12, and 253B.17 subject to the same requirements and limitations in section
304.35 253B.02, subdivision 7. Such examiner may initiate an emergency hold under section
304.36 253B.05 on a Minnesota resident who is in a hospital that is under contract with a

305.1 Minnesota governmental entity under this section provided the resident, in the opinion of
305.2 the examiner, meets the criteria in section 253B.05.

305.3 (g) This section shall apply to detoxification services that are unrelated to treatment
305.4 whether the services are provided on a voluntary or involuntary basis.

305.5 Sec. 2. Minnesota Statutes 2010, section 246B.10, is amended to read:

305.6 **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

305.7 The civilly committed sex offender's county shall pay to the state a portion of the
305.8 cost of care provided in the Minnesota sex offender program to a civilly committed sex
305.9 offender who has legally settled in that county. A county's payment must be made from
305.10 the county's own sources of revenue and payments must equal ~~ten~~ 25 percent of the cost of
305.11 care, as determined by the commissioner, for each day or portion of a day, that the civilly
305.12 committed sex offender spends at the facility. If payments received by the state under this
305.13 chapter exceed ~~90~~ 75 percent of the cost of care, the county is responsible for paying the
305.14 state the remaining amount. The county is not entitled to reimbursement from the civilly
305.15 committed sex offender, the civilly committed sex offender's estate, or from the civilly
305.16 committed sex offender's relatives, except as provided in section 246B.07.

305.17 **EFFECTIVE DATE.** This section is effective for all individuals who are civilly
305.18 committed to the Minnesota sex offender program on or after August 1, 2011.

305.19 Sec. 3. Minnesota Statutes 2010, section 252.025, subdivision 7, is amended to read:

305.20 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
305.21 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who
305.22 have developmental disabilities and exhibit severe behaviors which present a risk to
305.23 public safety. This program is statewide and must provide specialized residential services
305.24 in Cambridge and an array of community-based services with sufficient levels of care
305.25 and a sufficient number of specialists to ensure that individuals referred to the program
305.26 receive the appropriate care. The individuals working in the community-based services
305.27 under this section are state employees supervised by the commissioner of human services.
305.28 No midcontract layoffs shall occur as a result of restructuring under this section, but
305.29 layoffs may occur as a normal consequence of a low census or closure of the facility
305.30 due to decreased census.

Sec. 4. Minnesota Statutes 2010, section 253B.212, is amended to read:

**253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS;
WHITE EARTH BAND OF OJIBWE.**

Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake Band of Chippewa Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the Red Lake Band of Chippewa Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service may not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

Subd. 1a. **Cost of care; commitment by tribal court order; White Earth Band of Ojibwe Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the White Earth Band of Ojibwe Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The tribe may also contract directly with the commissioner for treatment of those members of the White Earth Band who have been committed by tribal court order to the White Earth Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and the White Earth Band shall not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

Subd. 2. **Effect given to tribal commitment order.** When, under an agreement entered into pursuant to ~~subdivision 1~~ subdivisions 1 or 1a, the Indian Health Service applies to a regional center for admission of a person committed to the jurisdiction of the health service by the tribal court as a person who is mentally ill, developmentally disabled, or chemically dependent, the commissioner may treat the patient with the consent of the Indian Health Service.

A person admitted to a regional center pursuant to this section has all the rights accorded by section 253B.03. In addition, treatment reports, prepared in accordance with the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health Service within 60 days of commencement of the patient's stay at the facility. A subsequent

307.1 treatment report shall be filed with the Indian Health Service within six months of the
307.2 patient's admission to the facility or prior to discharge, whichever comes first. Provisional
307.3 discharge or transfer of the patient may be authorized by the head of the treatment facility
307.4 only with the consent of the Indian Health Service. Discharge from the facility to the
307.5 Indian Health Service may be authorized by the head of the treatment facility after notice
307.6 to and consultation with the Indian Health Service.

307.7 Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 1, is amended to read:

307.8 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
307.9 dependency services to persons residing within its jurisdiction who meet criteria
307.10 established by the commissioner for placement in a chemical dependency residential
307.11 or nonresidential treatment service subject to the limitations on residential chemical
307.12 dependency treatment in section 254B.04, subdivision 1. Chemical dependency money
307.13 must be administered by the local agencies according to law and rules adopted by the
307.14 commissioner under sections 14.001 to 14.69.

307.15 (b) In order to contain costs, the commissioner of human services shall select eligible
307.16 vendors of chemical dependency services who can provide economical and appropriate
307.17 treatment. Unless the local agency is a social services department directly administered by
307.18 a county or human services board, the local agency shall not be an eligible vendor under
307.19 section 254B.05. The commissioner may approve proposals from county boards to provide
307.20 services in an economical manner or to control utilization, with safeguards to ensure that
307.21 necessary services are provided. If a county implements a demonstration or experimental
307.22 medical services funding plan, the commissioner shall transfer the money as appropriate.

307.23 (c) A culturally specific vendor that provides assessments under a variance under
307.24 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
307.25 persons not covered by the variance.

307.26 Sec. 6. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

307.27 Subd. 4. **Division of costs.** Except for services provided by a county under
307.28 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
307.29 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for
307.30 ~~16.14~~ 22.95 percent of the cost of chemical dependency services, including those services
307.31 provided to persons eligible for medical assistance under chapter 256B and general
307.32 assistance medical care under chapter 256D. Counties may use the indigent hospitalization
307.33 levy for treatment and hospital payments made under this section. ~~16.14~~ 22.95 percent
307.34 of any state collections from private or third-party pay, less 15 percent for the cost of

308.1 payment and collections, must be distributed to the county that paid for a portion of the
308.2 treatment under this section.

308.3 **EFFECTIVE DATE.** This section is effective for claims processed beginning
308.4 July 1, 2011.

308.5 Sec. 7. Minnesota Statutes 2010, section 254B.04, subdivision 1, is amended to read:

308.6 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
308.7 Regulations, title 25, part 20, persons eligible for medical assistance benefits under
308.8 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet
308.9 the income standards of section 256B.056, subdivision 4, and persons eligible for general
308.10 assistance medical care under section 256D.03, subdivision 3, are entitled to chemical
308.11 dependency fund services subject to the following limitations: (1) no more than three
308.12 residential chemical dependency treatment episodes for the same person in a four-year
308.13 period of time unless the person meets the criteria established by the commissioner of
308.14 human services; and (2) no more than four residential chemical dependency treatment
308.15 episodes in a lifetime unless the person meets the criteria established by the commissioner
308.16 of human services. State money appropriated for this paragraph must be placed in a
308.17 separate account established for this purpose.

308.18 Persons with dependent children who are determined to be in need of chemical
308.19 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
308.20 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
308.21 local agency to access needed treatment services. Treatment services must be appropriate
308.22 for the individual or family, which may include long-term care treatment or treatment in a
308.23 facility that allows the dependent children to stay in the treatment facility. The county
308.24 shall pay for out-of-home placement costs, if applicable.

308.25 (b) A person not entitled to services under paragraph (a), but with family income
308.26 that is less than 215 percent of the federal poverty guidelines for the applicable family
308.27 size, shall be eligible to receive chemical dependency fund services within the limit
308.28 of funds appropriated for this group for the fiscal year. If notified by the state agency
308.29 of limited funds, a county must give preferential treatment to persons with dependent
308.30 children who are in need of chemical dependency treatment pursuant to an assessment
308.31 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
308.32 6, or 260C.212. A county may spend money from its own sources to serve persons under
308.33 this paragraph. State money appropriated for this paragraph must be placed in a separate
308.34 account established for this purpose.

309.1 (c) Persons whose income is between 215 percent and 412 percent of the federal
309.2 poverty guidelines for the applicable family size shall be eligible for chemical dependency
309.3 services on a sliding fee basis, within the limit of funds appropriated for this group for the
309.4 fiscal year. Persons eligible under this paragraph must contribute to the cost of services
309.5 according to the sliding fee scale established under subdivision 3. A county may spend
309.6 money from its own sources to provide services to persons under this paragraph. State
309.7 money appropriated for this paragraph must be placed in a separate account established
309.8 for this purpose.

309.9 **EFFECTIVE DATE.** This section is effective for all chemical dependency
309.10 residential treatment beginning on or after July 1, 2011.

309.11 Sec. 8. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision
309.12 to read:

309.13 **Subd. 2a. Eligibility for treatment in residential settings.** Notwithstanding
309.14 provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's
309.15 discretion in making placements to residential treatment settings, a person eligible for
309.16 services under this section must score at level 4 on assessment dimensions related to
309.17 relapse, continued use, and recovery environment in order to be assigned to services with
309.18 a room and board component reimbursed under this section.

309.19 Sec. 9. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

309.20 **Subd. 2. Allocation of collections.** The commissioner shall allocate all federal
309.21 financial participation collections to a special revenue account. The commissioner shall
309.22 allocate ~~83.86~~ 77.05 percent of patient payments and third-party payments to the special
309.23 revenue account and ~~16.14~~ 22.95 percent to the county financially responsible for the
309.24 patient.

309.25 **EFFECTIVE DATE.** This section is effective for claims processed beginning
309.26 July 1, 2011.

309.27 Sec. 10. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to
309.28 read:

309.29 **Subd. 41. Residential services for children with severe emotional disturbance.**
309.30 Medical assistance covers rehabilitative services in accordance with section 256B.0945
309.31 that are provided by a county or an American Indian tribe through a residential facility,

310.1 for children who have been diagnosed with severe emotional disturbance and have been
310.2 determined to require the level of care provided in a residential facility.

310.3 **EFFECTIVE DATE.** This section is effective October 1, 2011.

310.4 Sec. 11. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to
310.5 read:

310.6 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
310.7 payments to counties for residential services provided by a residential facility shall only
310.8 be made of federal earnings for services provided under this section, and the nonfederal
310.9 share of costs for services provided under this section shall be paid by the county from
310.10 sources other than federal funds or funds used to match other federal funds. Payment to
310.11 counties for services provided according to this section shall be a proportion of the per
310.12 day contract rate that relates to rehabilitative mental health services and shall not include
310.13 payment for costs or services that are billed to the IV-E program as room and board.

310.14 (b) Per diem rates paid to providers under this section by prepaid plans shall be
310.15 the proportion of the per-day contract rate that relates to rehabilitative mental health
310.16 services and shall not include payment for group foster care costs or services that are
310.17 billed to the county of financial responsibility. Services provided in facilities located in
310.18 bordering states are eligible for reimbursement on a fee-for-service basis only as described
310.19 in paragraph (a) and are not covered under prepaid health plans.

