S.F. No. 760, 4th Engrossment - 87th Legislative Session (2011-2012) [S0760-4]

SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

(Senate Authors: HANN)

DATE D-PG OFFICIAL STATUS
03/28/2011 931 Rule 12.10: report of votes in committee
03/29/2011 1030a Comm report: To pass as amended
03/30/2011 1033 Second reading
04/07/2011 1118 Third reading Passed
04/11/2011 1228 Returned from House with amendment
04/13/2011 1268 Senateconference Hann; Benson; Hoffman; Newman; Nienow
04/14/2011 1273 House conference Abeler; Gottwalt; Kiffmeyer; Lohmer; Huntley
05/18/2011 2266c Conference committee report, delete everything
2516 Motion to reject CC report, did not prevail
Laid on table
Taken from table
Senate adopted CC report and repassed bill
2517 Third reading
Laid on table
Taken from table
2518 Bill repassed
2731 House adopted SCC report and repassed bill
Presentment date 05/21/11
3588 Governor's action Veto Chapter 41 05/24/11
3600 Veto message laid on table
See SF54, Art. 4 (human services forecast adjustments)
See HF25, Art. 1-3, 5-7 (First Special Session)

1.1 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 8.31, subdivisions 1, 3a; 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.692; 62Q.32; 62U.04, subdivisions 3, 9; 62U.06, subdivision 2; 119B.011, subdivision 13; 119B.035, subdivision 4; 119B.09, subdivision 10, by adding subdivisions;
119B.125, by adding a subdivision; 119B.13, subdivisions 1, 1a, 7; 144.1501, subdivision 1; 144.396, subdivisions 5, 6; 144.98, subdivisions 2a, 7, by adding subdivisions; 144A.102; 144A.61, by adding a subdivision; 144E.123; 145.925, subdivisions 1, 2; 145.928, subdivisions 7, 8; 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; 152.12, subdivision 3; 157.15, by adding a subdivision; 157.20, by adding a subdivision; 245A.14, subdivision 4; 245C.03, by adding a subdivision; 245C.10, by adding a subdivision; 246B.10; 252.025, subdivision 7; 252.27, subdivision 2a; 253B.212; 253B.03, subdivisions 1, 4; 254B.04, subdivision 1, by adding a subdivision; 254B.06, subdivision 2, 256.01, subdivisions 2b, 14, 14b, 24, 29, by adding a subdivision; 256.969, subdivision 2b; 256B.04, subdivisions 14a, 18, by adding a subdivision; 256B.05, by adding a subdivision; 256B.056, subdivisions 3, 4; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8b, 8c, 8e, 13e, 13h, 17, 17a, 18, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.0644; 256B.0659, subdivisions 11, 28; 256B.0751, subdivision 4, by adding a subdivision; 256B.0911, subdivisions 1a, 3a; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 10; 256B.0916, subdivision 6a; 256B.092, subdivisions 1b, 1e, 1g, 3, 8; 256B.0943, by adding a subdivision; 256B.0945, subdivision 4; 256B.14, by adding a subdivision; 256B.431, subdivisions 2r, 32; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.441, subdivision 50a, by adding a subdivision; 256B.48, subdivision
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 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 90.68 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.

**EFFECTIVE DATE.** This section is effective October 31, 2011.

Sec. 3. 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. 4. 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 child'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. 5. 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. 6. Minnesota Statutes 2010, section 119B.125, is amended by adding a subdivision to read:
Subd. 1b. **Training required.** (a) Effective November 1, 2011, prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the county. The training documentation must have valid effective dates as of the date the registration request is submitted to the county and the training must have been provided by an individual approved to provide first aid and CPR instruction.

(b) Legal nonlicensed family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012.

(c) Upon each reauthorization after the authorization period when the initial first aid and CPR training requirements are met, a legal nonlicensed family child care provider must provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry.

(d) This subdivision only applies to legal nonlicensed family child care providers.

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 2400.0185, subparts 3 and 4.

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

(e) 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.
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.

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.

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.

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.

All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

EFFECTIVE DATE. Paragraph (d) is effective April 16, 2012. Paragraph (e) is effective September 3, 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% 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. 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 68 and 0.80 to 0.68 is effective October 31, 2011.

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

Subd. 7. **Absent days.** (a) Licensed child care providers must and license-exempt centers must not be reimbursed for more than 25 ten full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full-day absent days; unless the child has a documented medical condition that causes more frequent absences.

Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the 25-day absent day limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to; fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ten consecutive or 25 cumulative absent day limits.

Children in families where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, may be exempt from the absent day limits upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day. Child care providers may only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

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

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

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

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

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

Sec. 10. [256.987] ELECTRONIC BENEFIT TRANSFER CARD.

Subdivision 1. Electronic benefit transfer (EBT) card. 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. A retailer must not be held liable for the crime of another under section
609.05, for actions taken under this subdivision.

**EFFECTIVE DATE.** Subdivisions 1 and 2 of this section are effective June 1, 2012.

Sec. 11. Minnesota Statutes 2010, section 256D.02, subdivision 12a, is amended to
read:

Subd. 12a. **Resident; general assistance medical care.** (a) For purposes of
eligibility for general assistance and general assistance medical care, a person must be a
resident of this state.

(b) A "resident" is a person living in the state for at least 30 days with the intention of
making the person's home here and not for any temporary purpose. Time spent in a shelter
for battered women shall count toward satisfying the 30-day residency requirement. All
applicants for these programs are required to demonstrate the requisite intent and can do
so in any of the following ways:

(1) by showing that the applicant maintains a residence at a verified address, other
than a place of public accommodation. An applicant may verify a residence address by
presenting a valid state driver's license; a state identification card; a voter registration
card; a rent receipt; a statement by the landlord, apartment manager, or homeowner
verifying that the individual is residing at the address; or other form of verification
approved by the commissioner; or

(2) by verifying residence according to Minnesota Rules, part 9500.1219, subpart
3, item C.

(c) For general assistance medical care, a county agency shall waive the 30-day
residency requirement in cases of medical emergencies. For general assistance, a county
shall waive the 30-day residency requirement where unusual hardship would result from
denial of general assistance. For purposes of this subdivision, "unusual hardship" means
the applicant is without shelter or is without available resources for food.

The county agency must report to the commissioner within 30 days on any waiver
granted under this section. The county shall not deny an application solely because the
applicant does not meet at least one of the criteria in this subdivision, but shall continue to
process the application and leave the application pending until the residency requirement
is met or until eligibility or ineligibility is established.
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(d) For purposes of paragraph (e), the following definitions apply: (1) "metropolitan statistical area" is as defined by the United States Census Bureau; (2) "shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the applicant is eligible, provided the applicant does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(e) Migrant workers as defined in section 256J.08 and, until March 31, 1998, their immediate families are exempt from the residency requirements of this section, provided the migrant worker provides verification that the migrant family worked in this state within the last 12 months and earned at least $1,000 in gross wages during the time the migrant worker worked in this state.

(f) For purposes of eligibility for emergency general assistance, the 30-day residency requirement under this section shall not be waived.

(e) If any provision of this subdivision is enjoined from implementation or found unconstitutional by any court of competent jurisdiction, the remaining provisions shall remain valid and shall be given full effect.

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

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

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

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 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) 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) a person who resides in a shelter facility described in subdivision 3;
(5)(4) a person not described in clause (1) or (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)(7) 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;

(+1,2) (8) 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;
(+1,2) a person who lives more than four hours round-trip traveling time from any
potential suitable employment;
(+1,2) (9) 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
(+1,2) (10) a person over age 18 whose primary language is not English and who is
attending high school at least half-time; or
(+1,2) (10) 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), (2), (4),
(5), and (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) 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.

**EFFECTIVE DATE.** This section is effective May 1, 2012.
Sec. 13. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:
Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need, as defined in rules promulgated by the commissioner, where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist and the individual or family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP under written criteria adopted by the county agency. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision.

(b) The applicant must be ineligible for assistance under chapter 256J, must have annual net income no greater than 200 percent of the federal poverty guidelines for the previous calendar year, and may receive an emergency general assistance grant if available to a recipient not more than once in any 12-month period.

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

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

**EFFECTIVE DATE.** This section is effective November 1, 2011.

Sec. 14. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:
Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

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

1. high protein diet, at least 80 grams daily; 25 percent of thrifty food plan;
2. controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;
3. controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;
4. low-cholesterol diet, 25 percent of thrifty food plan;
5. high residue diet, 20 percent of thrifty food plan;
6. pregnancy and lactation diet, 35 percent of thrifty food plan;
7. gluten-free diet, 25 percent of thrifty food plan;
8. lactose-free diet, 25 percent of thrifty food plan;
9. antidumping diet, 15 percent of thrifty food plan;
10. hypoglycemic diet, 15 percent of thrifty food plan; or
11. ketogenic diet, 25 percent of thrifty food plan.

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

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

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

**EFFECTIVE DATE.** This section is effective November 1, 2011.
16.1 Sec. 16. Minnesota Statutes 2010, section 256D.47, is amended to read:

256D.47 PAYMENT METHODS.

Minnesota supplemental aid payments must be issued to the recipient, a protective payee, or a conservator or guardian of the recipient's estate in the form of county warrants immediately redeemable in cash, electronic benefits transfer, or by direct deposit into the recipient's account in a financial institution. Minnesota supplemental aid payments must be issued regularly on the first day of the month. The supplemental aid warrants must be mailed only to the address at which the recipient resides, unless another address has been approved in advance by the county agency. Vendor payments must not be issued by the county agency except for nonrecurring emergency need payments; at the request of the recipient; for special needs, other than special diets; or when the agency determines the need for protective payments exist.

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

16.14 Sec. 17. Minnesota Statutes 2010, section 256E.35, subdivision 5, is amended to read:

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

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

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

16.15 Sec. 18. Minnesota Statutes 2010, section 256E.35, subdivision 6, is amended to read:

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

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

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

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

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

Sec. 19. Minnesota Statutes 2010, section 2561.03, is amended by adding a subdivision
to read:

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

Sec. 20. Minnesota Statutes 2010, section 2561.04, subdivision 1, is amended to read:

Subdivision 1. Individual eligibility requirements. An individual is eligible for
and entitled to a group residential housing payment to be made on the individual's behalf
if the county agency has approved the individual's residence in a group residential housing
setting and the individual meets the requirements in paragraph (a) or (b) this section.

(a) The individual is aged, blind, or is over 18 years of age and disabled as
determined under the criteria used by the title II program of the Social Security Act,
and meets the resource restrictions and standards of the supplemental security income
program, and the individual's countable income after deducting the (1) exclusions and
disregards of the SSI program, (2) the medical assistance personal needs allowance
under section 256B.35, and (3) an amount equal to the income actually made available
to a community spouse by an elderly waiver recipient under the provisions of sections
256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the
monthly rate specified in the county agency's agreement with the provider of group
residential housing in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision
1, paragraph (a), and the individual's resources are less than the standards specified by
section 256D.08, and the individual's countable income as determined under sections
256D.01 to 256D.21, less the medical assistance personal needs allowance under section
256D.35 is less than the monthly rate specified in the county agency's agreement with the
provider of group residential housing in which the individual resides:

(b) Each individual with income and resources less than the standard of assistance
established by the commissioner and who is a resident of the state shall be eligible for and
entitled to group residential housing 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 90 days and
which prevents the person from obtaining or retaining employment;

(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;

(3) a person not described in clause (1) or (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;

(4) 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;

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

(6) a person whose alcohol and drug addiction is a material factor that contributes
to the person's disability.
(c) As a condition of eligibility under paragraph (b), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256N.35, and must comply with efforts to determine the recipient’s eligibility for those other maintenance benefits.

(d) 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 group residential housing under this section.

(e) The burden of providing documentation for a county agency to use to verify eligibility under this section 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.

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

Sec. 21. Minnesota Statutes 2010, section 256L.04, subdivision 2b, is amended to read:

Subd. 2b. Group residential housing agreements. (a) Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256L.01 to 256L.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) 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. This paragraph does not apply to group residential housing providers who serve people aged 21 or younger if the residents are required to attend school or improve independent living skills.

**EFFECTIVE DATE.** This section is effective May 1, 2012.

Sec. 22. 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) 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 encourage a policy of sobriety on their premises.

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

Sec. 23. Minnesota Statutes 2010, section 256J.12, subdivision 1a, is amended to read:

Subd. 1a. 30-day 60-day residency requirement. An assistance unit is considered to have established residency in this state only when a child or caregiver has resided in this state for at least 30 consecutive days with the intention of making the person's home here and not for any temporary purpose. The birth of a child in Minnesota to a member of the assistance unit does not automatically establish the residency in this state under this subdivision of the other members of the assistance unit. Time spent in a shelter for battered women shall count toward satisfying the 30-day 60-day residency requirement.

Sec. 24. Minnesota Statutes 2010, section 256J.12, subdivision 2, is amended to read:

Subd. 2. Exceptions. (a) A county shall waive the 30-day residency requirement where unusual hardship would result from denial of assistance.

(b) For purposes of this section, unusual hardship means an assistance unit:

(1) is without alternative shelter; or

(2) is without available resources for food.

(c) For purposes of this subdivision, the following definitions apply: (1) "metropolitan statistical area" as defined by the U.S. Census Bureau; (2) "alternative shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the family is eligible, provided the assistance unit does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(d) Applicants are considered to meet the residency requirement under subdivision 1a if they once resided in Minnesota and:
(1) joined the United States armed services, returned to Minnesota within 30 days of
leaving the armed services, and intend to remain in Minnesota; or

(2) left to attend school in another state, paid nonresident tuition or Minnesota
tuition rates under a reciprocity agreement, and returned to Minnesota within 30 days of
graduation with the intent to remain in Minnesota.

(b) The 30-day 60-day residence requirement is met when:

(1) a minor child or a minor caregiver moves from another state to the residence of
a relative caregiver; and

(2) the relative caregiver has resided in Minnesota for at least 60 consecutive
days and:

   (i) the minor caregiver applies for and receives MFIP; or
   (ii) the relative caregiver applies for assistance for the minor child but does not
choose to be a member of the MFIP assistance unit.