310.20 (c) Payment for mental health rehabilitative services provided under this section by
310.21 or under contract with an American Indian tribe or tribal organization or by agencies
310.22 operated by or under contract with an American Indian tribe or tribal organization must
310.23 be made according to section 256B.0625, subdivision 34, or other relevant federally
310.24 approved rate-setting methodology.

310.25 (d) The commissioner shall set aside a portion not to exceed five percent of the
310.26 federal funds earned for county expenditures under this section to cover the state costs of
310.27 administering this section. Any unexpended funds from the set-aside shall be distributed
310.28 to the counties in proportion to their earnings under this section.

310.29 **EFFECTIVE DATE.** This section is effective October 1, 2011.

310.30 Sec. 12. **COMMUNITY MENTAL HEALTH SERVICES; USE OF**
310.31 **BEHAVIORAL HEALTH HOSPITALS.**

310.32 The commissioner shall issue a written report to the chairs and ranking minority
310.33 members of the house and senate committees with jurisdiction of health and human

311.1 services by December 31, 2011, on how the community behavioral health hospital
311.2 facilities will be fully utilized to meet the mental health needs of regions in which the
311.3 hospitals are located. The commissioner must consult with the regional planning work
311.4 groups for adult mental health and must include the recommendations of the work groups
311.5 in the legislative report. The report must address future use of community behavioral
311.6 health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65
311.7 percent licensed bed occupancy rate, and using the facilities for another purpose that will
311.8 meet the mental health needs of residents of the region. The regional planning work
311.9 groups shall work with the commissioner to prioritize the needs of their regions. These
311.10 priorities, by region, must be included in the commissioner's report to the legislature.

311.11 Sec. 13. **INTEGRATED DUAL DIAGNOSIS TREATMENT.**

311.12 (a) The commissioner shall require individuals who perform chemical dependency
311.13 assessments or mental health assessments to use approved screening tools in order to
311.14 identify whether an individual who is the subject of the assessment has a co-occurring
311.15 mental health or chemical dependency disorder. Screening for co-occurring disorders must
311.16 begin no later than December 31, 2011.

311.17 (b) No later than October 1, 2011, the commissioner shall develop and implement a
311.18 certification process for integrated dual diagnosis treatment providers.

311.19 (c) No later than December 31, 2011, the commissioner shall develop and implement
311.20 a referral system so that individuals who, at screening, are identified with co-occurring
311.21 disorders are referred to certified integrated dual diagnosis treatment providers.

311.22 (d) The commissioner shall apply for any federal waivers necessary to secure, to the
311.23 extent allowed by law, federal financial participation for the provision of integrated dual
311.24 diagnosis treatment to persons with co-occurring disorders.

311.25 Sec. 14. **STATE-OPERATED SERVICES FACILITIES.**

311.26 (a) The commissioner shall close the Willmar Community Behavioral Health
311.27 Hospital no later than October 1, 2011.

311.28 (b) The commissioner shall present a plan to the legislative committees with
311.29 jurisdiction over health and human services finance no later than January 1, 2012, on
311.30 how the department will:

311.31 (1) accommodate the mental health needs of clients impacted by the closure or
311.32 redesign of any state-operated services facilities; and

311.33 (2) accommodate the state employees adversely affected by the closure or redesign
311.34 of any state-operated services facilities.

Sec. 15. **REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.**

(a) No layoffs shall occur as a result of restructuring services at the Anoka-Metro Regional Treatment Center.

(b) The commissioner shall issue a report to the legislative committees with jurisdiction over health and human services finance no later than December 31, 2011, 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. 16. **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. 17. **MINNESOTA STATE-OPERATED COMMUNITY SERVICES.**

The commissioner shall evaluate the effectiveness of overnight supervision provided at the Minnesota state-operated community services residential programs. The commissioner shall determine whether safety is compromised when only one overnight staff person is scheduled to work, and shall document the incidents in which the staff person called for assistance or reported behavior that threatened the safety of clients or the staff person. The commissioner shall report findings to the legislative committees with jurisdiction over health and human services no later than January 15, 2012.

Sec. 18. **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 9

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>\$ 5,646,994,000</u>	<u>\$ 5,159,920,000</u>	<u>\$ 10,806,914,000</u>

313.1	<u>State Government Special</u>			
313.2	<u>Revenue</u>	<u>63,198,000</u>	<u>63,154,000</u>	<u>126,352,000</u>
313.3	<u>Health Care Access</u>	<u>400,917,000</u>	<u>409,880,000</u>	<u>810,797,000</u>
313.4	<u>Federal TANF</u>	<u>274,091,000</u>	<u>282,814,000</u>	<u>556,905,000</u>
313.5	<u>Lottery Prize Fund</u>	<u>1,665,000</u>	<u>1,665,000</u>	<u>3,330,000</u>
313.6	Total	\$ 6,386,865,000	\$ 5,917,433,000	\$ 12,304,298,000

313.7 **Sec. 2. HUMAN SERVICES APPROPRIATIONS.**

313.8 The sums shown in the columns marked "Appropriations" are appropriated to the
313.9 agencies and for the purposes specified in this article. The appropriations are from the
313.10 general fund, or another named fund, and are available for the fiscal years indicated
313.11 for each purpose. The figures "2012" and "2013" used in this article mean that the
313.12 appropriations listed under them are available for the fiscal year ending June 30, 2012, or
313.13 June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal
313.14 year 2013. "The biennium" is fiscal years 2012 and 2013.

313.9 agencies and for the purposes specified in this article. The appropriations are from the

313.10 general fund, or another named fund, and are available for the fiscal years indicated

313.11 for each purpose. The figures "2012" and "2013" used in this article mean that the

313.12 appropriations listed under them are available for the fiscal year ending June 30, 2012, or

313.13 June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal

313.14 year 2013. "The biennium" is fiscal years 2012 and 2013.

313.15	<u>APPROPRIATIONS</u>	
313.16	<u>Available for the Year</u>	
313.17	<u>Ending June 30</u>	
313.18	2012	2013

313.19 Sec. 3. COMMISSIONER OF HUMAN
313.20 SERVICES

313.20 SERVICES

313.21	Subdivision 1. Total Appropriation	\$	6,215,925,000	\$	5,756,045,000

313.22 Appropriations by Fund

313.23		<u>2012</u>	<u>2013</u>
313.24	<u>General</u>	<u>5,564,174,000</u>	<u>5,081,996,000</u>
313.25	<u>State Government</u>		
313.26	<u>Special Revenue</u>	<u>565,000</u>	<u>565,000</u>
313.27	<u>Health Care Access</u>	<u>387,143,000</u>	<u>400,718,000</u>
313.28	<u>Federal TANF</u>	<u>262,378,000</u>	<u>271,101,000</u>
313.29	Lottery Prize Fund	1,665,000	1,665,000

313.30 Receipts for Systems Projects.

313.31 Appropriations and federal receipts for

313.32 information systems projects for MAXIS,

313.33 PRISM, MMIS, and SSIS must be deposited

313.34 in the state systems account authorized in

313.35 Minnesota Statutes, section 256.014. Money

313.36 appropriated for computer projects approved

313.37 by the Minnesota Office of Enterprise

314.1 Technology, funded by the legislature,
314.2 and approved by the commissioner of
314.3 Minnesota Management and Budget, may
314.4 be transferred from one project to another
314.5 and from development to operations as the
314.6 commissioner of human services considers
314.7 necessary. Any unexpended balance in
314.8 the appropriation for these projects does
314.9 not cancel but is available for ongoing
314.10 development and operations.

314.11 **Nonfederal Share Transfers.** The
314.12 nonfederal share of activities for which
314.13 federal administrative reimbursement is
314.14 appropriated to the commissioner may be
314.15 transferred to the special revenue fund.

314.16 **TANF Maintenance of Effort.**

314.17 (a) In order to meet the basic maintenance
314.18 of effort (MOE) requirements of the TANF
314.19 block grant specified under Code of Federal
314.20 Regulations, title 45, section 263.1, the
314.21 commissioner may only report nonfederal
314.22 money expended for allowable activities
314.23 listed in the following clauses as TANF/MOE
314.24 expenditures:

314.25 (1) MFIP cash, diversionary work program,
314.26 and food assistance benefits under Minnesota
314.27 Statutes, chapter 256J;

314.28 (2) the child care assistance programs
314.29 under Minnesota Statutes, sections 119B.03
314.30 and 119B.05, and county child care
314.31 administrative costs under Minnesota
314.32 Statutes, section 119B.15;

314.33 (3) state and county MFIP administrative
314.34 costs under Minnesota Statutes, chapters
314.35 256J and 256K;

315.1 (4) state, county, and tribal MFIP
315.2 employment services under Minnesota
315.3 Statutes, chapters 256J and 256K;
315.4 (5) expenditures made on behalf of
315.5 noncitizen MFIP recipients who qualify
315.6 for the medical assistance without federal
315.7 financial participation program under
315.8 Minnesota Statutes, section 256B.06,
315.9 subdivision 4, paragraphs (d), (e), and (j);
315.10 (6) qualifying working family credit
315.11 expenditures under Minnesota Statutes,
315.12 section 290.0671; and
315.13 (7) qualifying Minnesota education credit
315.14 expenditures under Minnesota Statutes,
315.15 section 290.0674.
315.16 (b) The commissioner shall ensure that
315.17 sufficient qualified nonfederal expenditures
315.18 are made each year to meet the state's
315.19 TANF/MOE requirements. For the activities
315.20 listed in paragraph (a), clauses (2) to
315.21 (7), the commissioner may only report
315.22 expenditures that are excluded from the
315.23 definition of assistance under Code of
315.24 Federal Regulations, title 45, section 260.31.
315.25 (c) For fiscal years beginning with state fiscal
315.26 year 2003, the commissioner shall assure
315.27 that the maintenance of effort used by the
315.28 commissioner of management and budget
315.29 for the February and November forecasts
315.30 required under Minnesota Statutes, section
315.31 16A.103, contains expenditures under
315.32 paragraph (a), clause (1), equal to at least 16
315.33 percent of the total required under Code of
315.34 Federal Regulations, title 45, section 263.1.

316.1 (d) Minnesota Statutes, section 256.011,
316.2 subdivision 3, which requires that federal
316.3 grants or aids secured or obtained under that
316.4 subdivision be used to reduce any direct
316.5 appropriations provided by law, do not apply
316.6 if the grants or aids are federal TANF funds.

316.7 (e) Notwithstanding any contrary provision
316.8 in this article, paragraph (a), clauses (1) to
316.9 (7), and paragraphs (b) to (d), expire June
316.10 30, 2015.

316.11 **Working Family Credit Expenditures**
316.12 **as TANF/MOE.** The commissioner may
316.13 claim as TANF maintenance of effort up to
316.14 \$6,707,000 per year of working family credit
316.15 expenditures for fiscal years 2012 and 2013.

316.16 **Working Family Credit Expenditures**
316.17 **to be Claimed for TANF/MOE.** The
316.18 commissioner may count the following
316.19 amounts of working family credit
316.20 expenditures as TANF/MOE:

316.21 (1) fiscal year 2012, \$12,037,000;
316.22 (2) fiscal year 2013, \$29,942,000;
316.23 (3) fiscal year 2014, \$23,235,000; and
316.24 (4) fiscal year 2015, \$23,198,000.

316.25 Notwithstanding any contrary provision in
316.26 this article, this rider expires June 30, 2015.

316.27 **TANF Transfer to Federal Child Care**
316.28 **and Development Fund.** (a) The following
316.29 TANF fund amounts are appropriated
316.30 to the commissioner for purposes of
316.31 MFIP/Transition Year Child Care Assistance
316.32 under Minnesota Statutes, section 119B.05:

316.33 (1) fiscal year 2012, \$11,020,000;

317.1 (2) fiscal year 2013, \$35,020,000;

317.2 (3) fiscal year 2014, \$14,020,000; and

317.3 (4) fiscal year 2015, \$14,020,000.

317.4 (b) The commissioner shall authorize the

317.5 transfer of sufficient TANF funds to the

317.6 federal child care and development fund to

317.7 meet this appropriation and shall ensure that

317.8 all transferred funds are expended according

317.9 to federal child care and development fund

317.10 regulations.

317.11 **Food Stamps Employment and Training**

317.12 **Funds.** (a) Notwithstanding Minnesota

317.13 Statutes, sections 256D.051, subdivisions 1a,

317.14 6b, and 6c, and 256J.626, federal food stamps

317.15 employment and training funds received

317.16 as reimbursement for child care assistance

317.17 program expenditures must be deposited in

317.18 the general fund. The amount of funds must

317.19 be limited to \$500,000 per year in fiscal

317.20 years 2012 through 2015, contingent upon

317.21 approval by the federal Food and Nutrition

317.22 Service.

317.23 (b) Consistent with the receipt of these

317.24 federal funds, the commissioner may

317.25 adjust the level of working family credit

317.26 expenditures claimed as TANF maintenance

317.27 of effort. Notwithstanding any contrary

317.28 provision in this article, this rider expires

317.29 June 30, 2015.

317.30 **ARRA Food Support Benefit Increases.**

317.31 The funds provided for food support benefit

317.32 increases under the Supplemental Nutrition

317.33 Assistance Program provisions of the

317.34 American Recovery and Reinvestment Act

318.1 (ARRA) of 2009 must be used for benefit
318.2 increases beginning July 1, 2009.

318.3 **Supplemental Security Interim Assistance**
318.4 **Reimbursement Funds.** \$2,800,000 of
318.5 uncommitted revenue available to the
318.6 commissioner of human services for SSI
318.7 advocacy and outreach services must be
318.8 transferred to and deposited into the general
318.9 fund by June 30, 2012.

318.10 **Subd. 2. Central Office Operations**

318.11 The amounts that may be spent from this
318.12 appropriation for each purpose are as follows:

318.13 **(a) Operations**

318.14	<u>Appropriations by Fund</u>		
318.15	<u>General</u>	<u>81,458,000</u>	<u>80,335,000</u>
318.16	<u>Health Care Access</u>	<u>11,742,000</u>	<u>11,508,000</u>
318.17	<u>State Government</u>		
318.18	<u>Special Revenue</u>	<u>440,000</u>	<u>440,000</u>
318.19	<u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>

318.20 **DHS Receipt Center Accounting.** The
318.21 commissioner is authorized to transfer
318.22 appropriations to, and account for DHS
318.23 receipt center operations in, the special
318.24 revenue fund.

318.25 **Base Adjustment.** The general fund base
318.26 for fiscal year 2014 shall be increased by
318.27 \$79,000. This adjustment is onetime.

318.28 **(b) Children and Families**

318.29	<u>Appropriations by Fund</u>		
318.30	<u>General</u>	<u>9,615,000</u>	<u>9,417,000</u>
318.31	<u>Federal TANF</u>	<u>2,160,000</u>	<u>2,160,000</u>

318.32 **Financial Institution Data Match and**
318.33 **Payment of Fees.** The commissioner is
318.34 authorized to allocate up to \$310,000 each
318.35 year in fiscal years 2012 and 2013 from the

319.1 PRISM special revenue account to make
319.2 payments to financial institutions in exchange
319.3 for performing data matches between account
319.4 information held by financial institutions
319.5 and the public authority's database of child
319.6 support obligors as authorized by Minnesota
319.7 Statutes, section 13B.06, subdivision 7.

319.8 (c) Health Care

319.9	<u>Appropriations by Fund</u>		
319.10	<u>General</u>	<u>16,284,000</u>	<u>16,030,000</u>
319.11	<u>Health Care Access</u>	<u>22,574,000</u>	<u>26,555,000</u>

319.12 Minnesota Senior Health Options

319.13 Reimbursement. Federal administrative
319.14 reimbursement resulting from the Minnesota
319.15 senior health options project is appropriated
319.16 to the commissioner for this activity.

319.17 Utilization Review. Federal administrative
319.18 reimbursement resulting from prior
319.19 authorization and inpatient admission
319.20 certification by a professional review
319.21 organization shall be dedicated to the
319.22 commissioner for these purposes. A portion
319.23 of these funds must be used for activities to
319.24 decrease unnecessary pharmaceutical costs
319.25 in medical assistance.

319.26 Base Adjustment. The general fund base
319.27 shall be decreased by \$2,000 in fiscal year
319.28 2014 and \$114,000 in 2015.

319.29 The health care access fund base is decreased
319.30 by \$16,000 in fiscal year 2014 and \$142,000
319.31 in 2015.

319.32 (d) Continuing Care

320.1	<u>Appropriations by Fund</u>		
320.2	<u>General</u>	<u>18,110,000</u>	<u>18,011,000</u>
320.3	<u>State Government</u>		
320.4	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>
320.5	<u>Region 10 Administrative Expenses.</u>		
320.6	<u>\$100,000 is appropriated each fiscal</u>		
320.7	<u>year, beginning in fiscal year 2012, for</u>		
320.8	<u>the administration of the State Quality</u>		
320.9	<u>Improvement and Licensing System under</u>		
320.10	<u>Minnesota Statutes, section 256B.0961.</u>		
320.11	<u>Base Adjustment.</u> <u>The general fund base is</u>		
320.12	<u>decreased by \$259,000 in each of fiscal years</u>		
320.13	<u>2014 and 2015.</u>		
320.14	<u>(e) Chemical and Mental Health</u>		
320.15	<u>Appropriations by Fund</u>		
320.16	<u>General</u>	<u>4,194,000</u>	<u>4,194,000</u>
320.17	<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>
320.18	<u>Subd. 3. Forecasted Programs</u>		
320.19	<u>The amounts that may be spent from this</u>		
320.20	<u>appropriation for each purpose are as follows:</u>		
320.21	<u>(a) MFIP/DWP Grants</u>		
320.22	<u>Appropriations by Fund</u>		
320.23	<u>General</u>	<u>84,256,000</u>	<u>91,212,000</u>
320.24	<u>Federal TANF</u>	<u>84,425,000</u>	<u>75,417,000</u>
320.25	<u>(b) MFIP Child Care Assistance Grants</u>	<u>55,726,000</u>	<u>26,652,000</u>
320.26	<u>(c) General Assistance Grants</u>	<u>43,629,000</u>	<u>42,440,000</u>
320.27	<u>General Assistance Standard.</u> <u>The</u>		
320.28	<u>commissioner shall set the monthly standard</u>		
320.29	<u>of assistance for general assistance units</u>		
320.30	<u>consisting of an adult recipient who is</u>		
320.31	<u>childless and unmarried or living apart</u>		
320.32	<u>from parents or a legal guardian at \$203.</u>		
320.33	<u>The commissioner may reduce this amount</u>		

321.1	<u>according to Laws 1997, chapter 85, article</u>		
321.2	<u>3, section 54.</u>		
321.3	<u>Emergency General Assistance. The</u>		
321.4	<u>amount appropriated for emergency general</u>		
321.5	<u>assistance funds is limited to no more</u>		
321.6	<u>than \$7,889,812 in fiscal year 2012 and</u>		
321.7	<u>\$7,889,812 in fiscal year 2013. Funds</u>		
321.8	<u>to counties shall be allocated by the</u>		
321.9	<u>commissioner using the allocation method</u>		
321.10	<u>specified in Minnesota Statutes, section</u>		
321.11	<u>256D.06.</u>		
321.12	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>38,091,000</u>	<u>39,092,000</u>
321.13	<u>Emergency Minnesota Supplemental</u>		
321.14	<u>Aid Funds. The amount appropriated for</u>		
321.15	<u>emergency Minnesota supplemental aid</u>		
321.16	<u>funds is limited to no more than \$1,100,000</u>		
321.17	<u>in fiscal year 2012 and \$1,100,000 in fiscal</u>		
321.18	<u>year 2013. Funds to counties shall be</u>		
321.19	<u>allocated by the commissioner using the</u>		
321.20	<u>allocation method specified in Minnesota</u>		
321.21	<u>Statutes, section 256D.46.</u>		
321.22	<u>(e) Group Residential Housing Grants</u>	<u>121,092,000</u>	<u>129,250,000</u>
321.23	<u>(f) MinnesotaCare Grants</u>	<u>351,927,000</u>	<u>361,755,000</u>
321.24	<u>This appropriation is from the health care</u>		
321.25	<u>access fund.</u>		
321.26	<u>(g) GAMC Grants</u>	<u>120,000,000</u>	<u>280,000,000</u>
321.27	<u>Coordinated Care Delivery System. This</u>		
321.28	<u>appropriation is to fund coordinated care</u>		
321.29	<u>delivery systems under Minnesota Statutes,</u>		
321.30	<u>section 256D.031, subdivision 6.</u>		
321.31	<u>Payments for Cost Settlements. The</u>		
321.32	<u>commissioner is authorized to use amounts</u>		
321.33	<u>repaid to the general assistance medical care</u>		
321.34	<u>program under Minnesota Statutes 2009</u>		

322.1 Supplement, section 256D.03, subdivision
322.2 3, to pay cost settlements for claims for
322.3 services provided prior to June 1, 2010.
322.4 Notwithstanding any contrary provision in
322.5 this article, this provision does not expire.