Sec. 25. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

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

To establish the loan value of vehicles, a county agency must use the N.A.D.A.
Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not
listed in the guidebook, or when the applicant or participant disputes the loan value listed
in the guidebook as unreasonable given the condition of the particular vehicle, the county
agency may require the applicant or participant document the loan value by securing a
written statement from a motor vehicle dealer licensed under section 168.27, stating
the amount that the dealer would pay to purchase the vehicle. The county agency shall
reimburse the applicant or participant for the cost of a written statement that documents
a lower loan value;
(2) the value of life insurance policies for members of the assistance unit;
(3) one burial plot per member of an assistance unit;
(4) the value of personal property needed to produce earned income, including
tools, implements, farm animals, inventory, business loans, business checking and
savings accounts used at least annually and used exclusively for the operation of a
self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use
is to produce income and if the vehicles are essential for the self-employment business;
(5) the value of personal property not otherwise specified which is commonly
used by household members in day-to-day living such as clothing, necessary household
furniture, equipment, and other basic maintenance items essential for daily living;
(6) the value of real and personal property owned by a recipient of Supplemental
Security Income or Minnesota supplemental aid;
(7) the value of corrective payments, but only for the month in which the payment
is received and for the following month;
(8) a mobile home or other vehicle used by an applicant or participant as the
applicant's or participant's home;
(9) money in a separate escrow account that is needed to pay real estate taxes or
insurance and that is used for this purpose;
(10) money held in escrow to cover employee FICA, employee tax withholding,
sales tax withholding, employee worker compensation, business insurance, property rental,
property taxes, and other costs that are paid at least annually, but less often than monthly;
(11) monthly assistance payments for the current month's or short-term emergency
needs under section 256J.626, subdivision 2;
(12) the value of school loans, grants, or scholarships for the period they are
intended to cover;
(13) payments listed in section 256J.21, subdivision 2, clause (9), which are held
in escrow for a period not to exceed three months to replace or repair personal or real
property;
(14) income received in a budget month through the end of the payment month;
(15) savings from earned income of a minor child or a minor parent that are set aside
in a separate account designated specifically for future education or employment costs;
(16) the federal earned income credit, Minnesota working family credit, state and
federal income tax refunds, state homeowners and renters credits under chapter 290A,
property tax rebates and other federal or state tax rebates in the month received and the
following month;

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

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

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

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

Sec. 26. Minnesota Statutes 2010, section 256J.37, is amended by adding a subdivision
to read:

Subd. 3c. Treatment of Supplemental Security Income. The county shall reduce
the cash portion of the MFIP grant by $50 per adult SSI recipient who resides in the
household, and who would otherwise be included in the MFIP assistance unit under
section 256J.24, subdivision 2, but is excluded solely due to the SSI recipient status under
section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives less
than $50 of SSI, only the amount received shall be used in calculating the MFIP cash
assistance payment. This provision does not apply to relative caregivers who could elect
to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the
caregiver's children or stepchildren are included in the MFIP assistance unit.

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

Sec. 27. Minnesota Statutes 2010, section 256J.49, subdivision 13, is amended to read:

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

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

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

(3) unpaid work experience, including community service, volunteer work,
the community work experience program as specified in section 256J.67, unpaid
apprenticeships or internships, and supported work when a wage subsidy is not provided.

Unpaid work experience is only an option if the participant has been unable to obtain or
maintain paid employment in the competitive labor market, and no paid work experience
programs are available to the participant. Prior to placing a participant in unpaid work,
the county must inform the participant that the participant will be notified if a paid work
experience or supported work position becomes available. Unless a participant consents in
writing to participate in unpaid work experience, the participant's employment plan may
only include unpaid work experience if including the unpaid work experience in the plan
will meet the following criteria:

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

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

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

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

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

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

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

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

   (b) "Work activity" does not include activities done for political purposes as defined

in section 211B.01, subdivision 6.

Sec. 28. Minnesota Statutes 2010, section 256J.53, subdivision 2, is amended to read:
Subd. 2. **Approval of postsecondary education or training.** (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35 participant must be working in unsubsidized employment at least 10 hours per week.

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

1. the employment goal can only be met with the additional education or training;
2. there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;
3. the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;
4. the participant can meet the requirements for admission into the program; and
5. there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

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

Sec. 29. **[256N.10] ADULT ASSISTANCE GRANT PROGRAM.**

The adult assistance grant program is a capped allocation to counties that can be spent in a flexible manner, to the extent funds are available, for adult assistance.

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

Sec. 30. **[256N.20] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 256N.01 to 256N.80, the terms defined in this section have the meanings given them.

Subd. 2. **Adult assistance.** "Adult assistance" means a capped allocation provided or arranged for by county boards for ongoing emergency needs, special diets, or special needs as determined by the county.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **County board.** "County board" means the board of county commissioners in each county.
Subd. 5. Eligible participant. "Eligible participant" means low-income adults who meet the residency requirements under section 256N.22, and who were previously eligible for programs under subdivision 6 are eligible for adult assistance. The commissioner may develop more specific eligibility criteria.

Subd. 6. Former programs. "Former programs" means funding for:

1. general assistance;
2. emergency general assistance;
3. emergency supplemental aid; and
4. Minnesota supplemental aid special needs and special diets.

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

Sec. 31. [256N.22] RESIDENCY.
(a) For purposes of eligibility for adult assistance, a person must be a resident of this state.
(b) A "resident" is a person living in the state for at least 60 days with the intention of making the person's home here and not for any temporary purpose. Time spent in a shelter for battered women shall count toward satisfying the 60-day residency requirement. All applicants for these programs are required to demonstrate the requisite intent and may do so in any of the following ways:
1. by showing that the applicant maintains a residence at a verified address, other than a place of public accommodation. An applicant may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, or a rent receipt; or
2. by verifying residence according to Minnesota Rules, part 9500.1219, subpart 3, item C.
(c) The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.
(d) If any provision of this subdivision is enjoined from implementation or found unconstitutional by any court of competent jurisdiction, the remaining provisions shall remain valid and shall be given full effect.

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

Sec. 32. [256N.25] PROGRAM EVALUATION.
Subdivision 1. **County evaluation.** Each county shall submit to the commissioner
data from the past calendar year on the outcomes and performance indicators, and
information as to how grant funds are being spent on the target population. The
commissioner shall prescribe standard methods to be used by the counties in providing
the data. The data shall be submitted no later than March 1 of each year, beginning with
March 1, 2013. The commissioner shall define outcomes and performance indicators.

Subd. 2. **Statewide evaluation.** Six months after the end of the first full calendar
year and biennially thereafter, the commissioner shall prepare a report on the counties'
progress in improving the outcomes of adults related to safety and well-being. This report
shall be disseminated electronically throughout the state.

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

Sec. 33. **[256N.30] FUNDING.**

Subdivision 1. **Assistance.** (a) Counties may use the capped allocation for adult
assistance for individuals under section 256N.20, subdivision 2.

(b) The county agency shall, within available appropriations, provide a personal
needs allowance to individuals eligible for group residential housing under section
256L.04, subdivision 1, paragraph (b), and to other individuals who reside in licensed
residential facilities other than group residential housing. The county may determine the
amount of the personal needs allowance based on the individual's net income and need.

(c) In determining the amount of assistance, the county shall disregard the first
$150 of earned income per month. In addition, the county shall disregard additional
earned income up to a maximum of $500 per month for individuals residing in facilities or
group residential housing for whom the county agency has approved a discharge plan that
includes work. The additional amount disregarded must be placed in a separate savings
account by the eligible individual, to be used upon discharge from the residential facility
into the community, up to a maximum of $2,000.

(d) The county shall give priority to eligible individuals who are enrolled in a
12-month residential chemical dependency treatment program.

Subd. 2. **Allocation.** Funding for the adult assistance grant program is limited to the
appropriation. The commissioner shall allocate to counties the money appropriated for the
program based on each county agency's average share of the state's former programs under
section 256N.20, subdivision 6. The commissioner may reallocate any unspent amounts
to other counties. No county shall be allocated less than $1,000 for the fiscal year. Any
adult assistance aid expenditures by a county above the amount of the commissioner's
allocation to the county must be made from county funds.
EFFECTIVE DATE. This section is effective October 1, 2012.

Sec. 34. [256N.35] APPLICANT REQUIREMENTS.

(a) Any applicant, otherwise eligible for adult assistance and possibly eligible for federal maintenance benefits from any other source shall: (1) make application for those benefits within 30 days of the adult assistance application; and (2) execute an interim assistance authorization on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other federal maintenance benefits and may require a recipient of adult assistance to file an appeal of the denial if appropriate.

(c) If found eligible for maintenance benefits, and maintenance benefits were received during the period in which adult assistance was also being received, the recipient shall be required to reimburse the state for the interim assistance paid. Reimbursement shall not exceed the amount of adult assistance paid during the time period to which the other maintenance benefits apply.

(d) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(e) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled.

(f) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

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

Sec. 35. Minnesota Statutes 2010, section 260C.157, subdivision 3, is amended to read:

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

The team may be the same team as defined in section 260B.157, subdivision 3.

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

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

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

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

d) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

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

(ii) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or
(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

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

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

Sec. 36. Minnesota Statutes 2010, section 260D.01, is amended to read:

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

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

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

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

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in
foster care to receive necessary treatment for an emotional disturbance or developmental
disability or related condition;
(2) establishes court review requirements for a child in voluntary foster care for
treatment due to emotional disturbance or developmental disability or a related condition;
(3) establishes the ongoing responsibility of the parent as legal custodian to visit the
child, to plan together with the agency for the child's treatment needs, to be available and
accessible to the agency to make treatment decisions, and to obtain necessary medical,
dental, and other care for the child; and
(4) applies to voluntary foster care when the child's parent and the agency agree that
the child's treatment needs require foster care either:
   (i) due to a level of care determination by the agency's screening team informed by
the diagnostic and functional assessment under section 245.4885; or
   (ii) due to a determination regarding the level of services needed by the responsible
social services' screening team under section 256B.092, and Minnesota Rules, parts
9525.0004 to 9525.0016.
(d) This chapter does not apply when there is a current determination under section
626.556 that the child requires child protective services or when the child is in foster care
for any reason other than treatment for the child's emotional disturbance or developmental
disability or related condition. When there is a determination under section 626.556 that
the child requires child protective services based on an assessment that there are safety
and risk issues for the child that have not been mitigated through the parent's engagement
in services or otherwise, or when the child is in foster care for any reason other than
the child's emotional disturbance or developmental disability or related condition, the
provisions of chapter 260C apply.
(e) The paramount consideration in all proceedings concerning a child in voluntary
foster care for treatment is the safety, health, and the best interests of the child. The
purpose of this chapter is:
   (1) to ensure a child with a disability is provided the services necessary to treat or
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. 37. 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 either: within five working days
   (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. 38. 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
counties must be reinvested in the child support enforcement program, and the counties
shall not reduce the funding of their child support programs by the amount of funding
distributed.

Sec. 39. REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES,
GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.

Liquor stores, tobacco stores, gambling establishments, and tattoo parlors must
negotiate with their third-party processors to block EBT card cash transactions at their

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places of business and withdrawals of cash at automatic teller machines located in their
places of business.

Sec. 40. 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 appointed by the speaker
of the house;
(2) two members of the Minnesota senate appointed by the senate majority 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.


Sec. 41. 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. 42. REVISOR'S INSTRUCTION.
The revisor of statutes shall make conforming amendments and correct statutory
cross-references as necessitated by the creation of Minnesota Statutes, chapter 256N, and
related repealers in this article.
Sec. 43. REPEALER.

(a) Minnesota Statutes 2010, section 256.9862, subdivision 2, is repealed effective February 1, 2012.

(b) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10; 256.9791; 256D.01, subdivisions 1, 1a, 1b, 1c, and 2; 256D.03, subdivisions 1, 2, and 2a; 256D.05, subdivisions 1, 2, 4, 5, 6, 7, and 8; 256D.0513; 256D.06, subdivisions 1, 1b, 2, 5, 7, and 8; 256D.09, subdivisions 1, 2, 2a, 2b, 5, and 6; 256D.10; 256D.13; 256D.15; 256D.16; 256D.35, subdivision 8b; and 256D.46, are repealed effective October 1, 2012.

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

(d) Minnesota Rules, part 9500.1261, subparts 3, items D and E, 4, and 5, are repealed effective November 1, 2011.

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

(5) undertake health planning responsibilities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2010, section 62J.692, is amended to read:

**62J.692 MEDICAL EDUCATION.**

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

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

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

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

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

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

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

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

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

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

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

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

A clinical medical education program that trains pediatricians is requested to include  
in its program curriculum training in case management and medication management for  
children suffering from mental illness to be eligible for funds under subdivision 4.
(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 or 11, as appropriate, if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

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

1. the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;
2. the name, title, and business address of those persons responsible for administering the funds;
3. for each clinical medical education program for which funds are being sought, the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and
4. other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

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

1. audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;
2. a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and
3. other revenue received for the purposes of clinical training.
(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

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

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

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

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students. Training sites whose training site level grant is less than $1,000, based on the formula described in this paragraph, are ineligible for funds available under this subdivision.

(b) $5,350,000 $2,680,000 of the available medical education funds shall be distributed as follows:

(1) $1,475,000 $740,000 to the University of Minnesota Medical Center-Fairview;
(2) $2,075,000 $970,000 to the University of Minnesota School of Dentistry; and
(3) $1,800,000 $970,000 to the Academic Health Center. $150,000 of the funds distributed to the Academic Health Center under this paragraph shall be used for a program to assist internationally trained physicians who are legal residents and who
commit to serving underserved Minnesota communities in a health professional shortage
area to successfully compete for family medicine residency programs at the University
of Minnesota.
(c) Funds distributed shall not be used to displace current funding appropriations
from federal or state sources.
(d) Funds shall be distributed to the sponsoring institutions indicating the amount
to be distributed to each of the sponsor's clinical medical education programs based on
the criteria in this subdivision and in accordance with the commissioner's approval letter.
Each clinical medical education program must distribute funds allocated under paragraph
(a) to the training sites as specified in the commissioner's approval letter. Sponsoring
institutions, which are accredited through an organization recognized by the Department
of Education or the Centers for Medicare and Medicaid Services, may contract directly
with training sites to provide clinical training. To ensure the quality of clinical training,
those accredited sponsoring institutions must:
(1) develop contracts specifying the terms, expectations, and outcomes of the clinical
training conducted at sites; and
(2) take necessary action if the contract requirements are not met. Action may
include the withholding of payments under this section or the removal of students from
the site.
(e) Any funds not distributed in accordance with the commissioner's approval letter
must be returned to the medical education and research fund within 30 days of receiving
notice from the commissioner. The commissioner shall distribute returned funds to the
appropriate training sites in accordance with the commissioner's approval letter.
(f) A maximum of $150,000 of the funds dedicated to the commissioner under
section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
administrative expenses associated with implementing this section.