322.6 **Base Adjustment.** The general fund base is
322.7 reduced by \$120,000,000 in fiscal year 2014
322.8 and by \$280,000,000 in fiscal year 2015.

322.9 <u>(h) Medical Assistance Grants</u>	<u>4,253,018,000</u>	<u>3,602,473,000</u>

322.10 **Managed Care Incentive Payments.** The
322.11 commissioner shall not make managed care
322.12 incentive payments for expanding preventive
322.13 services during fiscal years beginning July 1,
322.14 2011 and July 1, 2012.

322.15 **Reduction of Rates for Congregate**
322.16 **Living for Individuals with Lower Needs.**
322.17 Beginning October 1, 2011, lead agencies
322.18 must reduce rates in effect on January 1,
322.19 2011, by ten percent for individuals with
322.20 lower needs living in foster care settings
322.21 where the license holder does not share the
322.22 residence with recipients on the CADI, DD,
322.23 and TBI waivers and customized living
322.24 settings for CADI and TBI. Lead agencies
322.25 must adjust contracts within 60 days of the
322.26 effective date.

322.27 **Reduction of Lead Agency Waiver**
322.28 **Allocations to Implement Rate Reductions**
322.29 **for Congregate Living for Individuals**
322.30 **with Lower Needs.** Beginning October 1,
322.31 2011, the commissioner shall reduce lead
322.32 agency waiver allocations to implement the
322.33 reduction of rates for individuals with lower
322.34 needs living in foster care settings where the
322.35 license holder does not share the residence

323.1 with recipients on the CADI, DD, and TBI
323.2 waivers and customized living settings for
323.3 CADI and TBI.

323.4 **Reduce customized living and 24-hour**
323.5 **customized living component rates.**

323.6 Effective July 1, 2011, the commissioner
323.7 shall reduce elderly waiver customized living
323.8 and 24-hour customized living component
323.9 service spending by ten percent through
323.10 reductions in component rates and service
323.11 rate limits. The commissioner shall adjust
323.12 the elderly waiver capitation payment
323.13 rates for managed care organizations paid
323.14 under Minnesota Statutes, section 256B.69,
323.15 subdivisions 6a and 23, to reflect reductions
323.16 in component spending for customized living
323.17 services and 24-hour customized living
323.18 services under Minnesota Statutes, section
323.19 256B.0915, subdivisions 3e and 3h, for the
323.20 contract period beginning January 1, 2012.
323.21 To implement the reduction specified in
323.22 this provision, capitation rates paid by the
323.23 commissioner to managed care organizations
323.24 under Minnesota Statutes, section 256B.69,
323.25 shall reflect a 20 percent reduction for the
323.26 specified services for the period January 1,
323.27 2012, to June 30, 2012, and a ten percent
323.28 reduction for those services on or after July
323.29 1, 2012.

323.30 **Limit Growth in the Developmental**
323.31 **Disability Waiver.** For the biennium
323.32 beginning July 1, 2011, the commissioner
323.33 shall limit the developmental disability
323.34 waiver to the number of recipients served
323.35 in March 2010. To achieve this level, the
323.36 commissioner shall not refill waiver openings

324.1 until the number of waiver recipients
324.2 reaches the March 2010 level. Once the
324.3 March 2010 enrollment level is reached, the
324.4 commissioner shall refill vacated openings to
324.5 maintain the March 2010 enrollment level.
324.6 To the extent possible, waiver allocations
324.7 shall be available to individuals who meet
324.8 the priorities for accessing waiver services
324.9 described in Minnesota Statutes, section
324.10 256B.092, subdivision 12. The limits do not
324.11 include conversions from intermediate care
324.12 facilities for persons with developmental
324.13 disabilities. When implementing the waiver
324.14 enrollment limits under this provision, it
324.15 is an absolute defense to an appeal under
324.16 Minnesota Statutes, section 256.045, if
324.17 the commissioner or lead agency proves
324.18 that it followed the established written
324.19 procedures and criteria and determined that
324.20 home and community-based services could
324.21 not be provided to the person within the
324.22 appropriations or lead agency's allocation of
324.23 home and community-based services money.

324.24 **Limit Growth in the Community**

324.25 **Alternatives for Disabled Individuals**

324.26 **Waiver.** For the biennium beginning
324.27 July 1, 2011, the commissioner shall limit
324.28 the community alternatives for disabled
324.29 individuals waiver to the number of
324.30 recipients served in March 2010. To achieve
324.31 this level, the commissioner shall not
324.32 refill waiver openings until the number of
324.33 waiver recipients reaches the March 2010
324.34 level. Once the March 2010 enrollment
324.35 level is reached, the commissioner shall
324.36 refill vacated openings to maintain the

325.1 March 2010 enrollment level. To the
325.2 extent possible, waiver allocations shall
325.3 be available to individuals who meet the
325.4 priorities for accessing waiver services
325.5 described in Minnesota Statutes, section
325.6 256B.49, subdivision 11a. The limits include
325.7 conversions and diversions, unless the
325.8 commissioner has approved a plan to convert
325.9 funding due to the closure or downsizing
325.10 of a residential facility or nursing facility
325.11 to serve directly affected individuals on
325.12 the community alternatives for disabled
325.13 individuals waiver. When implementing
325.14 the waiver enrollment limits under this
325.15 provision, it is an absolute defense to an
325.16 appeal under Minnesota Statutes, section
325.17 256.045, if the commissioner or lead agency
325.18 proves that it followed the established written
325.19 procedures and criteria and determined that
325.20 home and community-based services could
325.21 not be provided to the person within the
325.22 appropriations or lead agency's allocation of
325.23 home and community-based services money.

325.24 **Limit Growth in the Waiver for**
325.25 **Individuals with Traumatic Brain Injury.**
325.26 For the biennium beginning July 1, 2011,
325.27 the commissioner shall limit the traumatic
325.28 brain injury waiver to the number of
325.29 recipients served in March 2010. To achieve
325.30 this level, the commissioner shall not
325.31 refill waiver openings until the number of
325.32 waiver recipients reaches the March 2010
325.33 level. Once the March 2010 enrollment
325.34 level is reached, the commissioner shall
325.35 refill vacated openings to maintain the
325.36 March 2010 enrollment level. To the

326.1 extent possible, waiver allocations shall
326.2 be available to individuals who meet the
326.3 priorities for accessing waiver services
326.4 described in Minnesota Statutes, section
326.5 256B.49, subdivision 11a. The limits include
326.6 conversions and diversions, unless the
326.7 commissioner has approved a plan to convert
326.8 funding due to the closure or downsizing of a
326.9 residential facility or nursing facility to serve
326.10 directly affected individuals on the traumatic
326.11 brain injury waiver. When implementing
326.12 the waiver enrollment limits under this
326.13 provision, it is an absolute defense to an
326.14 appeal under Minnesota Statutes, section
326.15 256.045, if the commissioner or lead agency
326.16 proves that it followed the established written
326.17 procedures and criteria and determined that
326.18 home and community-based services could
326.19 not be provided to the person within the
326.20 appropriations or lead agency's allocation of
326.21 home and community-based services money.

326.22 **Management of Fee-for-Service Spending.**
326.23 Total state and federal funding for the
326.24 biennium beginning on July 1, 2011, for
326.25 fee-for-service medical assistance basic care
326.26 for the elderly and persons with disabilities
326.27 is limited to \$2,536,949,000. Total state and
326.28 federal funding for the biennium beginning
326.29 July 1, 2011, for fee-for-service medical
326.30 assistance basic care for adults without
326.31 children is limited to \$526,251,000.

326.32 (1) Total state and federal funding for
326.33 fee-for-service medical assistance basic care
326.34 for the elderly and persons with disabilities is
326.35 limited to \$950,183,000 for fiscal year 2012
326.36 and \$1,115,961,000 for fiscal year 2013.

327.1 (2) The commissioner shall contract with
327.2 a vendor to manage spending within these
327.3 limits, beginning January 1, 2012. The
327.4 vendor selected may:
327.5 (i) manage and coordinate the care provided
327.6 by high-cost providers;
327.7 (ii) implement payment reform initiatives to
327.8 encourage efficient and cost-effective service
327.9 provision;
327.10 (iii) identify and deny payment for
327.11 unnecessary services; and
327.12 (iv) implement other initiatives proven to
327.13 improve the efficiency of fee-for-service care
327.14 delivery.
327.15 The contract with the vendor must be
327.16 on a contingency basis, under which the
327.17 vendor retains six percent of any savings
327.18 obtained from management of fee-for-service
327.19 spending.
327.20 (3) The commissioner, by October 1,
327.21 2012, shall evaluate the extent to which
327.22 initiatives implemented by the vendor will
327.23 be successful in managing spending within
327.24 the specified limits. If the commissioner
327.25 determines that the vendor will not be
327.26 successful in managing spending within
327.27 the specified limits, the commissioner shall
327.28 reduce medical assistance provider payments
327.29 by an amount sufficient to comply with
327.30 the spending limits. In implementing rate
327.31 reductions, the commissioner shall exempt
327.32 payments to nursing facilities and providers
327.33 of home and community-based waiver
327.34 services. No provider payment reduction

328.1 shall affect services provided to the elderly
328.2 or persons with disabilities.

328.3 **Contingent Rate Reductions.** If
328.4 the commissioner determines that
328.5 implementation of the global waiver under
328.6 Minnesota Statutes, sections 256B.841,
328.7 256B.842, and 256B.843, will not achieve a
328.8 state general fund savings of \$300,000,000
328.9 for the biennium beginning July 1, 2011, the
328.10 commissioner shall calculate an estimate
328.11 of the shortfall in savings, and, for the
328.12 fiscal year beginning July 1, 2012, shall
328.13 reduce medical assistance provider payment
328.14 rates, including but not limited to rates to
328.15 individual health care providers and provider
328.16 agencies, hospitals, other residential settings,
328.17 and capitation rates provided to managed
328.18 care and county-based purchasing plans, by
328.19 the amount necessary to recoup the shortfall
328.20 in savings over that fiscal year. No provider
328.21 payment reduction shall affect services
328.22 provided to the elderly or persons with
328.23 disabilities.

328.24	<u>(i) Alternative Care Grants</u>	<u>44,630,000</u>	<u>44,689,000</u>

328.25 **Alternative Care Transfer.** Any money
328.26 allocated to the alternative care program that
328.27 is not spent for the purposes indicated does
328.28 not cancel but shall be transferred to the
328.29 medical assistance account.

328.30	<u>(j) Chemical Dependency Entitlement Grants</u>	<u>104,113,000</u>	<u>127,281,000</u>

328.31 **Subd. 4. Grant Programs**

328.32 The amounts that may be spent from this
328.33 appropriation for each purpose are as follows:

328.34 **(a) Support Services Grants**

329.1	<u>Appropriations by Fund</u>		
329.2	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
329.3	<u>Federal TANF</u>	<u>96,525,000</u>	<u>90,611,000</u>

329.4 **MFIP Consolidated Fund Grants.** The
329.5 TANF fund base is reduced by \$14,000,000
329.6 each year beginning in fiscal year 2012.

329.7 **Subsidized Employment Funding Through**
329.8 **ARRA.** The commissioner is authorized to
329.9 apply for TANF emergency fund grants for
329.10 subsidized employment activities. Growth
329.11 in expenditures for subsidized employment
329.12 within the supported work program and the
329.13 MFIP consolidated fund over the amount
329.14 expended in the calendar year quarters in
329.15 the TANF emergency fund base year shall
329.16 be used to leverage the TANF emergency
329.17 fund grants for subsidized employment and
329.18 to fund supported work. The commissioner
329.19 shall develop procedures to maximize
329.20 reimbursement of these expenditures over the
329.21 TANF emergency fund base year quarters,
329.22 and may contract directly with employers
329.23 and providers to maximize these TANF
329.24 emergency fund grants.

329.25 **Healthy Communities.** \$150,000 in fiscal
329.26 year 2012 and \$150,000 in fiscal year 2013
329.27 are appropriated from the general fund to
329.28 the commissioner of human services for
329.29 contracting with the Search Institute to
329.30 promote healthy community initiatives.
329.31 The commissioner may expend up to five
329.32 percent of the appropriation to provide for
329.33 the program evaluation.

329.34 **Circles of Support.** \$200,000 in fiscal year
329.35 2012 and \$200,000 in fiscal year 2013 are

330.1	<u>appropriated from the general fund to the</u>		
330.2	<u>commissioner of human services for the</u>		
330.3	<u>purpose of providing grants to community</u>		
330.4	<u>action agencies for circles of support</u>		
330.5	<u>initiatives.</u>		
330.6	<u>Northern Connections.</u> \$100,000 is		
330.7	<u>appropriated in fiscal year 2012 and</u>		
330.8	<u>\$100,000 is appropriated in fiscal year 2013</u>		
330.9	<u>from the general fund to the commissioner</u>		
330.10	<u>of human services for a grant to expand</u>		
330.11	<u>Northern Connections workforce program</u>		
330.12	<u>that provides one-stop supportive services</u>		
330.13	<u>to individuals as they transition into the</u>		
330.14	<u>workforce to up to two interested counties in</u>		
330.15	<u>rural Minnesota.</u>		
330.16	<u>(b) Basic Sliding Fee Child Care Assistance</u>		
330.17	<u>Grants</u>	<u>38,131,000</u>	<u>41,035,000</u>
330.18	<u>Base Adjustment.</u> The general fund base is		
330.19	<u>decreased by \$1,131,000 in fiscal year 2014</u>		
330.20	<u>and \$1,126,000 in fiscal year 2015.</u>		
330.21	<u>Child Care and Development Fund</u>		
330.22	<u>Unexpended Balance.</u> In addition to		
330.23	<u>the amount provided in this section, the</u>		
330.24	<u>commissioner shall expend \$5,000,000</u>		
330.25	<u>in fiscal year 2012 from the federal child</u>		
330.26	<u>care and development fund unexpended</u>		
330.27	<u>balance for basic sliding fee child care under</u>		
330.28	<u>Minnesota Statutes, section 119B.03. The</u>		
330.29	<u>commissioner shall ensure that all child</u>		
330.30	<u>care and development funds are expended</u>		
330.31	<u>according to the federal child care and</u>		
330.32	<u>development fund regulations.</u>		
330.33	<u>(c) Child Care Development Grants</u>	<u>1,487,000</u>	<u>1,487,000</u>
330.34	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>

331.1	<u>Federal Child Support Demonstration</u>		
331.2	<u>Grants.</u> Federal administrative		
331.3	<u>reimbursement resulting from the federal</u>		
331.4	<u>child support grant expenditures authorized</u>		
331.5	<u>under section 1115a of the Social Security</u>		
331.6	<u>Act is appropriated to the commissioner for</u>		
331.7	<u>this activity.</u>		
331.8	<u>(e) Children's Services Grants</u>		
331.9	<u>Appropriations by Fund</u>		
331.10	<u>General</u>	<u>46,788,000</u>	<u>46,788,000</u>
331.11	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
331.12	<u>Adoption Assistance and Relative Custody</u>		
331.13	<u>Assistance Payments.</u> \$1,661,000 each		
331.14	<u>year is for continuation of current payments</u>		
331.15	<u>for adoption assistance and relative custody</u>		
331.16	<u>assistance.</u>		
331.17	<u>Adoption Assistance and Relative Custody</u>		
331.18	<u>Assistance Transfer.</u> The commissioner		
331.19	<u>may transfer unencumbered appropriation</u>		
331.20	<u>balances for adoption assistance and relative</u>		
331.21	<u>custody assistance between fiscal years and</u>		
331.22	<u>between programs.</u>		
331.23	<u>Privatized Adoption Grants.</u> Federal		
331.24	<u>reimbursement for privatized adoption grant</u>		
331.25	<u>and foster care recruitment grant expenditures</u>		
331.26	<u>is appropriated to the commissioner for</u>		
331.27	<u>adoption grants and foster care and adoption</u>		
331.28	<u>administrative purposes.</u>		
331.29	<u>Adoption Assistance Incentive Grants.</u>		
331.30	<u>Federal funds available during fiscal year</u>		
331.31	<u>2012 and fiscal year 2013 for adoption</u>		
331.32	<u>incentive grants are appropriated to the</u>		
331.33	<u>commissioner for these purposes.</u>		
331.34	<u>(f) Children and Community Services Grants</u>	<u>64,301,000</u>	<u>64,301,000</u>

332.1	<u>(g) Children and Economic Support Grants</u>	<u>16,755,000</u>	<u>16,265,000</u>
332.2	<u>Long-term homeless services. \$700,000</u>		
332.3	<u>is appropriated from the federal TANF</u>		
332.4	<u>fund for the biennium beginning July</u>		
332.5	<u>1, 2011, to the commissioner of human</u>		
332.6	<u>services for long-term homeless services</u>		
332.7	<u>for low-income homeless families under</u>		
332.8	<u>Minnesota Statutes, section 256K.26. This</u>		
332.9	<u>is a onetime appropriation and is not added</u>		
332.10	<u>to the base.</u>		
332.11	<u>Base Adjustment. The general fund base</u>		
332.12	<u>is increased by \$491,000 in fiscal year 2014</u>		
332.13	<u>only.</u>		
332.14	<u>(h) Health Care Grants</u>		
332.15	<u>Appropriations by Fund</u>		
332.16	<u>General</u>	<u>195,000</u>	<u>-0-</u>
332.17	<u>Health Care Access</u>	<u>900,000</u>	<u>900,000</u>
332.18	<u>Surplus Appropriation Canceled. Of the</u>		
332.19	<u>appropriation in Laws 2009, chapter 79,</u>		
332.20	<u>article 13, section 3, subdivision 6, paragraph</u>		
332.21	<u>(e), for the COBRA premium state subsidy</u>		
332.22	<u>program, \$11,750,000 must be canceled in</u>		
332.23	<u>fiscal year 2011. This provision is effective</u>		
332.24	<u>the day following final enactment.</u>		
332.25	<u>Grant Cancellation. Effective for the</u>		
332.26	<u>biennium beginning July 1, 2011, the</u>		
332.27	<u>following appropriations are canceled: (1) a</u>		
332.28	<u>general fund appropriation of \$205,000 for</u>		
332.29	<u>the U Special Kids program; (2) a general</u>		
332.30	<u>fund appropriation of \$90,000 for medical</u>		
332.31	<u>assistance outreach grants; and (3) a health</u>		
332.32	<u>care access fund appropriation of \$40,000 for</u>		
332.33	<u>MinnesotaCare outreach grants.</u>		

333.1 **State Subsidy Program for Community**
333.2 **Mental Health Centers.** \$100,000 is
333.3 appropriated from the general fund to
333.4 the commissioner of human services for
333.5 the biennium beginning July 1, 2011, to
333.6 provide onetime grants to establish new
333.7 community mental health centers that are
333.8 eligible for payment under Minnesota
333.9 Statutes, section 256B.0625, subdivision 5.
333.10 In awarding grants, the commissioner shall
333.11 give preference to areas of the state that
333.12 lack access to mental health services or are
333.13 underserved.

333.14 <u>(i) Aging and Adult Services Grants</u>	<u>18,734,000</u>	<u>18,910,000</u>

333.15 **Aging Grants Reduction.** Effective July
333.16 1, 2011, funding for grants made under
333.17 Minnesota Statutes, sections 256.9754 and
333.18 256B.0917, subdivision 13, is reduced by
333.19 \$3,600,000 for each year of the biennium.
333.20 These reductions are onetime and do
333.21 not affect base funding for the 2014-2015
333.22 biennium. Grants made during the 2012-2013
333.23 biennium under Minnesota Statutes, section
333.24 256B.9754, must not be used for new
333.25 construction or building renovation.

333.26 **Essential Community Support Grant**
333.27 **Delay.** Essential community supports
333.28 grants under Minnesota Statutes, section
333.29 256B.0917, subdivision 14, is reduced
333.30 by \$6,410,000 in fiscal year 2012 and
333.31 \$7,279,000 in fiscal year 2013. Base level
333.32 funding for fiscal year 2014 is reduced by
333.33 \$5,919,000. These reductions are onetime
333.34 and do not affect base level funding for fiscal
333.35 year 2015.