Subd. 5. Report. (a) Sponsoring institutions receiving funds under this section
must sign and submit a medical education grant verification report (GVR) to verify that
the correct grant amount was forwarded to each eligible training site. If the sponsoring
institution fails to submit the GVR by the stated deadline, or to request and meet
the deadline for an extension, the sponsoring institution is required to return the full
amount of funds received to the commissioner within 30 days of receiving notice from
the commissioner. The commissioner shall distribute returned funds to the appropriate
training sites in accordance with the commissioner's approval letter.
(b) The reports must provide verification of the distribution of the funds and must
include:
(1) the total number of eligible trainee FTEs in each clinical medical education program;
(2) the name of each funded program and, for each program, the dollar amount distributed to each training site;
(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;
(4) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and
(5) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for medical education.
(c) By February 15 of each year, the commissioner, with advice from the advisory committee, shall provide an annual summary report to the legislature on the implementation of this section.

Subd. 6. Other available funds. The commissioner is authorized to distribute, in accordance with subdivision 4 or 11, as appropriate, funds made available through:
(1) voluntary contributions by employers or other entities;
(2) allocations for the commissioner of human services to support medical education and research; and
(3) other sources as identified and deemed appropriate by the legislature for inclusion in the fund.

Subd. 7. Transfers from the commissioner of human services. Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), $21,714,000 shall be distributed as follows:
(1) $2,157,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;
(2) $1,035,360 shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education;
(3) $17,400,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for purposes of medical education;
(4) $1,121,640 shall be distributed by the commissioner to clinical medical education dental innovation grants in accordance with subdivision 7a; and
(5) the remainder of the amount transferred according to section 256B.69, subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a), or 11, as appropriate.
Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; and

(5) the priority level of the project in relation to state clinical education, access, and workforce goals.

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

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

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

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

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

(1) Following the distribution of funds described under subdivision 4, 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:
(i) 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

(ii) 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 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.

(2) Ten percent of available medical education funds shall be used to create a primary
care bonus pool. Grants to eligible training sites under this clause shall be determined by
dividing the total number of eligible FTE trainees from primary care medicine, advanced
practice nursing, or physician assistant programs at all eligible training sites by the amount
of funds available in the primary care bonus pool to determine a grant per primary care
FTE; each eligible training site shall receive a grant equal to the grant per primary care
FTE multiplied by the number of eligible primary care FTE's at the training site.

(3) After determining the grant amount for each training site under clause (1), items
(i) and (ii), and clause (2), the commissioner shall calculate a grant per eligible trainee for
each training site. Any training site whose grant per eligible trainee is greater than the
95th percentile grant per eligible trainee shall have the grant amount reduced to the 95th
percentile grant per eligible trainee. Grants in excess of this amount for any training site
shall be redistributed based on the criteria in clause (4).

Any training site with fewer than 0.1 FTE eligible trainees from all programs or a
calculated grant less than $1,000 based on the formula described in clauses (1) and (2)
shall be eliminated from the distribution; the calculated grants for these training sites shall
be redistributed based on the criteria in clause (4).

(4) The commissioner shall award from available funds appropriated for this purpose
and equally divided between the following programs:

(i) the community mental health center grants program under section 145.9272; and

(ii) the community health centers development grants program under section
145.987.

If federal approval for this funding mechanism is not received for either of the grant
programs described in this paragraph, available funds will be provided to the remaining
grant program described in this paragraph. If none of the grant programs described in this
paragraph receive federal approval, available funds will be distributed to eligible training
sites based on the formula in clauses (1) to (3).

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

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

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

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

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

(e) 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.
Sec. 6. [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. 7. 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. 8. Minnesota Statutes 2010, section 144.396, subdivision 5, is amended to read:
Subd. 5. **Statewide tobacco prevention grants.** (a) To the extent funds are appropriated for the purposes of this subdivision, the commissioner of health shall, within available appropriations, award competitive grants to eligible applicants for projects and initiatives directed at the prevention of tobacco use. The project areas for grants include:

1. statewide public education and information campaigns which include implementation at the local level; and
2. coordinated special projects, including training and technical assistance, a resource clearinghouse, and contracts with ethnic and minority communities.

(b) Eligible applicants may include, but are not limited to, nonprofit organizations, colleges and universities, professional health associations, community health boards, and other health care organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented to target tobacco use among youth, and must take into account the need for a coordinated statewide tobacco prevention effort.

(c) The commissioner must give priority to applicants who demonstrate that the proposed project:

1. is research based or based on proven effective strategies;
2. is designed to coordinate with other activities and education messages related to other health initiatives;
3. utilizes and enhances existing prevention activities and resources; or
4. involves innovative approaches preventing tobacco use among youth.

Sec. 9. Minnesota Statutes 2010, section 144.396, subdivision 6, is amended to read:

Subd. 6. **Local tobacco prevention grants.** (a) The commissioner shall award grants, within available appropriations, to eligible applicants for local and regional projects and initiatives directed at tobacco prevention in coordination with other health areas aimed at reducing high-risk behaviors in youth that lead to adverse health-related problems. The project areas for grants include:

1. school-based tobacco prevention programs aimed at youth and parents;
2. local public awareness and education projects aimed at tobacco prevention in coordination with locally assessed community public health needs pursuant to chapter 145A; or
3. local initiatives aimed at reducing high-risk behavior in youth associated with tobacco use and the health consequences of these behaviors.

(b) Eligible applicants may include, but are not limited to, community health boards, school districts, community clinics, Indian tribes, nonprofit organizations, and other health...
care organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented to target tobacco use among youth, and must be targeted to achieve the outcomes established in subdivision 2.

(c) The commissioner must give priority to applicants who demonstrate that the proposed project or initiative is:

(1) supported by the community in which the applicant serves;

(2) is based on research or on proven effective strategies;

(3) is designed to coordinate with other community activities related to other health initiatives;

(4) incorporates an understanding of the role of community in influencing behavioral changes among youth regarding tobacco use and other high-risk health-related behaviors; or

(5) addresses disparities among populations of color related to tobacco use and other high-risk health-related behaviors.

d) The commissioner shall divide the state into specific geographic regions and allocate a percentage of the money available for distribution to projects or initiatives aimed at that geographic region. If the commissioner does not receive a sufficient number of grant proposals from applicants that serve a particular region or the proposals submitted do not meet the criteria developed by the commissioner, the commissioner shall provide technical assistance and expertise to ensure the development of adequate proposals aimed at addressing the public health needs of that region. In awarding the grants, the commissioner shall consider locally assessed community public health needs pursuant to chapter 145A.

Sec. 10. Minnesota Statutes 2010, section 144.98, subdivision 2a, is amended to read:

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

Sec. 11. Minnesota Statutes 2010, section 144.98, subdivision 7, is amended to read:

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

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

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

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

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

Sec. 12. Minnesota Statutes 2010, section 144.98, is amended by adding a subdivision
to read:

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

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

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

A laboratory applying for this exemption shall not apply for simultaneous
accreditation under the national standard.
Sec. 13. 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. 14. Minnesota Statutes 2010, section 144A.102, is amended to read:

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

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

1. allow the use of civil money penalties imposed upon nursing facilities to abate any deficiencies identified in a nursing facility's plan of correction; and
2. stop the accrual of any fine imposed by the Health Department when a follow-up inspection survey is not conducted by the department within the regulatory deadline.
(b) By January 2012, the commissioner of health shall work with providers and
the ombudsman for long-term care to examine state and federal rules and regulations
governing the provision of care in licensed nursing facilities and apply for federal waivers
and identify necessary changes in state law to:

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

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

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

Sec. 15. Minnesota Statutes 2010, section 144A.61, is amended by adding a
subdivision to read:

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

Sec. 16. Minnesota Statutes 2010, section 144E.123, is amended to read:

144E.123 PREHOSPITAL CARE DATA.

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

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

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

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 July 1, 2012.

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

Sec. 17. [145.4221] HUMAN CLONING PROHIBITED.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms
have the meanings given.

(b) "Human cloning" means human asexual reproduction accomplished by
introducing nuclear material from one or more human somatic cells into a fertilized
or unfertilized oocyte whose nuclear material has been removed or inactivated so as
to produce a living organism at any stage of development that is genetically virtually
identical to an existing or previously existing human organism.

(c) "Somatic cell" means a diploid cell, having a complete set of chromosomes,
obtained or derived from a living or deceased human body at any stage of development.

Subd. 2. **Prohibition on cloning.** No person or entity, whether public or private,
may:

(1) perform or attempt to perform human cloning;

(2) participate in an attempt to perform human cloning;

(3) ship, import, or receive for any purpose an embryo produced by human cloning
or any product derived from such an embryo; or

(4) ship or receive, in whole or in part, any oocyte, embryo, fetus, or human somatic
cell, for the purpose of human cloning.

Subd. 3. **Scientific research.** Nothing in this section shall restrict areas of scientific
research not specifically prohibited by this section, including research in the use of nuclear
transfer or other cloning techniques to produce molecules, DNA, cells other than human
embryos, tissues, organs, plants, or animals other than humans. In addition, nothing in this
section shall restrict, inhibit, or make unlawful the scientific field of stem cell research,
unless explicitly prohibited.

Subd. 4. **Penalties.** Any person or entity that knowingly or recklessly violates
subdivision 2 is guilty of a misdemeanor.

Subd. 5. **Severability.** If any provision, section, subdivision, sentence, clause,
phrase, or word in this section or the application thereof to any person or circumstance is
found to be unconstitutional, the same is hereby declared to be severable and the remainder
of this section shall remain effective notwithstanding such unconstitutional provision. The
legislature declares that it would have passed this section and each provision, subdivision,
sentence, clause, phrase, or word thereof, regardless of the fact that any provision, section,
subdivision, sentence, clause, phrase, or word is declared unconstitutional.

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

Sec. 18. Minnesota Statutes 2010, section 145.925, subdivision 1, is amended to read:

**Subdivision 1. Eligible organizations; purpose.** The commissioner of health may, within available appropriations, make special grants to cities, counties, groups of cities or
counties, or nonprofit corporations to provide prepregnancy family planning services.

Sec. 19. Minnesota Statutes 2010, section 145.925, subdivision 2, is amended to read:

**Subd. 2. Prohibition.** The commissioner shall not make special grants pursuant to
this section to any nonprofit corporation which performs abortions eligible organization
that performs abortions or provides referrals for abortion services. No state funds shall be
used under contract from a grantee to any nonprofit corporation which performs abortions.
This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56,
or health maintenance organizations certified pursuant to chapter 62D eligible organization
that performs abortions or provides referrals for abortion services.

Sec. 20. [145.9271] WHITE EARTH BAND URBAN CLINIC.

**Subdivision 1. 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 this section for application to qualify as a federally qualified health center.

**Subd. 2. Grant agreements.** Before receiving the funds under this section, 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. 21. [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.

EFFECTIVE DATE. This section is effective July 1, 2011, or upon federal approval of the funding mechanism set out in Minnesota Statutes, section 62J.692, subdivision 11, whichever is later.

Sec. 22. Minnesota Statutes 2010, section 145.928, subdivision 7, is amended to read:

Subd. 7. Community grant program; immunization rates and infant mortality rates. (a) The commissioner shall, within available appropriations, award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

1. decreasing racial and ethnic disparities in infant mortality rates; or
2. increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

1. is supported by the community the applicant will serve;
2. is research-based or based on promising strategies;
3. is designed to complement other related community activities;
(4) utilizes strategies that positively impact both priority areas;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect
the race or ethnicity of the population to be reached.

Sec. 23. Minnesota Statutes 2010, section 145.928, subdivision 8, is amended to read:

Subd. 8. Community grant program; other health disparities. (a) The
commissioner shall, within available appropriations, award grants to eligible applicants
for local or regional projects and initiatives directed at reducing health disparities in
one or more of the following priority areas:

1. decreasing racial and ethnic disparities in morbidity and mortality rates from
breast and cervical cancer;

2. decreasing racial and ethnic disparities in morbidity and mortality rates from
HIV/AIDS and sexually transmitted infections;

3. decreasing racial and ethnic disparities in morbidity and mortality rates from
cardiovascular disease;

4. decreasing racial and ethnic disparities in morbidity and mortality rates from
diabetes; or

5. decreasing racial and ethnic disparities in morbidity and mortality rates from
accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning
grants. Planning grants must be used to address such areas as community assessment,
determining community priority areas, coordination activities, and development of
community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations,
social service organizations, community nonprofit organizations, community health
boards, and community clinics. Applicants shall submit proposals to the commissioner.

A proposal must specify the strategies to be implemented to address one or more of
the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes
established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their
proposed project or initiative:

1. is supported by the community the applicant will serve;

2. is research-based or based on promising strategies;

3. is designed to complement other related community activities;

4. utilizes strategies that positively impact more than one priority area;
(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect

the race or ethnicity of the population to be reached.

Sec. 24. [145.987] COMMUNITY HEALTH CENTERS DEVELOPMENT

GRANTS.

(a) The commissioner of health shall award grants from money appropriated for this

purpose to expand community health centers, as defined in section 145.9269, subdivision

1, in the state through the establishment of new community health centers or sites in

areas defined as small rural areas or isolated rural areas according to the four category

classification of the Rural Urban Commuting Area system developed for the United States

Health Resources and Services Administration or serving underserved patient populations.

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

(1) costs for an organization to develop and submit a proposal to the federal

government for the designation of a new community health center or site; and

(2) costs of planning, designing, remodeling, constructing, or purchasing equipment

for a new center or site.

Funds may not be used for operating costs.

(c) The commissioner shall award grants on a competitive basis.

EFFECTIVE DATE. This section is effective July 1, 2011, or upon federal

approval of the funding mechanism set out in Minnesota Statutes, section 62J.692.

subdivision 11, whichever is later.

Sec. 25. Minnesota Statutes 2010, section 145A.17, subdivision 3, is amended to read:

Subd. 3. Requirements for programs; process. (a) Community health boards

and tribal governments that receive funding under this section must submit a plan to

the commissioner describing a multidisciplinary approach to targeted home visiting for

families. The plan must be submitted on forms provided by the commissioner. At a

minimum, the plan must include the following:

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

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

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

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

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

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

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

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

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

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

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

(5) provide youth development programs when appropriate;

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

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision
to read:

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

**EFFECTIVE DATE.** This section is effective July 1, 2011, and applies to
applications for licensure submitted on or after that date.
Sec. 27. Minnesota Statutes 2010, section 157.20, is amended by adding a subdivision to read:

Subd. 5. Variance requests. (a) A person may request a variance from all parts of Minnesota Rules, chapter 4626, except as provided in paragraph (b) or Minnesota Rules, chapter 4626. At the time of application for plan review, the person, operator, or submitter must be notified of the right to request variances.