334.1	<u>(j) Deaf and Hard-of-Hearing Grants</u>	<u>1,936,000</u>	<u>1,767,000</u>
334.2	<u>(k) Disabilities Grants</u>	<u>22,025,000</u>	<u>23,863,000</u>
334.3	<u>Money Follows the Person Rebalancing</u>		
334.4	<u>Demonstration Project.</u> Notwithstanding		
334.5	<u>the provisions of Minnesota Statutes, section</u>		
334.6	<u>256.011, subdivision 3, estimated general</u>		
334.7	<u>fund savings resulting from the operation of</u>		
334.8	<u>the Money Follows the Person federal grant</u>		
334.9	<u>fund must be retained within the medical</u>		
334.10	<u>assistance general fund appropriation for the</u>		
334.11	<u>payment of federally required rebalancing</u>		
334.12	<u>expenditures. If a rebalancing expenditure</u>		
334.13	<u>is not eligible for medical assistance, the</u>		
334.14	<u>corresponding portion of estimated savings</u>		
334.15	<u>must be transferred to and paid from a special</u>		
334.16	<u>revenue account established for this purpose.</u>		
334.17	<u>Money in the account does not cancel and</u>		
334.18	<u>is appropriated to the commissioner for the</u>		
334.19	<u>purposes of the demonstration project.</u>		
334.20	<u>Region 10.</u> <u>Any unspent allocation for</u>		
334.21	<u>Region 10 Quality Assurance from the</u>		
334.22	<u>biennium beginning on July 1, 2009, may be</u>		
334.23	<u>carried over into the biennium beginning on</u>		
334.24	<u>July 1, 2011.</u>		
334.25	<u>Local Planning Grants for Creating</u>		
334.26	<u>Alternatives to Congregate Living for</u>		
334.27	<u>Individuals with Lower Needs.</u> <u>The</u>		
334.28	<u>commissioner shall make available a total</u>		
334.29	<u>of \$250,000 per year in local planning</u>		
334.30	<u>grants, beginning July 1, 2011, to assist</u>		
334.31	<u>lead agencies and provider organizations in</u>		
334.32	<u>developing alternatives to congregate living</u>		
334.33	<u>within the available level of resources for the</u>		
334.34	<u>home and community-based services waivers</u>		
334.35	<u>for persons with disabilities.</u>		

335.1	<u>(l) Adult Mental Health Grants</u>		
335.2	<u>Appropriations by Fund</u>		
335.3	<u>General</u>	<u>77,539,000</u>	<u>77,539,000</u>
335.4	<u>Lottery Prize Fund</u>	<u>1,508,000</u>	<u>1,508,000</u>
335.5	<u>Funding Usage. Up to 75 percent of a fiscal</u>		
335.6	<u>year's appropriation for adult mental health</u>		
335.7	<u>grants may be used to fund allocations in that</u>		
335.8	<u>portion of the fiscal year ending December</u>		
335.9	<u>31.</u>		
335.10	<u>Base Adjustment. The lottery prize fund</u>		
335.11	<u>base for this program shall be increased by</u>		
335.12	<u>\$78,000 in each of fiscal years 2014 and</u>		
335.13	<u>2015.</u>		
335.14	<u>(m) Children's Mental Health Grants</u>	<u>16,682,000</u>	<u>16,682,000</u>
335.15	<u>Funding Usage. Up to 75 percent of a fiscal</u>		
335.16	<u>year's appropriation for children's mental</u>		
335.17	<u>health grants may be used to fund allocations</u>		
335.18	<u>in that portion of the fiscal year ending</u>		
335.19	<u>December 31.</u>		
335.20	<u>(n) Chemical Dependency Nonentitlement</u>		
335.21	<u>Grants</u>	<u>1,336,000</u>	<u>1,336,000</u>
335.22	<u>Subd. 5. State-Operated Services</u>		
335.23	<u>Transfer Authority Related to</u>		
335.24	<u>State-Operated Services. Money</u>		
335.25	<u>appropriated for state-operated services</u>		
335.26	<u>may be transferred between fiscal years</u>		
335.27	<u>of the biennium with the approval of the</u>		
335.28	<u>commissioner of management and budget.</u>		
335.29	<u>(a) State-Operated Services Mental Health</u>	<u>115,286,000</u>	<u>115,135,000</u>
335.30	<u>State-Operated Services. To achieve these</u>		
335.31	<u>savings, the commissioner shall close the</u>		
335.32	<u>Willmar Community Behavioral Health</u>		
335.33	<u>Hospital no later than October 1, 2011, and</u>		
335.34	<u>shall close the inpatient child and adolescent</u>		

336.1	<u>behavioral health service program in</u>		
336.2	<u>Willmar, the subacute mental health facility</u>		
336.3	<u>in Wadena, and the community behavioral</u>		
336.4	<u>health hospitals in Alexandria, Annandale,</u>		
336.5	<u>Baxter, Bemidji, Fergus Falls, and Rochester</u>		
336.6	<u>no later than October 1, 2012.</u>		
336.7	<u>Base Adjustment.</u> The general fund base is		
336.8	<u>reduced by \$8,443,000 in fiscal year 2014</u>		
336.9	<u>and \$11,543,000 in fiscal year 2015.</u>		
336.10	<u>(b) Minnesota Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>
336.11	<u>Subd. 6. Sex Offender Program</u>	<u>70,416,000</u>	<u>67,570,000</u>
336.12	<u>Transfer Authority Related to Minnesota</u>		
336.13	<u>Sex Offender Program.</u> Money		
336.14	<u>appropriated for the Minnesota sex offender</u>		
336.15	<u>program may be transferred between fiscal</u>		
336.16	<u>years of the biennium with the approval</u>		
336.17	<u>of the commissioner of management and</u>		
336.18	<u>budget.</u>		
336.19	<u>Minnesota Sex Offender Program</u>		
336.20	<u>Reduction.</u> The fiscal year 2011 general		
336.21	<u>fund appropriation for Minnesota sex</u>		
336.22	<u>offender services under Laws 2009, chapter</u>		
336.23	<u>79, article 13, section 3, subdivision 10,</u>		
336.24	<u>paragraph (b), is reduced by \$3,000,000.</u>		
336.25	<u>Subd. 7. Technical Activities</u>	<u>78,206,000</u>	<u>102,551,000</u>
336.26	<u>This appropriation is from the federal TANF</u>		
336.27	<u>fund.</u>		
336.28	<u>Sec. 4. COMMISSIONER OF HEALTH</u>		
336.29	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 147,939,000</u>	<u>\$ 136,632,000</u>
336.30	<u>Appropriations by Fund</u>		
336.31		<u>2012</u>	<u>2013</u>
336.32	<u>General</u>	<u>77,634,000</u>	<u>72,738,000</u>
336.33	<u>State Government</u>		
336.34	<u>Special Revenue</u>	<u>45,268,000</u>	<u>45,325,000</u>

337.1	<u>Health Care Access</u>	<u>13,774,000</u>	<u>9,162,000</u>
337.2	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

337.3 The amounts that may be spent for each
337.4 purpose are specified in the following
337.5 subdivisions.

337.6 Subd. 2. **Community and Family Health**
337.7 **Promotion**

337.8	<u>Appropriations by Fund</u>		
337.9	<u>General</u>	<u>50,430,000</u>	<u>45,690,000</u>
337.10	<u>State Government</u>		
337.11	<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>
337.12	<u>Health Care Access</u>	<u>2,918,000</u>	<u>2,459,000</u>
337.13	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

337.14 **TANF Appropriations.** (1) \$1,156,000 of
337.15 the TANF funds is appropriated each year to
337.16 the commissioner for family planning grants
337.17 under Minnesota Statutes, section 145.925.

337.18 (2) \$3,579,000 of the TANF funds is
337.19 appropriated each year to the commissioner
337.20 for home visiting and nutritional services
337.21 listed under Minnesota Statutes, section
337.22 145.882, subdivision 7, clauses (6) and (7).

337.23 Funds must be distributed to community
337.24 health boards according to Minnesota
337.25 Statutes, section 145A.131, subdivision 1.

337.26 (3) \$2,000,000 of the TANF funds is
337.27 appropriated each year to the commissioner
337.28 for decreasing racial and ethnic disparities
337.29 in infant mortality rates under Minnesota
337.30 Statutes, section 145.928, subdivision 7.

337.31 (4) \$4,978,000 of the TANF funds is
337.32 appropriated each year to the commissioner
337.33 for the family home visiting grant program
337.34 according to Minnesota Statutes, section
337.35 145A.17. \$4,000,000 of the funding must
337.36 be distributed to community health boards

338.1 according to Minnesota Statutes, section
338.2 145A.131, subdivision 1. \$978,000 of
338.3 the funding must be distributed to tribal
338.4 governments based on Minnesota Statutes,
338.5 section 145A.14, subdivision 2a.

338.6 (5) The commissioner may use up to 6.23
338.7 percent of the funds appropriated each fiscal
338.8 year to conduct the ongoing evaluations
338.9 required under Minnesota Statutes, section
338.10 145A.17, subdivision 7, and training and
338.11 technical assistance as required under
338.12 Minnesota Statutes, section 145A.17,
338.13 subdivisions 4 and 5.

338.14 **TANF Carryforward.** Any unexpended
338.15 balance of the TANF appropriation in the
338.16 first year of the biennium does not cancel but
338.17 is available for the second year.

338.18 **Subd. 3. Policy Quality and Compliance**

338.19	<u>Appropriations by Fund</u>		
338.20	<u>General</u>	<u>10,434,000</u>	<u>10,230,000</u>
338.21	<u>State Government</u>		
338.22	<u>Special Revenue</u>	<u>14,026,000</u>	<u>14,083,000</u>
338.23	<u>Health Care Access</u>	<u>10,856,000</u>	<u>6,703,000</u>

338.24 **MERC Fund Transfers.** The commissioner
338.25 of management and budget shall transfer
338.26 \$9,800,000 from the MERC fund to the
338.27 general fund by October 1, 2011.

338.28 **Comprehensive Advanced Life Support.**
338.29 Of the general fund appropriation, \$31,000
338.30 each year is added to the base of the
338.31 comprehensive advanced life support
338.32 (CALS) program under Minnesota Statutes,
338.33 section 144.6062.

338.34 **Unused Federal Match Funds.** Of the
338.35 funds appropriated in Laws 2009, chapter

339.1 79, article 13, section 4, subdivision 3, for
339.2 state matching funds for the federal Health
339.3 Information Technology for Economic and
339.4 Clinical Health Act, \$2,800,000 is transferred
339.5 to the health care access fund by October 1,
339.6 2011.

339.7 **Health Careers Opportunities Grants.**
339.8 \$447,000 each year is appropriated to the
339.9 commissioner of health from the health
339.10 care access fund for the health careers
339.11 opportunities grant program under Minnesota
339.12 Statutes, section 144.1499.

339.13 **Health Professions Opportunities**
339.14 **Scholarship Program.** \$63,000 each year is
339.15 appropriated to the commissioner of health
339.16 from the health care access fund for the
339.17 health professions opportunities scholarship
339.18 program under Minnesota Statutes, section
339.19 144.1503. \$138,000 in fiscal year 2012 and
339.20 \$276,000 each year thereafter is appropriated
339.21 to the commissioner of health from the
339.22 general fund for the health professions
339.23 opportunities scholarship program under
339.24 Minnesota Statutes, section 144.1503.