(b) No variance may be requested or approved for the following parts of Minnesota Rules, chapter 4626:

1. Minnesota Rules, part 4626.0020, subpart 35;
2. Minnesota Rules, parts 4626.0040 to 4626.0060;
3. Minnesota Rules, parts 4626.0065 to 4626.0100;
4. Minnesota Rules, parts 4626.0105 to 4626.0120;
5. Minnesota Rules, part 4626.1565;
6. Minnesota Rules, parts 4626.1590 and 4626.1595; and
7. Minnesota Rules, parts 4626.1600 to 4626.1675.

Sec. 28. 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. $8,550,000 for fiscal year 2006 and $8,550,000 for fiscal years 2007 and each year thereafter through fiscal year 2011 and $6,244,000 each fiscal 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 621.692, subdivision 4 or 11, as appropriate; and
3. (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. 29. 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,

(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. 30. 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.
46. Sec. 31. MINNESOTA TASK FORCE ON PREMATURENESS.

46.1 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.

46.2 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:

46.3 (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;

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

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

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

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

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

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

46.10 (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.

46.11 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:

46.12 (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;

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

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

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

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

46.17 (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;
(7) a review of the potential improvements in health status related to the use of
health care homes to provide and coordinate pregnancy-related services; and
(8) 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. 32. NURSING HOME REGULATORY EFFICIENCY.**
The commissioner of health must work with long-term care providers, provider
associations, and consumer advocates to clarify for the benefit of providers, survey
teams, and investigators from the office of health facility complaints all of the situations
that providers must report and are required to report to the department under federal
certification regulations and to the common entry point under the Minnesota Vulnerable
Adults Act. The commissioner must produce decision trees, flow sheets, or other
reproducible materials to guide the parties and to reduce the number of unnecessary
reports.

**Sec. 33. REPEALER.**
(a) Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8;
62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; 144.1464; 144.147; and
144.1499, are repealed.
(b) 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 245A.14, subdivision 4, is amended to
read:

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Article 3 Section 1. 65
Subd. 4. Special family day care homes. Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

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

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

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

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

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

4. the facility has square footage required per child under Minnesota Rules, part 9502.0425;

5. the program is in compliance with local zoning regulations;

6. the program is in compliance with the applicable fire code as follows:

i. if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003, Section 202; or
(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2003, Section 202; and

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

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

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

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

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

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

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

Sec. 2. Minnesota Statutes 2010, section 245C.03, is amended by adding a subdivision to read:

Subd. 7. Children's therapeutic services and supports providers. The commissioner shall conduct background studies according to this chapter when initiated by a children's therapeutic services and supports provider under section 256B.0943.

Sec. 3. Minnesota Statutes 2010, section 245C.10, is amended by adding a subdivision to read:

Subd. 8. Children's therapeutic services and supports providers. The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than $20 per study charged to
the license holder. The fees collected under this subdivision are appropriated to the
commissioner for the purpose of conducting background studies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to 112.5 percent of the respective mileage rate in clause (1).
S.F. No. 760, 4th Engrossment - 87th Legislative Session (2011-2012) [S0760-4]

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

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

70.7 Sec. 6. Minnesota Statutes 2010, section 256B.0943, is amended by adding a subdivision to read:

70.9 Subd. 5a. Background studies. The requirements for background studies under this section may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

70.13 Sec. 7. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision to read:

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

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

70.18 (2) "community spouse" means the spouse, who lives in the community, of an individual receiving long-term care services in a long-term care facility or home care services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913. A community spouse does not include a spouse living in the community who receives a monthly income allowance under section 256B.058, subdivision 2, or who receives home and community-based services under section 256B.0915, 256B.092, or 256B.49, or the alternative care program under section 256B.0913;

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

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

70.23 (5) "disabled child" means a blind or permanently and totally disabled son or daughter of any age based on the Social Security Administration disability standards;

70.25 (6) "income" means earned and unearned income, attributable to the community spouse, used to calculate the adjusted gross income on the prior year's income tax return.

70.27 Evidence of income includes, but is not limited to, W-2 and 1099 forms; and
(7) "long-term care spouse" means the spouse who is receiving long-term care services in a long-term care facility or home and community based services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913.

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

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

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

(e) For a community spouse with an income equal to or greater than 750 percent of the federal poverty guidelines for a family of two and less than 975 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 25 percent of the community spouse's income and increases to 33 percent for those with an income of up to 975 percent of the federal poverty guidelines for a family of two.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) When the county or tribal agency receives a request for a variance, written notice
of a grant or denial of the variance shall be mailed to the spouse within 30 calendar days
after the county or tribal agency receives the financial information required in this clause.

The granting of a variance will necessitate a written agreement between the spouse and the
county or tribal agency with regard to the specific terms of the variance. The variance
will not become effective until the written agreement is signed by the spouse. If the
county or tribal agency denies in whole or in part the request for a variance, the denial
notice shall set forth in writing the reasons for the denial that address the specific hardship
and right to appeal.

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

(5) Undue hardship does not include action taken by a spouse which divested or
diverted income in order to avoid being assessed a spousal contribution.
(l) A spouse aggrieved by an action under this subdivision has the right to appeal under subdivision 4. If the spouse appeals on or before the effective date of an increase in the spousal fee, the spouse shall continue to make payments to the county or tribal agency in the lower amount while the appeal is pending. A spouse appealing an initial determination of a spousal contribution shall not be required to make monthly payments pending an appeal decision. Payments made that result in an overpayment shall be reimbursed to the spouse if the long-term care spouse is no longer receiving services, or applied to the spousal contribution remaining in the current year. If the county or tribal agency's determination is affirmed, the community spouse shall pay within 90 calendar days of the order the total amount due from the effective date of the original notice of determination of the spousal contribution. The commissioner's order is binding on the spouse and the agency and shall be implemented subject to section 256.045, subdivision 7. No additional notice is required to enforce the commissioner's order.

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

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

**EFFECTIVE DATE.** This section is effective July 1, 2012.

Sec. 8. Minnesota Statutes 2010, section 326B.175, is amended to read:

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

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

Sec. 9. [326B.188] COMPLIANCE WITH ELEVATOR CODE CHANGES.
(a) This section applies to code requirements for existing elevators and related
devices under Minnesota Rules, chapter 1307, where the deadline set by law for meeting
the code requirements is January 29, 2012, or later.
(b) If the department or municipality conducting elevator inspections within its
jurisdiction notifies the owner of an existing elevator or related device of the code
requirements before the effective date of this section, the owner may submit a compliance
plan by December 30, 2011. If the department or municipality does not notify the owner
of an existing elevator or related device of the code requirements before the effective
date of this section, the department or municipality shall notify the owner of the code
requirements and permit the owner to submit a compliance plan by December 30, 2011, or
within 60 days after the date of notification, whichever is later.
(c) Any compliance plan submitted under this section must result in compliance with
the code requirements by the later of January 29, 2012, or three years after submission of
the compliance plan. Elevators and related devices that are not in compliance with the
code requirements by the later of January 29, 2012, or three years after the submission of
the compliance plan may be taken out of service as provided in section 326B.175.

Sec. 10. NONEMERGENCY MEDICAL TRANSPORTATION SINGLE
ADMINISTRATIVE STRUCTURE PROPOSAL.
(a) The commissioner of human services shall develop a proposal to create a single
administrative structure for providing nonemergency medical transportation services to
fee-for-service medical assistance recipients. This proposal must consolidate access and
special transportation into one administrative structure with the goal of standardizing
eligibility determination processes, scheduling arrangements, billing procedures, data
collection, and oversight mechanisms in order to enhance coordination, improve
accountability, and lessen confusion.
(b) In developing the proposal, the commissioner shall:
(1) examine the current responsibilities performed by the counties and the
Department of Human Services and consider the shift in costs if these responsibilities are
changed;
(2) identify key performance measures to assess the cost effectiveness of nonemergency medical transportation statewide, including a process to collect, audit, and report data;

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

(4) establish a standardized billing process;

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

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

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

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

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

(d) The commissioner shall establish the nonemergency medical transportation advisory council to assist the commissioner in developing a single administrative structure for providing nonemergency medical transportation services. The council shall be comprised of:

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

(2) one representative each from the following organizations: the Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, ARC of Minnesota, the Association of Minnesota Counties, the Metropolitan Inter-County Association, the R-80 Medical Transportation Coalition, the Minnesota Paratransit Association, legal aid, the Minnesota Ambulance Association, the National Alliance on Mental Illness, Medical Transportation Management, and other transportation providers;

and

(3) four members from the house of representatives, two from the majority party and two from the minority party, appointed by the speaker, and four members from the senate, two from the majority party and two from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration.
The council is governed by Minnesota Statutes, section 15.509, except that members shall not receive per diems. The commissioner of human services shall fund all costs related to the council from existing resources.

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

ARTICLE 4

HEALTH RELATED LICENSING

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

Article 4 Sec. 3.
record of all persons licensed by the board to practice professional or practical nursing and
all registered nurses who hold Minnesota licensure and registration and are certified as
advanced practice registered nurses. It shall cause the prosecution of all persons violating
sections 148.171 to 148.285 and have power to incur such necessary expense therefor.
It shall register public health nurses who meet educational and other requirements
established by the board by rule, including payment of a fee. Prior to the adoption of rules,
the board shall use the same procedures used by the Department of Health to certify public
health nurses. It shall have power to issue subpoenas, and to compel the attendance of
witnesses and the production of all necessary documents and other evidentiary material.
Any board member may administer oaths to witnesses, or take their affirmation. It shall
keep a record of all its proceedings.

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

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

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

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

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

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

(b) The applicant for licensure by endorsement under section 148.211, subdivision 2, is currently licensed to practice professional or practical nursing in another state, territory, or Canadian province. The permit is valid from submission of a proper request until the date of board action on the application or for 60 days, whichever comes first.

c) 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. 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 reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, the registration certificate shall be issued to the person who shall immediately be placed on the practicing list as a registered nurse or licensed practical nurse.

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 10. **Verification of examination scores.** The fee for verification of examination scores is $20.
Subd. 11. **Microfilmed licensure application materials.** The fee for a copy of microfilmed licensure application materials is $20.

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

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

Subd. 14. **Practicing without current registration.** The fee for practicing without current registration is two times the amount of the current registration renewal fee for any part of the first calendar month, plus the current registration renewal fee for any part of any subsequent month up to 24 months.

Subd. 15. **Practicing without current APRN certification.** The fee for practicing without current APRN certification is $200 for the first month or any part thereof, plus $100 for each subsequent month or part thereof.

Subd. 16. **Dishonored check fee.** The service fee for a dishonored check is as provided in section 604.113.

Subd. 17. **Border state registry fee.** The initial application fee for border state registration is $50. Any subsequent notice of employment change to remain or be reinstated on the registry is $50.

Sec. 8. **[148.2855] NURSE LICENSURE COMPACT.**

The Nurse Licensure Compact is enacted into law and entered into with all other jurisdictions legally joining in it, in the form substantially as follows:

**ARTICLE 1**

**DEFINITIONS**

As used in this compact:

(a) "Adverse action" means a home or remote state action.

(b) "Alternative program" means a voluntary, nondisciplinary monitoring program approved by a nurse licensing board.

(c) "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards.

(d) "Current significant investigative information" means:

(1) investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law,
has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(2) investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

(e) "Home state" means the party state which is the nurse's primary state of residence.

(f) "Home state action" means any administrative, civil, equitable, or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as revocation, suspension, probation, or any other action which affects a nurse's authorization to practice.

(g) " Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

(h) "Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in the party state. All party states have the authority, according to existing state due process law, to take actions against the nurse's privilege such as revocation, suspension, probation, or any other action which affects a nurse's authorization to practice.

(i) "Nurse" means a registered nurse or licensed practical/vocational nurse as those terms are defined by each party state's practice laws.

(j) "Party state" means any state that has adopted this compact.

(k) "Remote state" means a party state other than the home state:

(1) where the patient is located at the time nursing care is provided; or

(2) in the case of the practice of nursing not involving a patient, in the party state where the recipient of nursing practice is located.

(l) "Remote state action" means:

(1) any administrative, civil, equitable, or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state; and

(2) cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards of those states.

(m) "State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.
(n) "State practice laws" means individual party state laws and regulations that
govern the practice of nursing, define the scope of nursing practice, and create the
methods and grounds for imposing discipline. State practice laws does not include the
initial qualifications for licensure or requirements necessary to obtain and retain a license,
except for qualifications or requirements of the home state.

ARTICLE 2

GENERAL PROVISIONS AND JURISDICTION

(a) A license to practice registered nursing issued by a home state to a resident in
that state will be recognized by each party state as authorizing a multistate licensure
privilege to practice as a registered nurse in the party state. A license to practice licensed
practical/vocational nursing issued by a home state to a resident in that state will be
recognized by each party state as authorizing a multistate licensure privilege to practice
as a licensed practical/vocational nurse in the party state. In order to obtain or retain a
license, an applicant must meet the home state's qualifications for licensure and license
renewal as well as all other applicable state laws.

(b) Party states may, according to state due process laws, limit or revoke the
multistate licensure privilege of any nurse to practice in their state and may take any other
actions under their applicable state laws necessary to protect the health and safety of
their citizens. If a party state takes such action, it shall promptly notify the administrator
of the coordinated licensure information system. The administrator of the coordinated
licensure information system shall promptly notify the home state of any such actions by
remote states.

(c) Every nurse practicing in a party state must comply with the state practice laws of
the state in which the patient is located at the time care is rendered. In addition, the practice
of nursing is not limited to patient care, but shall include all nursing practice as defined by
the state practice laws of the party state. The practice of nursing will subject a nurse to the
jurisdiction of the nurse licensing board, the courts, and the laws in the party state.

(d) This compact does not affect additional requirements imposed by states for
advanced practice registered nursing. However, a multistate licensure privilege to practice
registered nursing granted by a party state shall be recognized by other party states as a
license to practice registered nursing if one is required by state law as a precondition for
qualifying for advanced practice registered nurse authorization.

(e) Individuals not residing in a party state shall continue to be able to apply for
nurse licensure as provided for under the laws of each party state. However, the license
granted to these individuals will not be recognized as granting the privilege to practice
nursing in any other party state unless explicitly agreed to by that party state.
ARTICLE 3
APPLICATIONS FOR LICENSURE IN A PARTY STATE
(a) Upon application for a license, the licensing board in a party state shall ascertain,
through the coordinated licensure information system, whether the applicant has ever held
or is the holder of a license issued by any other state, whether there are any restrictions
on the multistate licensure privilege, and whether any other adverse action by a state
has been taken against the license.
(b) A nurse in a party state shall hold licensure in only one party state at a time.
(c) A nurse who intends to change primary state of residence may apply for licensure
in the new home state in advance of the change. However, new licenses will not be
issued by a party state until after a nurse provides evidence of change in primary state of
residence satisfactory to the new home state's licensing board.
(d) When a nurse changes primary state of residence by:
   (1) moving between two party states, and obtains a license from the new home state,
       the license from the former home state is no longer valid;
   (2) moving from a nonparty state to a party state, and obtains a license from the new
       home state, the individual state license issued by the nonparty state is not affected and will
       remain in full force if so provided by the laws of the nonparty state; or
   (3) moving from a party state to a nonparty state, the license issued by the prior
       home state converts to an individual state license, valid only in the former home state,
       without the multistate licensure privilege to practice in other party states.

ARTICLE 4
ADVERSE ACTIONS
In addition to the general provisions described in article 2, the provisions in this
article apply.
(a) The licensing board of a remote state shall promptly report to the administrator
of the coordinated licensure information system any remote state actions including the
factual and legal basis for the action, if known. The licensing board of a remote state shall
also promptly report any significant current investigative information yet to result in a
remote state action. The administrator of the coordinated licensure information system
shall promptly notify the home state of any reports.
(b) The licensing board of a party state shall have the authority to complete any
pending investigation for a nurse who changes primary state of residence during the
course of the investigation. The board shall also have the authority to take appropriate
action, and shall promptly report the conclusion of the investigation to the administrator
of the coordinated licensure information system. The administrator of the coordinated
licensure information system shall promptly notify the new home state of any action.

(c) A remote state may take adverse action affecting the multistate licensure
privilege to practice within that party state. However, only the home state shall have the
power to impose adverse action against the license issued by the home state.

(d) For purposes of imposing adverse actions, the licensing board of the home state
shall give the same priority and effect to reported conduct received from a remote state as
it would if the conduct had occurred within the home state. In so doing, it shall apply its
own state laws to determine appropriate action.

(e) The home state may take adverse action based on the factual findings of the
remote state, provided each state follows its own procedures for imposing the adverse
action.

(f) Nothing in this compact shall override a party state's decision that participation
in an alternative program may be used in lieu of licensure action and that participation
shall remain nonpublic if required by the party state's laws.

Party states must require nurses who enter any alternative programs to agree not to
practice in any other party state during the term of the alternative program without prior
authorization from the other party state.

ARTICLE 5

ADDITIONAL AUTHORITIES INVESTED IN
PARTY STATE NURSE LICENSING BOARDS

Notwithstanding any other laws, party state nurse licensing boards shall have the
authority to:

(1) if otherwise permitted by state law, recover from the affected nurse the costs of
investigation and disposition of cases resulting from any adverse action taken against
that nurse;

(2) issue subpoenas for both hearings and investigations which require the attendance
and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse
licensing board in a party state for the attendance and testimony of witnesses, and the
production of evidence from another party state, shall be enforced in the latter state by
any court of competent jurisdiction according to the practice and procedure of that court
applicable to subpoenas issued in proceedings pending before it. The issuing authority
shall pay any witness fees, travel expenses, mileage, and other fees required by the service
statutes of the state where the witnesses and evidence are located;

(3) issue cease and desist orders to limit or revoke a nurse's authority to practice
in the nurse's state; and
(4) adopt uniform rules and regulations as provided for in article 7, paragraph (c).

ARTICLE 6

COORDINATED LICENSURE INFORMATION SYSTEM

(a) All party states shall participate in a cooperative effort to create a coordinated database of all licensed registered nurses and licensed practical/vocational nurses. This system shall include information on the licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(b) Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for the denials to the coordinated licensure information system.

(c) Current significant investigatory information shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(d) Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.

(e) Any personally identifiable information obtained by a party state's licensing board from the coordinated licensure information system may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(f) Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

(g) The compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this compact.

ARTICLE 7

COMPACT ADMINISTRATION AND INTERCHANGE OF INFORMATION

(a) The head or designee of the nurse licensing board of each party state shall be the administrator of this compact for that state.

(b) The compact administrator of each party state shall furnish to the compact administrator of each other party state any information and documents including, but not
limited to, a uniform data set of investigations, identifying information, licensure data, and
disclosable alternative program participation information to facilitate the administration of
this compact.

(c) Compact administrators shall have the authority to develop uniform rules to
facilitate and coordinate implementation of this compact. These uniform rules shall be
adopted by party states under the authority in article 5, clause (4).

ARTICLE 8

IMMUNITY

A party state or the officers, employees, or agents of a party state's nurse licensing
board who acts in good faith according to the provisions of this compact shall not be
liable for any act or omission while engaged in the performance of their duties under
this compact. Good faith shall not include willful misconduct, gross negligence, or
recklessness.

ARTICLE 9

ENACTMENT, WITHDRAWAL, AND AMENDMENT

(a) This compact shall become effective for each state when it has been enacted by
that state. Any party state may withdraw from this compact by repealing the nurse licensure
compact, but no withdrawal shall take effect until six months after the withdrawing state
has given notice of the withdrawal to the executive heads of all other party states.

(b) No withdrawal shall affect the validity or applicability by the licensing boards
of states remaining party to the compact of any report of adverse action occurring prior
to the withdrawal.

(c) Nothing contained in this compact shall be construed to invalidate or prevent any
nurse licensure agreement or other cooperative arrangement between a party state and a
nonparty state that is made according to the other provisions of this compact.

(d) This compact may be amended by the party states. No amendment to this
compact shall become effective and binding upon the party states until it is enacted into
the laws of all party states.

ARTICLE 10

CONSTRUCTION AND SEVERABILITY

(a) This compact shall be liberally construed to effectuate the purposes of the
compact. The provisions of this compact shall be severable and if any phrase, clause,
sentence, or provision of this compact is declared to be contrary to the constitution of any
party state or of the United States or the applicability thereof to any government, agency,
person, or circumstance is held invalid, the validity of the remainder of this compact and
the applicability of it to any government, agency, person, or circumstance shall not be
affected by it. If this compact is held contrary to the constitution of any party state, the
compact shall remain in full force and effect for the remaining party states and in full force
and effect for the party state affected as to all severable matters.

(b) In the event party states find a need for settling disputes arising under this
compact:

(1) the party states may submit the issues in dispute to an arbitration panel which
shall be comprised of an individual appointed by the compact administrator in the home
state, an individual appointed by the compact administrator in the remote states involved,
and an individual mutually agreed upon by the compact administrators of the party states
involved in the dispute; and

(2) the decision of a majority of the arbitrators shall be final and binding.

Sec. 9. [148.2856] APPLICATION OF NURSE LICENSURE COMPACT TO
EXISTING LAWS.

(a) A nurse practicing professional or practical nursing in Minnesota under the
authority of section 148.2855 shall have the same obligations, privileges, and rights as if
the nurse was licensed in Minnesota. Notwithstanding any contrary provisions in section
148.2855, the Board of Nursing shall comply with and follow all laws and rules with
respect to registered and licensed practical nurses practicing professional or practical
nursing in Minnesota under the authority of section 148.2855, and all such individuals
shall be governed and regulated as if they were licensed by the board.

(b) Section 148.2855 does not relieve employers of nurses from complying with
statutorily imposed obligations.

(c) Section 148.2855 does not supersede existing state labor laws.

(d) For purposes of the Minnesota Government Data Practices Act, chapter 13,
an individual not licensed as a nurse under sections 148.171 to 148.285 who practices
professional or practical nursing in Minnesota under the authority of section 148.2855 is
considered to be a licensee of the board.

(e) Uniform rules developed by the compact administrators shall not be subject
to the provisions of sections 14.05 to 14.389, except for sections 14.07, 14.08, 14.101,

(f) Proceedings brought against an individual's multistate privilege shall be
adjudicated following the procedures listed in sections 14.50 to 14.62 and shall be subject
to judicial review as provided in sections 14.63 to 14.69.

(g) For purposes of sections 62M.09, subdivision 2; 121A.22, subdivision 4;
144.051; 144.052; 145A.02, subdivision 18; 148.975; 151.37; 152.12; 154.04; 256B.0917,
subdivision 8; 595.02, subdivision 1, paragraph (g); 604.20, subdivision 5; and 631.40,
subdivision 2; and chapters 319B and 364, holders of a multistate privilege who are
licensed as registered or licensed practical nurses in the home state shall be considered
to be licensees in Minnesota. If any of the statutes listed in this paragraph are limited to
registered nurses or the practice of professional nursing, then only holders of a multistate
privilege who are licensed as registered nurses in the home state shall be considered
licensees.

(h) The reporting requirements of sections 144.4175, 148.263, 626.52, and 626.557
apply to individuals not licensed as registered or licensed practical nurses under sections
148.171 to 148.285 who practice professional or practical nursing in Minnesota under
the authority of section 148.2855.

(i) The board may take action against an individual's multistate privilege based on
the grounds listed in section 148.261, subdivision 1, and any other statute authorizing or
requiring the board to take corrective or disciplinary action.

(j) The board may take all forms of disciplinary action provided for in section
148.262, subdivision 1, and corrective action provided for in section 214.103, subdivision
6, against an individual's multistate privilege.

(k) The immunity provisions of section 148.264, subdivision 1, apply to individuals
who practice professional or practical nursing in Minnesota under the authority of section
148.2855.

(l) The cooperation requirements of section 148.265 apply to individuals who
practice professional or practical nursing in Minnesota under the authority of section
148.2855.

(m) The provisions of section 148.283 shall not apply to individuals who practice
professional or practical nursing in Minnesota under the authority of section 148.2855.

(n) Complaints against individuals who practice professional or practical nursing
in Minnesota under the authority of section 148.2855 shall be handled as provided in
sections 214.10 and 214.103.

(o) All provisions of section 148.2855 authorizing or requiring the board to provide
data to party states are authorized by section 214.10, subdivision 8, paragraph (d).

(p) Except as provided in section 13.41, subdivision 6, the board shall not report to a
remote state any active investigative data regarding a complaint investigation against a
nurse licensed under sections 148.171 to 148.285, unless the board obtains reasonable
assurances from the remote state that the data will be maintained with the same protections
as provided in Minnesota law.
(q) The provisions of sections 214.17 to 214.25 apply to individuals who practice 
professional or practical nursing in Minnesota under the authority of section 148.2855 
when the practice involves direct physical contact between the nurse and a patient.

(r) A nurse practicing professional or practical nursing in Minnesota under the 
authority of section 148.2855 must comply with any criminal background check required 
under Minnesota law.

Sec. 10. [148.2857] WITHDRAWAL FROM COMPACT. 
The governor may withdraw the state from the compact in section 148.2855 if 
the Board of Nursing notifies the governor that a party state to the compact changed 
the party state's requirements for nurse licensure after July 1, 2009, and that the party 
state's requirements, as changed, are substantially lower than the requirements for nurse 
licensure in this state.

Sec. 11. [148.2858] MISCELLANEOUS PROVISIONS. 
(a) For the purposes of section 148.2855, "head of the Nurse Licensing Board" 
means the executive director of the board.

(b) The Board of Nursing shall have the authority to recover from a nurse practicing 
professional or practical nursing in Minnesota under the authority of section 148.2855 
the costs of investigation and disposition of cases resulting from any adverse action 
taken against the nurse.

(c) The board may implement a system of identifying individuals who practice 
professional or practical nursing in Minnesota under the authority of section 148.2855.

Sec. 12. [148.2859] NURSE LICENSURE COMPACT ADVISORY 
COMMITTEE.

Subdivision 1. Establishment; membership. A Nurse Licensure Compact Advisory 
Committee is established to advise the compact administrator in the implementation of 
section 148.2855. Members of the advisory committee shall be appointed by the board 
and shall be composed of representatives of Minnesota nursing organizations, Minnesota 
licensed nurses who practice in nursing facilities or hospitals, Minnesota licensed nurses 
who provide home care, Minnesota licensed advanced practice registered nurses, and 
public members as defined in section 214.02.

Subd. 2. Duties. The advisory committee shall advise the compact administrator in 
the implementation of section 148.2855.
Subd. 3. Organization. The advisory committee shall be organized and administered under section 15.059.

Sec. 13. 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:

1. sponsor application fee for approval of a continuing education course is $60;
2. fee for license verification by mail is $10;
3. duplicate license fee is $25;
4. duplicate renewal card fee is $10;
5. fee for licensee mailing list is $60;
6. fee for a rule book is $10; and
7. fees as authorized by section 148B.175, subdivision 6, clause (7).
Sec. 14. Minnesota Statutes 2010, section 148B.33, subdivision 2, is amended to read:

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

Sec. 15. Minnesota Statutes 2010, section 148B.52, is amended to read:

148B.52 DUTIES OF THE BOARD.

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

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

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

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

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

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

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

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

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

(b) The board may appoint a professional discipline committee for each occupational license regulated by the board, and may appoint a board member as chair. The professional discipline committee shall consist of five members representative of the licensed occupation and shall provide recommendations to the board with regard to rule techniques, standards, procedures, and related issues specific to the licensed occupation.

Sec. 16. Minnesota Statutes 2010, section 150A.091, subdivision 2, is amended to read:

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

(1) dentist, $140;

(2) full faculty dentist, $140;
(3) limited faculty dentist, $140;

(4) resident dentist or dental provider, $55;

(5) advanced dental therapist, $100;

(6) dental therapist, $100;

(7) dental hygienist, $55;

(8) licensed dental assistant, $55; and

(9) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $15.

Sec. 17. Minnesota Statutes 2010, section 150A.091, subdivision 3, is amended to read:

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

1. dentist or full faculty dentist, $14 times the number of months of the initial term;

2. dental therapist, $10 times the number of months of the initial term;

3. dental hygienist, $5 times the number of months of the initial term;

4. licensed dental assistant, $3 times the number of months of the initial term; and

5. dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $1 times the number of months of the initial term.