339.25 **Base Level Adjustment.** The state
339.26 government special revenue fund base shall
339.27 be reduced by \$141,000 in fiscal years 2014
339.28 and 2015. The health care access base shall
339.29 be increased by \$600,000 in fiscal year 2014.

339.30 **Subd. 4. Health Protection**

339.31	<u>Appropriations by Fund</u>		
339.32	<u>General</u>	<u>9,370,000</u>	<u>9,370,000</u>
339.33	<u>State Government</u>		
339.34	<u>Special Revenue</u>	<u>30,209,000</u>	<u>30,209,000</u>

339.35	<u>Subd. 5. Administrative Support Services</u>	<u>7,400,000</u>	<u>7,448,000</u>

340.1	Sec. 5. <u>COUNCIL ON DISABILITY</u>	\$	<u>524,000</u>	\$	<u>524,000</u>
340.2	Sec. 6. <u>OMBUDSMAN FOR MENTAL</u>				
340.3	<u>HEALTH AND DEVELOPMENTAL</u>				
340.4	<u>DISABILITIES</u>	\$	<u>1,655,000</u>	\$	<u>1,655,000</u>
340.5	<u>Funds appropriated for fiscal year 2011 are</u>				
340.6	<u>available until expended.</u>				
340.7	Sec. 7. <u>OMBUDSPERSON FOR FAMILIES</u>	\$	<u>265,000</u>	\$	<u>265,000</u>
340.8	Sec. 8. <u>HEALTH-RELATED BOARDS</u>				
340.9	<u>Subdivision 1. Total Appropriation</u>	\$	<u>17,365,000</u>	\$	<u>17,264,000</u>
340.10	<u>This appropriation is from the state</u>				
340.11	<u>government special revenue fund. The</u>				
340.12	<u>amounts that may be spent for each purpose</u>				
340.13	<u>are specified in the following subdivisions.</u>				
340.14	<u>Subd. 2. Board of Chiropractic Examiners</u>		<u>469,000</u>		<u>469,000</u>
340.15	<u>Subd. 3. Board of Dentistry</u>		<u>1,959,000</u>		<u>1,914,000</u>
340.16	<u>Health Professional Services Program.</u>				
340.17	<u>\$834,000 in fiscal year 2012 and \$804,000 in</u>				
340.18	<u>fiscal year 2013 from the state government</u>				
340.19	<u>special revenue fund are for the health</u>				
340.20	<u>professional services program.</u>				
340.21	<u>Subd. 4. Board of Dietetic and Nutrition</u>				
340.22	<u>Practice</u>		<u>110,000</u>		<u>110,000</u>
340.23	<u>Subd. 5. Board of Marriage and Family</u>				
340.24	<u>Therapy</u>		<u>192,000</u>		<u>167,000</u>
340.25	<u>Rulemaking. Of this appropriation, \$25,000</u>				
340.26	<u>in fiscal year 2012 is for rulemaking. This is</u>				
340.27	<u>a onetime appropriation.</u>				
340.28	<u>Subd. 6. Board of Medical Practice</u>		<u>3,866,000</u>		<u>3,866,000</u>
340.29	<u>Subd. 7. Board of Nursing</u>		<u>3,545,000</u>		<u>3,545,000</u>
340.30	<u>Subd. 8. Board of Nursing Home</u>				
340.31	<u>Administrators</u>		<u>2,153,000</u>		<u>2,145,000</u>

341.1 **Rulemaking.** Of this appropriation, \$44,000
341.2 in fiscal year 2012 is for rulemaking. This is
341.3 a onetime appropriation.

341.4 **Electronic Licensing System Adaptors.**
341.5 Of this appropriation, \$761,000 in fiscal
341.6 year 2013 from the state government special
341.7 revenue fund is to the administrative services
341.8 unit to cover the costs to connect to the
341.9 e-licensing system. Minnesota Statutes,
341.10 section 16E.22. Base level funding for this
341.11 activity in fiscal year 2014 shall be \$100,000.
341.12 Base level funding for this activity in fiscal
341.13 year 2015 shall be \$50,000.

341.14 **Development and Implementation of a**
341.15 **Disciplinary, Regulatory, Licensing and**
341.16 **Information Management System.** Of this
341.17 appropriation, \$800,000 in fiscal year 2012
341.18 and \$300,000 in fiscal year 2013 are for the
341.19 development of a shared system. Base level
341.20 funding for this activity in fiscal year 2014
341.21 shall be \$50,000.

341.22 **Administrative Services Unit - Operating**
341.23 **Costs.** Of this appropriation, \$526,000
341.24 in fiscal year 2012 and \$526,000 in
341.25 fiscal year 2013 are for operating costs
341.26 of the administrative services unit. The
341.27 administrative services unit may receive
341.28 and expend reimbursements for services
341.29 performed by other agencies.

341.30 **Administrative Services Unit - Retirement**
341.31 **Costs.** Of this appropriation in fiscal year
341.32 2012, \$225,000 is for onetime retirement
341.33 costs in the health-related boards. This
341.34 funding may be transferred to the health
341.35 boards incurring those costs for their

342.1 payment. These funds are available either
342.2 year of the biennium.

342.3 **Administrative Services Unit - Volunteer**
342.4 **Health Care Provider Program.** Of this
342.5 appropriation, \$150,000 in fiscal year 2012
342.6 and \$150,000 in fiscal year 2013 are to pay
342.7 for medical professional liability coverage
342.8 required under Minnesota Statutes, section
342.9 214.40.

342.10 **Administrative Services Unit - Contested**
342.11 **Cases and Other Legal Proceedings.** Of this appropriation, \$200,000 in fiscal
342.12 year 2012 and \$200,000 in fiscal year
342.13 2013 are for costs of contested case
342.14 hearings and other unanticipated costs of
342.15 legal proceedings involving health-related
342.16 boards funded under this section. Upon
342.17 certification of a health-related board to the
342.18 administrative services unit that the costs
342.19 will be incurred and that there is insufficient
342.20 money available to pay for the costs out of
342.21 money currently available to that board, the
342.22 administrative services unit is authorized
342.23 to transfer money from this appropriation
342.24 to the board for payment of those costs
342.25 with the approval of the commissioner of
342.26 finance. This appropriation does not cancel.
342.27 Any unencumbered and unspent balances
342.28 remain available for these expenditures in
342.29 subsequent fiscal years.

342.30

342.31 Subd. 9. **Board of Optometry** 106,000 106,000

342.32 Subd. 10. **Board of Pharmacy** 1,977,000 1,980,000

342.33 **Prescription Electronic Reporting.** Of
342.34 this appropriation, \$356,000 in fiscal year
342.35 2012 and \$356,000 in fiscal year 2013 from

343.1 the state government special revenue fund
343.2 are to the board to operate the prescription
343.3 electronic reporting system in Minnesota
343.4 Statutes, section 152.126. Base level funding
343.5 for this activity in fiscal year 2014 shall be
343.6 \$356,000.

343.7	<u>Subd. 11. Board of Physical Therapy</u>	<u>389,000</u>	<u>345,000</u>

343.8 **Rulemaking.** Of this appropriation, \$44,000
343.9 in fiscal year 2012 is for rulemaking. This is
343.10 a onetime appropriation.

343.11	<u>Subd. 12. Board of Podiatry</u>	<u>75,000</u>	<u>75,000</u>
343.12	<u>Subd. 13. Board of Psychology</u>	<u>846,000</u>	<u>846,000</u>
343.13	<u>Subd. 14. Board of Social Work</u>	<u>1,036,000</u>	<u>1,053,000</u>
343.14	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>228,000</u>	<u>229,000</u>
343.15	<u>Subd. 16. Board of Behavioral Health and</u>		
343.16	<u>Therapy</u>	<u>414,000</u>	<u>414,000</u>

343.17	<u>Sec. 9. EMERGENCY MEDICAL SERVICES</u>		
343.18	<u>BOARD</u>	<u>\$ 2,742,000</u>	<u>\$ 2,742,000</u>

343.19 Of the appropriation, \$700,000 in fiscal year
343.20 2012 and \$700,000 in fiscal year 2013 are
343.21 for the Cooper/Sams volunteer ambulance
343.22 program under Minnesota Statutes, section
343.23 144E.40.

343.24 Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
343.25 to read:

343.26 Subd. 33. **Federal administrative reimbursement dedicated.** Federal
343.27 administrative reimbursement resulting from the following activities is appropriated to the
343.28 commissioner for the designated purposes:

343.29 (1) reimbursement for the Minnesota senior health options project; and
343.30 (2) reimbursement related to prior authorization and inpatient admission certification
343.31 by a professional review organization. A portion of these funds must be used for activities
343.32 to decrease unnecessary pharmaceutical costs in medical assistance.

344.1 Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision

344.2 6. is amended to read:

344.3 Subd. 6. Continuing Care Grants

344.4	(a) Aging and Adult Services Grants	(3,600,000)	(3,600,000)

344.5 **Community Service/Service Development**

344.6 **Grants Reduction.** Effective retroactively
344.7 from July 1, 2009, funding for grants made
344.8 under Minnesota Statutes, sections 256.9754
344.9 and 256B.0917, subdivision 13, is reduced
344.10 by \$5,807,000 for each year of the biennium.

344.11 Grants made during the biennium under
344.12 Minnesota Statutes, section 256.9754, shall
344.13 not be used for new construction or building
344.14 renovation.

344.15 **Aging Grants Delay.** Aging grants must be
344.16 reduced by \$917,000 in fiscal year 2011 and
344.17 increased by \$917,000 in fiscal year 2012.
344.18 These adjustments are onetime and must not
344.19 be applied to the base. This provision expires
344.20 June 30, 2012.

344.21	(b) Medical Assistance Long-Term Care		
344.22	Facilities Grants	(3,827,000)	(2,745,000)

344.23 **ICF/MR Variable Rates Suspension.**
344.24 Effective retroactively from July 1, 2009,
344.25 to June 30, 2010, no new variable rates
344.26 shall be authorized for intermediate care
344.27 facilities for persons with developmental
344.28 disabilities under Minnesota Statutes, section
344.29 256B.5013, subdivision 1.