Sec. 18. Minnesota Statutes 2010, section 150A.091, subdivision 4, is amended to read:

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

1. limited faculty dentist, $168; and

2. resident dentist or dental provider, $59.

Sec. 19. Minnesota Statutes 2010, section 150A.091, subdivision 5, is amended to read:

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

1. dentist or full faculty dentist, $336;

2. dental therapist, $180;

3. dental hygienist, $118;
94.1 (4) licensed dental assistant, $80; and
94.2 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $24.
94.4 Sec. 20. Minnesota Statutes 2010, section 150A.091, subdivision 8, is amended to read:
94.5 Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with
94.6 a request for issuance of a duplicate of the original license, or of an annual or biennial
94.7 renewal certificate for a license or permit, a fee in the following amounts:
94.8 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental
94.9 assistant license, $35; and
94.10 (2) annual or biennial renewal certificates, $10.
94.11 Sec. 21. Minnesota Statutes 2010, section 150A.091, is amended by adding a
94.12 subdivision to read:
94.13 Subd. 16. **Failure of professional development portfolio audit.** A licensee shall
94.14 submit a fee as established by the board not to exceed the amount of $250 after failing
94.15 two consecutive professional development portfolio audits and, thereafter, for each failed
94.16 professional development portfolio audit under Minnesota Rules, part 3100.5300.
94.17 Sec. 22. **[151.065] FEE AMOUNTS.**
94.18 Subdivision 1. **Application fees.** Application fees for licensure and registration
94.19 are as follows:
94.20 (1) pharmacist licensed by examination, $130;
94.21 (2) pharmacist licensed by reciprocity, $225;
94.22 (3) pharmacy intern, $30;
94.23 (4) pharmacy technician, $30;
94.24 (5) pharmacy, $190;
94.25 (6) drug wholesaler, legend drugs only, $200;
94.26 (7) drug wholesaler, legend and nonlegend drugs, $200;
94.27 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $175;
94.28 (9) drug wholesaler, medical gases, $150;
94.29 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, $125;
94.30 (11) drug manufacturer, legend drugs only, $200;
94.31 (12) drug manufacturer, legend and nonlegend drugs, $200;
94.32 (13) drug manufacturer, nonlegend or veterinary legend drugs, $175;
94.33 (14) drug manufacturer, medical gases, $150;

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(15) drug manufacturer, also licensed as a pharmacy in Minnesota, $125;
(16) medical gas distributor, $75;
(17) controlled substance researcher, $50; and
(18) pharmacy professional corporation, $100.

Subd. 2. **Original license fee.** The pharmacist original licensure fee, $130.

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, $130;
(2) pharmacy technician, $30;
(3) pharmacy, $190;
(4) drug wholesaler, legend drugs only, $200;
(5) drug wholesaler, legend and nonlegend drugs, $200;
(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $175;
(7) drug wholesaler, medical gases, $150;
(8) drug wholesaler, also licensed as a pharmacy in Minnesota, $125;
(9) drug manufacturer, legend drugs only, $200;
(10) drug manufacturer, legend and nonlegend drugs, $200;
(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, $175;
(12) drug manufacturer, medical gases, $150;
(13) drug manufacturer, also licensed as a pharmacy in Minnesota, $125;
(14) medical gas distributor, $75;
(15) controlled substance researcher, $50; and
(16) pharmacy professional corporation, $45.

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, $15;
(2) duplicate small license, $15; and
(3) duplicate large certificate, $25.

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

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.
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96.1 (b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $90.

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

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

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

96.5 Sec. 23. Minnesota Statutes 2010, section 151.07, is amended to read:

151.07 MEETINGS; EXAMINATION FEE.

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

96.7 Sec. 24. Minnesota Statutes 2010, section 151.101, is amended to read:

151.101 INTERNSHIP.

96.8 Upon payment of the fee specified in section 151.065, the board may license register as an intern any natural persons who have satisfied the board that they are of good moral character, not physically or mentally unfit, and who have successfully completed the educational requirements for intern registration prescribed by the board. The board shall prescribe standards and requirements for interns, pharmacist-preceptors, and internship training but may not require more than one year of such training.

96.9 The board in its discretion may accept internship experience obtained in another state provided the internship requirements in such other state are in the opinion of the board equivalent to those herein provided.
Sec. 25. Minnesota Statutes 2010, section 151.102, is amended by adding a subdivision to read:

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

Sec. 26. Minnesota Statutes 2010, section 151.12, is amended to read:

151.12 RECIPROCITY; LICENSURE.

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

Sec. 27. Minnesota Statutes 2010, section 151.13, subdivision 1, is amended to read:

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

Sec. 28. Minnesota Statutes 2010, section 151.19, is amended to read:

151.19 REGISTRATION; FEES.

Subdivision 1. Pharmacy registration. The board shall require and provide for the annual registration of every pharmacy now or hereafter doing business within this state. Upon the payment of any applicable fee to be set by the board specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such persons as may be qualified by law to conduct a pharmacy. Such certificate shall be displayed in a conspicuous place in the pharmacy for which it is issued and expire on the 30th day of June following the date of issue. It shall be unlawful for any person to conduct a pharmacy unless such certificate has been issued to the person by the board.

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

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

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

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

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

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

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

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

Subd. 3. Sale of federally restricted medical gases. The board shall require and
provide for the annual registration of every person or establishment not licensed as a
pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted
medical gases. Upon the payment of any applicable fee to be set by the board specified
in section 151.065, the board shall issue a registration certificate in such form as it may
determine to prescribe to those persons or places that may be qualified to sell or distribute federally
restricted medical gases. The certificate shall be displayed in a conspicuous place in the
business for which it is issued and expire on the date set by the board. It is unlawful for
a person to sell or distribute federally restricted medical gases unless a certificate has
been issued to that person by the board.

Sec. 29. Minnesota Statutes 2010, section 151.25, is amended to read:

151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.

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

Sec. 30. Minnesota Statutes 2010, section 151.47, subdivision 1, is amended to read:

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

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

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

(c) The board may require a separate license for each facility directly or indirectly
owned or operated by the same business entity within the state, or for a parent entity
with divisions, subsidiaries, or affiliate companies within the state, when operations
are conducted at more than one location and joint ownership and control exists among
all the entities.

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

(1) adequate storage conditions and facilities;
(2) minimum liability and other insurance as may be required under any applicable federal or state law;

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

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

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

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

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

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

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

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

(f) A wholesale drug distributor shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement or other compensation authorized under section 151.461, clauses (3) to (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more, to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this provision are public data.
Sec. 31. Minnesota Statutes 2010, section 151.48, is amended to read:

151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.

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

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

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

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

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

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

Sec. 32. Minnesota Statutes 2010, section 152.12, subdivision 3, is amended to read:

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

Sec. 33. [214.107] HEALTH-RELATED LICENSING BOARDS

ADMINISTRATIVE SERVICES UNIT.

Subdivision 1. Establishment. An administrative services unit is established for the health-related licensing boards in section 214.01, subdivision 2, to perform administrative, financial, and management functions common to all the boards in a manner that streamlines services, reduces expenditures, targets the use of state resources, and meets the mission of public protection.
Subd. 2. **Authority.** The administrative services unit shall act as an agent of the boards.

Subd. 3. **Funding.** (a) The administrative service unit shall apportion among the health-related licensing boards an amount to be allocated to each health-related licensing board. The amount apportioned to each board shall equal each board's share of the annual operating costs for the unit and shall be deposited into the state government special revenue fund.

(b) The administrative services unit may receive and expend reimbursements for services performed for other agencies.

Sec. 34. **EFFECTIVE DATE.**

Sections 8 to 12 are effective upon implementation of the coordinated licensure information system defined in Minnesota Statutes, section 148.2855, but no sooner than July 1, 2012.

**ARTICLE 5**

**HEALTH CARE**

Section 1. [L.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 meaning 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. (a) No public official, employee, or agent of the state of Minnesota or any of its political subdivisions shall act to impose, collect, enforce, or effectuate any penalty in the state of Minnesota that violates the public policy set forth in this section.

(b) The attorney general shall take any action as is provided in this section or section 8.31 in the defense or prosecution of rights protected under this section.

Sec. 2. Minnesota Statutes 2010, section 8.31, subdivision 1, is amended to read:

Subdivision 1. Investigate offenses against provisions of certain designated sections; assist in enforcement. (a) The attorney general shall investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade, and specifically, but not exclusively, the Nonprofit Corporation Act (sections 317A.001 to 317A.909), the Act Against Unfair Discrimination and Competition (sections 325D.01 to 325D.07), the Unlawful Trade Practices Act (sections 325D.09 to 325D.16), the Antitrust Act (sections 325D.49 to 325D.66), section 325F.67 and other laws against false or fraudulent advertising, the antidiscrimination acts contained in section 325D.67, the act against monopolization of food products (section 325D.68), the act regulating telephone advertising services (section 325E.39), the Prevention of Consumer Fraud Act (sections 325F.68 to 325F.70), and chapter 53A regulating currency exchanges and assist in the enforcement of those laws as in this section provided.

(b) The attorney general shall seek injunctive and any other appropriate relief as expeditiously as possible to preserve the rights and property of the residents of Minnesota, and to defend as necessary the state of Minnesota, its officials, employees, and agents in
the event that any law or regulation violating the public policy set forth in the Freedom
of Choice in Health Care Act in this section is enacted by any government, subdivision,
or agency thereof.
(c) The attorney general shall seek injunctive and any other appropriate relief
as expeditiously as possible in the event that any law or regulation violating the public
policy set forth in the Freedom of Choice in Health Care Act in this section is enacted
without adequate federal funding to the state to ensure affordable health care coverage
is available to the residents of Minnesota.

Sec. 3. Minnesota Statutes 2010, section 8.31, subdivision 3a, is amended to read:
Subd. 3a. Private remedies. In addition to the remedies otherwise provided by law,
any person injured by a violation of any of the laws referred to in subdivision 1 or a
violation of the public policy in section 1.06 may bring a civil action and recover damages,
together with costs and disbursements, including costs of investigation and reasonable
attorney's fees, and receive other equitable relief as determined by the court. The court
may, as appropriate, enter a consent judgment or decree without the finding of illegality.
In any action brought by the attorney general pursuant to this section, the court may award
any of the remedies allowable under this subdivision. An action under this subdivision
for any violation of section 1.06 is in the public interest.

Sec. 4. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:
Subdivision 1. Establishment. The association shall establish the following
maximum premiums to be charged for membership in the comprehensive health insurance
plan:
(a) the premium for the number one qualified plan shall range from a minimum of
101 percent to a maximum of 125 percent of the weighted average of rates charged by
those insurers and health maintenance organizations with individuals enrolled in:
1. $1,000 annual deductible individual plans of insurance in force in Minnesota;
2. individual health maintenance organization contracts of coverage with a $1,000
annual deductible which are in force in Minnesota; and
3. other plans of coverage similar to plans offered by the association based on
generally accepted actuarial principles;
(b) the premium for the number two qualified plan shall range from a minimum of
101 percent to a maximum of 125 percent of the weighted average of rates charged by
those insurers and health maintenance organizations with individuals enrolled in:
1. $500 annual deductible individual plans of insurance in force in Minnesota;
(2) individual health maintenance organization contracts of coverage with a $500 annual deductible which are in force in Minnesota; and

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

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

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

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

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

(d) the premium for each type of Medicare supplement plan required to be offered by the association pursuant to section 62E.12 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) Medicare supplement plans in force in Minnesota;

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

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

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

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

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

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

1. multiplying the numbers of individuals covered by each insurer or health maintenance organization by the rates charged for coverage;
2. separately summing both the number of individuals covered by all the insurers and health maintenance organizations and all the products computed under clause (1); and
3. dividing the total of the products computed under clause (1) by the total number of individuals covered.

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

Sec. 5. [62E.121] HIGH-DEDUCTIBLE, BASIC PLAN.

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

Subd. 2. Annual deductible; out-of-pocket maximum. (a) The plan shall provide the following in-network annual deductible options: $3,000, $6,000, $9,000, and $12,000.

The in-network annual out-of-pocket maximum for each annual deductible option shall be $1,000 greater than the amount of the annual deductible.

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

Subd. 3. Office visits for nonpreventive care. The following co-payments shall apply for each of the first three office visits per calendar year for nonpreventive care:
(1) $30 per visit for the $3,000 annual deductible option;
(2) $40 per visit for the $6,000 annual deductible option;
(3) $50 per visit for the $9,000 annual deductible option; and
(4) $60 per visit for the $12,000 annual deductible option.
For the fourth and subsequent visits during the calendar year, 80 percent coverage is provided under all deductible options, after the deductible is met.

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

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

Subd. 6. **Convenience care center visits.** A $20 co-payment applies for the first three convenience care center visits during a calendar year. For the fourth and subsequent 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. 6. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision
to read:

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

Sec. 7. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

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

Sec. 8. Minnesota Statutes 2010, section 62J.692, subdivision 7, is amended to read:

Subd. 7. Transfers from the commissioner of human services. Of the amount
transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4),
$21,714,000 shall be distributed as follows:
(1) $2,157,000 shall be distributed by the commissioner to the University of
Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;
(2) $1,035,360 shall be distributed by the commissioner to the Hennepin County
Medical Center for clinical medical education;
(3) $17,400,000 shall be distributed by the commissioner to the University of
Minnesota Board of Regents for purposes of medical education;
(4) $1,121,640 shall be distributed by the commissioner to clinical medical education
dental innovation grants in accordance with subdivision 7a; and
(5) the remainder of the amount transferred according to section 256B.69,
subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to
clinical medical education programs that meet the qualifications of subdivision 3 based on
the formula in subdivision 4, paragraph (a), or subdivision 11, as appropriate.

Sec. 9. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:
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
chairs and ranking minority members of the legislative committees with jurisdiction over
health care policy and finance.

Sec. 10. [62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL
ERRORS PROHIBITED.
A health care provider shall not bill a patient, and shall not be reimbursed, for
any operation, treatment, or other care that is provided to reverse, correct, or otherwise
minimize the affects of an adverse health care event, as described in section 144.7065,
subdivisions 2 to 7, for which that health care provider is responsible.

Sec. 11. Minnesota Statutes 2010, section 62Q.32, is amended to read:
62Q.32 LOCAL OMBUDSPERSON.
County board or community health service agencies may establish an office of
ombudsperson to provide a system of consumer advocacy for persons receiving health
care services through a health plan company. The ombudsperson's functions may include,
but are not limited to:
(a) mediation or advocacy on behalf of a person accessing the complaint and appeal
procedures to ensure that necessary medical services are provided by the health plan
company; and
(b) investigation of the quality of services provided to a person and determine the
extent to which quality assurance mechanisms are needed or any other system change
may be needed. The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the Legislative Commission on Health Care Access by January 15, 1996.

Sec. 12. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

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

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

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

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:
(1) clearly indicate the reason they believe the data used to calculate the peer group
system results are not accurate;

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

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

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

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

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

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing
information under paragraph (e) or (f), the commissioner shall ensure the scientific
validity and reliability of the results according to the standards described in paragraph (h).

If additional time is needed to establish the scientific validity and reliability of the results,
the commissioner may delay the dissemination of data to providers under paragraph (b)
or (c), or the publication of information under paragraph (e) or (f). If the delay is more
than 60 days, the commissioner shall report in writing to the Legislative Commission on
Health Care Access, chairs and ranking minority members of the legislative committees
with jurisdiction over health care policy and finance the following information:

(1) the reason for the delay;

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

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

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

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

(1) use of the best available evidence, research, and methodologies; and
Sec. 13. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:
Subd. 2. Legislative oversight. Beginning January 15, 2009, the commissioner of health shall submit to the Legislative Commission on Health Care Access chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0754.

Sec. 15. Minnesota Statutes 2010, section 256.01, subdivision 2b, is amended to read:

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

Sec. 16. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

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

(b) Amounts attributed to new recoveries under this subdivision are appropriated to the commissioner to the extent they fulfill the payment terms of the contract with the vendor and shall be deposited into an account in a fund other than the general fund for purposes of fulfilling the terms of the vendor contract.

Sec. 17. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. Operating payment rates. In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment
rates per admission for each hospital based on the cost-finding methods and allowable
costs of the Medicare program in effect during the base year. Rates under the general
assistance medical care, medical assistance, and MinnesotaCare programs shall not be
rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months
of the rebased period beginning January 1, 2009. For the first 24 months of the rebased
period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota
long-term hospital shall be rebased effective January 1, 2011, based on its most recent
Medicare cost report ending on or before September 1, 2008, with the provisions under
subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent
rate setting periods in which the base years are updated, a Minnesota long-term hospital's
base year shall remain within the same period as other hospitals. Effective January 1,
2013, rates shall be rebased at full value. Rates must not be rebased to more current data
for the first six months of the rebased period beginning January 1, 2013. The base year
operating payment rate per admission is standardized by the case mix index and adjusted
by the hospital cost index, relative values, and disproportionate population adjustment.
The cost and charge data used to establish operating rates shall only reflect inpatient
services covered by medical assistance and shall not include property cost information
and costs recognized in outlier payments.

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

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

(b) The commissioner of human services shall modify the Minnesota health care
programs application form to add a question asking applicants whether they have ever
served in the United States military.

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

Sec. 19. 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 determinates
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

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 20. 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,
recipients of supplemental security income may have an income up to the supplemental
security income standard in effect on that date.

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

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children
may have an income up to 100 percent of the federal poverty guidelines for the family size.
(d) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size:

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

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 21. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or
(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

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

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

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

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

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

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

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

(v) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (i):

Notwithstanding paragraph (i), Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or (e) who are lawfully in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully present in the United States, as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the United States Citizenship and Immigration Services to pursue any applicable
immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(4) (a) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (e) (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(e) (f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care.

(h) (g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants and related care;
(iii) services for routine prenatal care;
(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;
(v) elective surgery;
(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;
(vii) preventative health care and family planning services;
(viii) dialysis;
(ix) chemotherapy or therapeutic radiation services;
(x) rehabilitation services;
(xi) physical, occupational, or speech therapy;
(xii) transportation services;
(xiii) case management;
(xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
(xv) dental services;
(xvi) hospice care;
(xvii) audiology services and hearing aids;
(xviii) podiatry services;
(xix) chiropractic services;
(xx) immunizations;
(xxi) vision services and eyeglasses;
(xxii) waiver services;
(xxiii) individualized education programs; or
(xxiv) chemical dependency treatment.

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present as designated in paragraph (e) and who in the United States as defined in Code of Federal Regulations, title 8, section 103.12, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(ii) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
assistance without federal financial participation. Qualified noncitizens as described
in paragraph (d) are only eligible for medical assistance without federal financial
participation for five years from their date of entry into the United States.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
services from a nonprofit center established to serve victims of torture and are otherwise
ineligible for medical assistance under this chapter are eligible for medical assistance
without federal financial participation. These individuals are eligible only for the period
during which they are receiving services from the center. Individuals eligible under this
paragraph shall not be required to participate in prepaid medical assistance.

Sec. 22. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
subdivision to read:

Subd. 3q. Evidence-based childbirth program. (a) The commissioner shall
implement a program to reduce the number of elective inductions of labor prior to 39
weeks' gestation. In this subdivision, the term "elective induction of labor" means the
use of artificial means to stimulate labor in a woman without the presence of a medical
condition affecting the woman or the child that makes the onset of labor a medical
necessity. The program must promote the implementation of policies within hospitals
providing services to recipients of medical assistance or MinnesotaCare that prohibit the
use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by
the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after
January 1, 2012, a payment for professional services associated with the delivery of a
child in a hospital must not be made unless the provider has submitted information about
the nature of the labor and delivery including any induction of labor that was performed
in conjunction with that specific birth. The information must be on a form prescribed by
the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed
at a hospital that has policies and processes in place that have been approved by the
commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process
for review of hospital induction policies must be established by the commissioner and
review of policies must occur at the discretion of the commissioner. The commissioner's
decision to approve or rescind approval must include verification and review of items
including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;
(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

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

Sec. 23. Minnesota Statutes 2010, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. Physical therapy. (a) Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

EFFECTIVE DATE. This section is effective July 1, 2011, for services provided on a fee-for-service basis, and January 1, 2012, for services provided by a managed care plan or county-based purchasing plan.
Sec. 24. Minnesota Statutes 2010, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. Occupational therapy. (a) Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or reevaluations. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

EFFECTIVE DATE. This section is effective July 1, 2011, for services provided on a fee-for-service basis, and January 1, 2012, for services provided by a managed care plan or county-based purchasing plan.

Sec. 25. Minnesota Statutes 2010, section 256B.0625, subdivision 8b, is amended to read:

Subd. 8b. Speech-language pathology and audiology services. (a) Medical assistance covers speech-language pathology and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary speech-language pathology services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 50 treatment sessions with any combination of approved CPT codes; and (2) one evaluation.

(c) Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed at the same rate as services performed by a speech-language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.
EFFECTIVE DATE. This section is effective July 1, 2011, for services provided on a fee-for-service basis, and January 1, 2012, for services provided by a managed care plan or county-based purchasing plan.

Sec. 26. Minnesota Statutes 2010, section 256B.0625, subdivision 8c, is amended to read:

Subd. 8c. Care management; rehabilitation services. (a) Effective July 1, 1999, onetime thresholds shall replace annual thresholds for provision of rehabilitation services described in subdivisions 8, 8a, and 8b. The onetime thresholds will be the same in amount and description as the thresholds prescribed by the Department of Human Services health care programs provider manual for calendar year 1997, except they will not be renewed annually, and they will include sensory skills and cognitive training skills.

(b) A care management approach for authorization of rehabilitation services beyond the threshold described in subdivisions 8, 8a, and 8b shall be instituted in conjunction with the onetime thresholds. The care management approach shall require the provider and the department rehabilitation reviewer to work together directly through written communication, or telephone communication when appropriate, to establish a medically necessary care management plan. Authorization for rehabilitation services shall include approval for up to 12 months of services at a time without additional documentation from the provider during the extended period, when the rehabilitation services are medically necessary due to an ongoing health condition.

(c) The commissioner shall implement an expedited five-day turnaround time to review authorization requests for recipients who need emergency rehabilitation services and who have exhausted their onetime threshold limit for those services.

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

Sec. 27. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to read:

Subd. 8e. Chiropractic services. Payment for chiropractic services is limited to one annual evaluation and 43 visits per year unless prior authorization of a greater number of visits is obtained.

Sec. 28. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8f. Acupuncture services. Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by
another Minnesota licensed practitioner for whom acupuncture is within the practitioner's
scope of practice and who has specific acupuncture training or credentialing.

Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to
read:

Subd. 13e. Payment rates. (a) The basis for determining the amount of payment
shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
or the maximum allowable cost set by the federal government or by the commissioner
plus the fixed dispensing fee; or the usual and customary price charged to the public. The
amount of payment basis must be reduced to reflect all discount amounts applied to the
charge by any provider/insurer agreement or contract for submitted charges to medical
assistance programs. The net submitted charge may not be greater than the patient liability
for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee
for intravenous solutions which must be compounded by the pharmacist shall be $8 per
bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral
nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral
nutritional products dispensed in quantities greater than one liter. Actual acquisition cost
includes quantity and other special discounts except time and cash discounts. Effective
July 1, 2009. The actual acquisition cost of a drug shall be estimated by the commissioner;
at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic
factor drugs shall be estimated at the average wholesale price minus 30 percent. wholesale
acquisition cost plus four percent for independently owned pharmacies located in a
designated rural area within Minnesota, and at wholesale acquisition cost plus two percent
for all other pharmacies. A pharmacy is "independently owned" if it is one of four or
fewer pharmacies under the same ownership nationally. A "designated rural area" means
an area defined as a small rural area or isolated rural area according to the four-category
classification of the Rural Urban Commuting Area system developed for the United States
Health Resources and Services Administration. Wholesale acquisition cost is defined as
the manufacturer's list price for a drug or biological to wholesalers or direct purchasers
in the United States, not including prompt pay or other discounts, rebates, or reductions
in price, for the most recent month for which information is available, as reported in
wholesale price guides or other publications of drug or biological pricing data. The
maximum allowable cost of a multisource drug may be set by the commissioner and it
shall be comparable to, but no higher than, the maximum amount paid by other third-party
payors in this state who have maximum allowable cost programs. Establishment of the
amount of payment for drugs shall not be subject to the requirements of the Administrative
Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
to pharmacists for legend drug prescriptions dispensed to residents of long-term care
facilities when a unit dose blister card system, approved by the department, is used. Under
this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.

The National Drug Code (NDC) from the drug container used to fill the blister card must
be identified on the claim to the department. The unit dose blister card containing the
drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
will be required to credit the department for the actual acquisition cost of all unused
drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
manufacturer's unopened package. The commissioner may permit the drug clozapine to be
dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug,
payment shall be on the basis of the lower of the usual and customary price charged
to the public or the maximum allowable cost established by the commissioner unless
prior authorization for the brand name product has been granted according to the criteria
established by the Drug Formulary Committee as required by subdivision 13f, paragraph
(a), and the prescriber has indicated "dispense as written" on the prescription in a manner
consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an
outpatient setting shall be the lower of the usual and customary cost submitted by the
provider or the amount established for Medicare by the
106 percent of the average sales
price as determined by the United States Department of Health and Human Services
pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales
price is unavailable, the amount of payment must be lower of the usual and customary cost
submitted by the provider or the wholesale acquisition cost.

(e) The commissioner may negotiate lower reimbursement rates for specialty
pharmacy products than the rates specified in paragraph (a). The commissioner may
require individuals enrolled in the health care programs administered by the department
to obtain specialty pharmacy products from providers with whom the commissioner has
negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
used by a small number of recipients or recipients with complex and chronic diseases
that require expensive and challenging drug regimens. Examples of these conditions
include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, **antihemophilic factor products**, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

**EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal approval, whichever is later.

Sec. 30. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

**Subd. 13h. Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking **four three** or more prescriptions to treat or prevent **two one** or more chronic medical conditions, or a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;
(2) formulating a medication treatment plan;
(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;
(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

1. have a valid license issued under chapter 151;

2. have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

3. be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding including long-term care and settings, group homes, if the service is ordered by the provider directed care coordination team and facilities providing assisted living services, but excluding skilled nursing facilities; and

4. make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also
be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

Sec. 31. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to read:

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

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

2) special transportation; or

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

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

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation providers shall perform driver-assisted services for eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger
securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation
providers must obtain written documentation from the health care service provider who
is serving the recipient being transported, identifying the time that the recipient arrived.
Special transportation providers may not bill for separate base rates for the continuation of
a trip beyond the original destination. Special transportation providers must take recipients
to the nearest appropriate health care provider, using the most direct route. The minimum
medical assistance reimbursement rates for special transportation services are:
(1) (i) $17 for the base rate and $1.35 per mile for special transportation services to
eligible persons who need a wheelchair-accessible van;
(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to
eligible persons who do not need a wheelchair-accessible van; and
(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for
special transportation services to eligible persons who need a stretcher-accessible vehicle;
(2) the base rates for special transportation services in areas defined under RUCA
to be super rural shall be equal to the reimbursement rate established in clause (1) plus
11.3 percent; and
(3) for special transportation services in areas defined under RUCA to be rural
or super rural areas:
(i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
percent of the respective mileage rate in clause (1); and
(ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
112.5 percent of the respective mileage rate in clause (1).
(c) For purposes of reimbursement rates for special transportation services under
paragraph (b), the zip code of the recipient's place of residence shall determine whether
the urban, rural, or super rural reimbursement rate applies.
(d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"
means a census-tract based classification system under which a geographical area is
determined to be urban, rural, or super rural.
(e) Effective for services provided on or after July 1, 2011, nonemergency
transportation rates, including special transportation, taxi, and other commercial carriers,
are reduced 4.5 percent. Payments made to managed care plans and county-based
purchasing plans must be reduced for services provided on or after January 1, 2012,
to reflect this reduction.

Sec. 32. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to
read:
Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2011, ambulance services payment rates are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 33. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to read:

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers costs of the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Sec. 34. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party payer.

A good faith effort is established by supplying with the authorization request to the commissioner the following:

1. a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

2. the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim experiences with
Medicare or because of written communication from Medicare, coverage is not available
for the service.

(c) Authorization is not required if a third-party payer has made payment that is
equal to or greater than 60 percent of the maximum payment amount for the service
allowed under medical assistance.