344.30 **ICF/MR Occupancy Rate Adjustment**
344.31 **Suspension.** Effective retroactively from
344.32 July 1, 2009, to June 30, 2011, approval
344.33 of new applications for occupancy rate
344.34 adjustments for unoccupied short-term

345.1	beds under Minnesota Statutes, section		
345.2	256B.5013, subdivision 7, is suspended.		
345.3	(c) Medical Assistance Long-Term Care	(2,318,000)	(5,807,000)
345.4	Waivers and Home Care Grants		
345.5	Developmental Disability Waiver Acuity		
345.6	Factor. Effective retroactively from January		
345.7	1, 2010, the January 1, 2010, one percent		
345.8	growth factor in the developmental disability		
345.9	waiver allocations under Minnesota Statutes,		
345.10	section 256B.092, subdivisions 4 and 5,		
345.11	that is attributable to changes in acuity;		
345.12	is ~~suspended to June 30, 2011~~ <u>eliminated.</u>		
345.13	<u>Effective January 1, 2012, the one percent</u>		
345.14	<u>growth factor in the developmental</u>		
345.15	<u>disability waiver allocations is eliminated.</u>		
345.16	<u>Notwithstanding any law to the contrary, this</u>		
345.17	<u>provision does not expire.</u>		
345.18	(d) Adult Mental Health Grants	(5,000,000)	-0-
345.19	(e) Chemical Dependency Entitlement Grants	(3,622,000)	(3,622,000)
345.20	(f) Chemical Dependency Nonentitlement		
345.21	Grants	(393,000)	(393,000)
345.22			~~(2,500,000)~~
345.23	(g) Other Continuing Care Grants	-0-	<u>(1,414,000)</u>
345.24	Other Continuing Care Grants Delay.		
345.25	Other continuing care grants must be reduced		
345.26	by \$1,414,000 in fiscal year 2011 and		
345.27	increased by \$1,414,000 in fiscal year 2012.		
345.28	These adjustments are onetime and must not		
345.29	be applied to the base. This provision expires		
345.30	June 30, 2012.		
345.31	<u>(h) Deaf and Hard-of-Hearing Grants</u>	<u>-0-</u>	<u>(169,000)</u>
345.32	<u>Deaf and Hard-of-Hearing Grants Delay.</u>		
345.33	<u>Effective retroactively from July 1, 2010,</u>		
345.34	<u>deaf and hard-of-hearing grants must be</u>		
345.35	<u>reduced by \$169,000 in fiscal year 2011 and</u>		

346.1 increased by \$169,000 in fiscal year 2012.
346.2 These adjustments are onetime and must not
346.3 be applied to the base. This provision expires
346.4 June 30, 2012.

346.5 Sec. 12. **TRANSFERS.**

346.6 Subdivision 1. **Grants.** The commissioner of human services, with the approval
346.7 of the commissioner of management and budget, and after notification of the chairs of
346.8 the senate health and human services budget and policy committee and the house of
346.9 representatives health and human services finance committee, may transfer unencumbered
346.10 appropriation balances for the biennium ending June 30, 2013, within fiscal years among
346.11 the MFIP; general assistance; general assistance medical care under Minnesota Statutes
346.12 2009 Supplement, section 256D.03, subdivision 3; medical assistance; MFIP child care
346.13 assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid;
346.14 and group residential housing programs, and the entitlement portion of the chemical
346.15 dependency consolidated treatment fund, and between fiscal years of the biennium.

346.16 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
346.17 money may be transferred within the Departments of Health and Human Services as the
346.18 commissioners consider necessary, with the advance approval of the commissioner of
346.19 management and budget. The commissioner shall inform the chairs of the senate health
346.20 and human services budget and policy committee and the house of representatives health
346.21 and human services finance committee quarterly about transfers made under this provision.

346.22 Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

346.23 The commissioners of health and human services shall not use indirect cost
346.24 allocations to pay for the operational costs of any program for which they are responsible.

346.25 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

346.26 All uncoded language contained in this article expires on June 30, 2013, unless a
346.27 different expiration date is explicit.

346.28 Sec. 15. **EFFECTIVE DATE.**

346.29 The provisions in this article are effective July 1, 2011, unless a different effective
346.30 date is specified.

ARTICLE 10

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 each purpose. The figure "2011" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2011.

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **\$ (235,463,000)**

Appropriations by Fund

2011

<u>General</u>	<u>(381,869,000)</u>
<u>Health Care Access</u>	<u>169,514,000</u>
<u>Federal TANF</u>	<u>(23,108,000)</u>

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Revenue and Pass-through** **732,000**

This appropriation is from the federal TANF fund.

Subd. 3. **Children and Economic Assistance Grants**

Appropriations by Fund

<u>General</u>	<u>(7,098,000)</u>
<u>Federal TANF</u>	<u>(23,840,000)</u>

(a) MFIP/DWP Grants

Appropriations by Fund

<u>General</u>	<u>18,715,000</u>
<u>Federal TANF</u>	<u>(23,840,000)</u>

348.1	<u>(b) MFIP Child Care Assistance Grants</u>		<u>(24,394,000)</u>
348.2	<u>(c) General Assistance Grants</u>		<u>(664,000)</u>
348.3	<u>(d) Minnesota Supplemental Aid Grants</u>		<u>793,000</u>
348.4	<u>(e) Group Residential Housing Grants</u>		<u>(1,548,000)</u>
348.5	Subd. 4. <u>Basic Health Care Grants</u>		
348.6	Appropriations by Fund		
348.7	General	<u>(335,050,000)</u>	
348.8	Health Care Access	<u>169,514,000</u>	
348.9	<u>(a) MinnesotaCare Grants</u>		<u>169,514,000</u>
348.10	<u>This appropriation is from the health care</u>		
348.11	<u>access fund.</u>		
348.12	<u>(b) Medical Assistance Basic Health Care -</u>		
348.13	<u>Families and Children</u>		<u>(49,368,000)</u>
348.14	<u>(c) Medical Assistance Basic Health Care -</u>		
348.15	<u>Elderly and Disabled</u>		<u>(43,258,000)</u>
348.16	<u>(d) Medical Assistance Basic Health Care -</u>		
348.17	<u>Adults without Children</u>		<u>(242,424,000)</u>
348.18	Subd. 5. <u>Continuing Care Grants</u>		<u>(39,721,000)</u>
348.19	<u>(a) Medical Assistance Long-Term Care</u>		
348.20	<u>Facilities</u>		<u>(14,627,000)</u>
348.21	<u>(b) Medical Assistance Long-Term Care</u>		
348.22	<u>Waivers</u>		<u>(44,718,000)</u>
348.23	<u>(c) Chemical Dependency Entitlement Grants</u>		<u>19,624,000</u>
348.24	Sec. 3. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6,		
348.25	is amended to read:		
348.26	Subd. 6. Health Care Grants		
348.27	(a) MinnesotaCare Grants	998,000	(13,376,000)
348.28	This appropriation is from the health care		
348.29	access fund.		
348.30	Health Care Access Fund Transfer to		
348.31	General Fund. The commissioner of		

349.1 management and budget shall transfer the
349.2 following amounts in the following years
349.3 from the health care access fund to the
349.4 general fund: ~~\$998,000~~ \$0 in fiscal year
349.5 2010; ~~\$176,704,000~~ \$59,901,000 in fiscal
349.6 year 2011; \$141,041,000 in fiscal year 2012;
349.7 and \$286,150,000 in fiscal year 2013. If at
349.8 any time the governor issues an executive
349.9 order not to participate in early medical
349.10 assistance expansion, no funds shall be
349.11 transferred from the health care access
349.12 fund to the general fund until early medical
349.13 assistance expansion takes effect. This
349.14 paragraph is effective the day following final
349.15 enactment.

349.16 **MinnesotaCare Ratable Reduction.**
349.17 Effective for services rendered on or after
349.18 July 1, 2010, to December 31, 2013,
349.19 MinnesotaCare payments to managed care
349.20 plans under Minnesota Statutes, section
349.21 256L.12, for single adults and households
349.22 without children whose income is greater
349.23 than 75 percent of federal poverty guidelines
349.24 shall be reduced by 15 percent. Effective
349.25 for services provided from July 1, 2010, to
349.26 June 30, 2011, this reduction shall apply to
349.27 all services. Effective for services provided
349.28 from July 1, 2011, to December 31, 2013, this
349.29 reduction shall apply to all services except
349.30 inpatient hospital services. Notwithstanding
349.31 any contrary provision of this article, this
349.32 paragraph shall expire on December 31,
349.33 2013.

349.34 (b) **Medical Assistance Basic Health Care**
349.35 **Grants - Families and Children** -0- 295,512,000

350.1 **Critical Access Dental.** Of the general
350.2 fund appropriation, \$731,000 in fiscal year
350.3 2011 is to the commissioner for critical
350.4 access dental provider reimbursement
350.5 payments under Minnesota Statutes, section
350.6 256B.76 subdivision 4. This is a onetime
350.7 appropriation.

350.8 **Nonadministrative Rate Reduction.** For
350.9 services rendered on or after July 1, 2010,
350.10 to December 31, 2013, the commissioner
350.11 shall reduce contract rates paid to managed
350.12 care plans under Minnesota Statutes,
350.13 sections 256B.69 and 256L.12, and to
350.14 county-based purchasing plans under
350.15 Minnesota Statutes, section 256B.692, by
350.16 three percent of the contract rate attributable
350.17 to nonadministrative services in effect on
350.18 June 30, 2010. Notwithstanding any contrary
350.19 provision in this article, this rider expires on
350.20 December 31, 2013.

350.21	(c) Medical Assistance Basic Health Care		
350.22	Grants - Elderly and Disabled	-0-	(30,265,000)
350.23			~~(75,389,000)~~
350.24	(d) General Assistance Medical Care Grants	-0-	<u>(59,583,000)</u>

350.25 The reduction to general assistance medical
350.26 care grants is contingent upon the effective
350.27 date in Laws 2010, First Special Session
350.28 chapter 1, article 16, section 48. The
350.29 reduction shall be reestimated based upon
350.30 the actual effective date of the law. The
350.31 commissioner of management and budget
350.32 shall make adjustments in fiscal year
350.33 2011 to general assistance medical care
350.34 appropriations to conform to the total
350.35 expected expenditure reductions specified in
350.36 this section.

351.1	(e) Other Health Care Grants	-0-	(7,000,000)
351.2	Cobra Carryforward. Unexpended funds		
351.3	appropriated in fiscal year 2010 for COBRA		
351.4	grants under Laws 2009, chapter 79, article		
351.5	5, section 78, do not cancel and are available		
351.6	to the commissioner for fiscal year 2011		
351.7	COBRA grant expenditures. Up to \$111,000		
351.8	of the fiscal year 2011 appropriation for		
351.9	COBRA grants provided in Laws 2009,		
351.10	chapter 79, article 13, section 3, subdivision		
351.11	6, may be used by the commissioner for costs		
351.12	related to administration of the COBRA		
351.13	grants.		
351.14	Sec. 4. <u>EFFECTIVE DATE.</u>		
351.15	<u>This article is effective the day following final enactment.</u>		