Sec. 35. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to
read:

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical
assistance covers augmentative and alternative communication systems consisting of
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. 36. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
subdivision to read:

Subd. 55. **Payment for noncovered services.** (a) Except when specifically
prohibited by the commissioner or federal law, a provider may seek payment from the
recipient for services not eligible for payment under the medical assistance program when
the provider, prior to delivering the service, reviews and considers all other available
covered alternatives with the recipient and obtains a signed acknowledgment from the
recipient of the potential of the recipient's liability. The signed acknowledgment must be
in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient
include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied
as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing
requirements;

(3) standard shipping or delivery and setup of medical equipment or medical
supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is
one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescriptive drug identified by the commissioner as
having the potential for abuse and overuse, except where payment by the recipient is
specifically approved by the commissioner on the date of service based upon compelling
evidence supplied by the prescribing provider that establishes medical necessity for that
particular drug.

(c) The payment requested from recipients for noncovered services under this
subdivision must not exceed the provider's usual and customary charge for the actual
service received by the recipient. A recipient must not be billed for the difference between
what medical assistance paid for the service or would pay for a less costly alternative
service.

Sec. 37. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
subdivision to read:

Subd. 56. Medical service coordination. (a) Medical assistance covers in-reach
community-based service coordination that is performed in a hospital emergency
department as an eligible procedure under a state healthcare program or private insurance
for a frequent user. A frequent user is defined as an individual who has frequented the
hospital emergency department for services three or more times in the previous four
consecutive months. In-reach community-based service coordination includes navigating
services to address a client's mental health, chemical health, social, economic, and housing
needs, or any other activity targeted at reducing the incidence of emergency room and
other nonmedically necessary health care utilization.
(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 a health care home framework is ineligible for reimbursement under this subdivision. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

Sec. 38. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 57. Payment for Part B Medicare crossover claims. Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

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

Sec. 39. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 58. Early and periodic screening, diagnosis, and treatment services. Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 40. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:
Subd. 59. Services provided by advanced dental therapists and dental therapists. Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

Sec. 41. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. Co-payments Cost-sharing. (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments cost-sharing for all recipients, effective for services provided on or after October 1, 2003, and before January 1, 2009 July 1, 2011:

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

(2) $3 for eyeglasses;

(3) $6 $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval; and

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

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

(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:

(1) $3.50 for nonemergency visits to a hospital-based emergency room;

(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(3) (6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly co-payments cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if
the spouse is enrolled in medical assistance and also subject to the five percent limit on

cost-sharing.

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

c) Effective January 1, 2012, or upon federal approval, whichever is later, the
following co-payments for nonpreventive visits shall apply to providers included in
provider peer grouping:

(1) $3 for visits to providers whose average, risk-adjusted, total annual cost of
care per medical assistance enrollee is at the 60th percentile or lower for providers of
the same type;

(2) $6 for visits to providers whose average, risk-adjusted, total annual cost of care
per medical assistance enrollee is greater than the 60th percentile but does not exceed the
80th percentile for providers of the same type; and

(3) $10 for visits to providers whose average, risk-adjusted, total annual cost of
care per medical assistance enrollee is greater than the 80th percentile for providers of
the same type.

Each managed care and county-based purchasing plan shall calculate the average,
risk-adjusted, total annual cost of care for providers under this paragraph using a
methodology approved by the commissioner. The commissioner shall develop a
methodology for calculating the average, risk-adjusted, total annual cost of care for
fee-for-service providers.

d) The commissioner shall seek any federal waivers and approvals necessary to
increase the co-payment for nonemergency visits to a hospital-based emergency room
under paragraph (a), clause (3), and to implement paragraph (c).

Sec. 42. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to
read:

Subd. 2. Exceptions. Co-payments and deductibles shall be subject to the following
exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical
condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;
(6) emergency services;
(7) family planning services;
(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and
(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Sec. 43. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. Collection. (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum or the $7 per month maximum effective January 1, 2009, for prescription drug co-payments; or
(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent co-payment cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

Sec. 44. Minnesota Statutes 2010, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall
not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers.
(e) A provider described in section 256B.76, subdivision 5, may limit the eligibility of new medical assistance, general assistance medical care, and MinnesotaCare patients for specific categories of rehabilitative services, if medical assistance, general assistance medical care, and MinnesotaCare patients served by the provider in the aggregate exceed 30 percent of the provider's overall patient population.

Sec. 45. 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 waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

Sec. 46. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waived services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and health care home.

Sec. 47. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner
shall withhold five percent of managed care plan payments under this section and
county-based purchasing plan payments under section 256B.692 for the prepaid medical
assistance program pending completion of performance targets. Each performance target
must be quantifiable, objective, measurable, and reasonably attainable, except in the case
of a performance target based on a federal or state law or rule. Criteria for assessment
of each performance target must be outlined in writing prior to the contract effective
date. The managed care plan must demonstrate, to the commissioner's satisfaction,
that the data submitted regarding attainment of the performance target is accurate. The
commissioner shall periodically change the administrative measures used as performance
targets in order to improve plan performance across a broader range of administrative
services. The performance targets must include measurement of plan efforts to contain
spending on health care services and administrative activities. The commissioner may
adopt plan-specific performance targets that take into account factors affecting only one
plan, including characteristics of the plan's enrollee population. The withheld funds
must be returned no sooner than July of the following year if performance targets in the
contract are achieved. The commissioner may exclude special demonstration projects
under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December
31, 2009, the commissioner shall withhold three percent of managed care plan payments
under this section and county-based purchasing plan payments under section 256B.692
for the prepaid medical assistance program. The withheld funds must be returned no
sooner than July 1 and no later than July 31 of the following year. The commissioner may
exclude special demonstration projects under subdivision 23.

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

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

(g) Effective for services rendered on or after January 1, 2011, the commissioner
shall include as part of the performance targets described in paragraph (c) a reduction in
the health plan's emergency room utilization rate for state health care program enrollees
by a measurable rate of five percent from the plan's utilization rate for state health care
program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31
of the following calendar year if the managed care plan demonstrates to the satisfaction of
the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive
contract period until the plan's emergency room utilization rate for state health care
program enrollees is reduced by 25 percent of the plan's emergency room utilization
rate for state health care program enrollees for calendar year 2009. Hospitals shall
cooperate with the health plans in meeting this performance target and shall accept
payment withholds that may be returned to the hospitals if the performance target is
achieved. The commissioner shall structure the withhold so that the commissioner returns
a portion of the withheld funds in amounts commensurate with achieved reductions in
utilization less than the targeted amount. The withhold in this paragraph does not apply to
county-based purchasing plans.

(h) Effective for services rendered on or after January 1, 2012, the commissioner
shall include as part of the performance targets described in paragraph (c) a reduction in
the plan's hospitalization rates or subsequent hospitalizations within 30 days of a previous
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 utilization rate
for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31
of the following calendar year if the managed care plan 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 utilization less than the targeted amount.

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

**(j)** Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

The return of the withhold under paragraphs (d), (f), and (h) to (k) is not subject to the requirements of paragraph (c).

Sec. 48. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. Medical education and research fund. (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

1. an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

2. beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

3. beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

4. beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. Effective July 1, 2009, and thereafter. The transfers required by amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009.
Any excess shall first reduce the amounts otherwise required to be transferred specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the transfers amount specified under paragraph (a), clause (1).

(c) Beginning July 1, 2009 2011, of the amounts amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund. The balance of the transfers under paragraph (a) shall be transferred to the medical education and research fund no earlier than July 1 of the following fiscal year.

(d) Beginning July 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $4,024,000 in fiscal year 2012 and $4,626,000 in fiscal year 2013 and thereafter.

Sec. 49. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

Subd. 28. Medicare special needs plans; medical assistance basic health care.

(a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare.

The commissioner shall consult with the stakeholder group under paragraph (d) in
developing program specifications for these services. The commissioner shall report to
the chairs of the house of representatives and senate committees with jurisdiction over
health and human services policy and finance by February 1, 2007, on implementation
of these programs and the need for increased funding for the ombudsman for managed
care and other consumer assistance and protections needed due to enrollment in managed
care of persons with disabilities. Payment for Medicaid services provided under this
subdivision for the months of May and June will be made no earlier than July 1 of the
same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2008 2012, the
commissioner may expand contracting under this subdivision to all shall enroll persons
with disabilities not otherwise required to enroll in managed care under this section,
unless the individual chooses to opt out of enrollment. The commissioner shall establish
enrollment and opt out procedures consistent with applicable enrollment procedures under
this subdivision.

(d) The commissioner shall establish a state-level stakeholder group to provide
advice on managed care programs for persons with disabilities, including both MnDHO
and contracts with special needs plans that provide basic health care services as described
in paragraphs (a) and (b). The stakeholder group shall provide advice on program
expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;
(2) consumer protections; and
(3) program specifications such as quality assurance measures, data collection and
reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services
shall establish a local or regional stakeholder group, including representatives of the
counties covered by the plan, members, consumer advocates, and providers, for advice on
issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees
to health plans for marketing purposes. The commissioner may shall mail no more than
two sets of marketing materials per contract year to potential enrollees on behalf of health
plans, in which case at the health plan's request. The marketing materials shall be mailed
by the commissioner within 30 days of receipt of these materials from the health plan. The
health plans shall cover any costs incurred by the commissioner for mailing marketing
materials.
Sec. 50. 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 withheld 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 the 70th percentile of providers of the same type or specialty, the plan shall return the full amount of any withhold. For each provider whose risk-adjusted total annual cost of care is above the 70th percentile, the plan shall return only the portion of the withhold sufficient to bring the provider's payment rate to the average for providers within the provider type whose risk-adjusted total annual cost of care is at the 70th percentile. Each plan shall reduce provider payments only as allowed under paragraph (f).

(d) Each managed care and county-based purchasing plan must establish an appeals process to allow providers to appeal determinations of risk-adjusted total annual cost of care. Each plan's appeals process must be approved by the commissioner.

(e) The commissioner shall require each plan to submit to the commissioner, in the form and manner specified by the commissioner, all provider payment data and information on the withhold methodology that the commissioner determines is necessary to verify compliance with this subdivision.

(f) The commissioner, for the contract year beginning January 1, 2012, shall reduce plan capitation rates by ten percent from the rates that would otherwise apply, absent application of this subdivision. The reduced rate shall be the historical base rate for negotiating capitation rates for future contract years. The commissioner may recommend additional reductions in capitation rates for future contract years to the legislature, if the commissioner determines this is necessary to ensure that health care providers under
contract with managed care and county-based purchasing plans practice in an efficient
manner. Effective for services rendered on or after January 1, 2012, managed care plans
and county-based purchasing plans contracted with the state to administer the health
care programs provided under sections 256B.69, 256B.692, and 256L.12, may reduce
payments made to providers employed or under contract with the plan. However, a
managed care or county-based purchasing plan is prohibited from: (1) reducing payments
made to providers whose risk-adjusted total annual cost of care is at or below the 70th
percentile of providers of the same type or specialty, or at or below the 80th percentile
for provider types or specialties currently subject to plan care management requirements
that in the aggregate are more extensive than those that apply to other provider types or
specialties, or for which a majority of services are currently subject to prior authorization
by the plan and (2) reducing payments to hospitals described under the Social Security
Act, title 18, section 1886, subsection (d), paragraph (l), and subparagraph (B), clause (iii).

(g) The commissioner of human services, in consultation with the commissioner of
health, shall develop and provide to managed care and county-based purchasing plans, by
September 1, 2011, standard criteria and definitions necessary for consistent calculation
of the total annual risk-adjusted cost of care across plans. The commissioner may use
encounter data to implement this subdivision, and may provide encounter data or analyses
to plans.

(h) For purposes of this subdivision, "provider" means a vendor of medical care
as defined in section 256B.02, subdivision 7, for which sufficient encounter data on
utilization and costs is available to implement this subdivision.

(i) A managed care or county-based purchasing plan must use the methodology
described in paragraphs (a) to (e), unless the plan develops an alternative model consistent
with the purpose of this subdivision.

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

Sec. 51. Minnesota Statutes 2010, section 256B.69, is amended by adding a
subdivision to read:

Subd. 32. Health education. The commissioner shall require managed care and
county-based purchasing plans, as a condition of contract, to provide health education,
wellness training, and information about the availability and benefits of preventive
services to all medical assistance and MinnesotaCare enrollees, beginning January 1,
2012. Plan initiatives developed or implemented to comply with this requirement must be
approved by the commissioner.
Sec. 52. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

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

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

1. nonprofit community clinics that:
   1. have nonprofit status in accordance with chapter 317A;
   2. have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);
   3. are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;
   4. have professional staff familiar with the cultural background of the clinic's patients;
   5. charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;
   6. do not restrict access or services because of a patient's financial limitations or public assistance status; and
   7. have free care available as needed;

2. federally qualified health centers, rural health clinics, and public health clinics;

3. county owned and operated hospital-based dental clinics;

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

5. a dental clinic associated with an oral health or dental education program owned and operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered...
by medical assistance, general assistance medical care, or MinnesotaCare at a level which
significantly increases access to dental care in the service area.
(d) Notwithstanding paragraph (a), critical access payments must not be made for
dental services provided from April 1, 2010, through June 30, 2010.
(e) Notwithstanding section 256B.04, subdivision 2, the commissioner of human
services shall not adopt rules governing this section or section 256L.11, subdivision 7.

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

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Sec. 53. [256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE

DEMONSTRATION PROJECT.

Subdivision 1. Establishment and implementation. The commissioner of
human services, in consultation with the commissioner of health, shall contract
with a Minnesota-based academic and research institution specializing in providing
complementary and alternative medicine education and clinical services to establish and
implement a five-year demonstration project in conjunction with federally qualified health
centers and federally qualified health center look-alikes as defined in section 145.9269, to
improve the quality and cost-effectiveness of care provided under medical assistance to
enrollees with neck and back problems. The demonstration project must maximize the use
of complementary and alternative medicine-oriented primary care providers, including but
not limited to physicians and chiropractors. The demonstration project must be designed
to significantly improve physical and mental health for enrollees who present with
neck and back problems while decreasing medical treatment costs. The commissioner,
in consultation with the commissioner of health, shall deliver services through the
demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

Subd. 2. RFP and project criteria. The commissioner, in consultation with the
commissioner of health, shall develop and issue a request for proposal (RFP) for the
demonstration project. The RFP must require the academic and research institution
selected to demonstrate a proven track record over at least five years of conducting
high-quality, federally funded clinical research. The RFP shall specify the state costs
directly related to the requirements of this section and shall require that the selected
institution pay those costs to the state. The institution and the federally qualified health
centers and federally qualified health center look-alikes shall also:

(1) provide patient education, provider education, and enrollment training
components on health and lifestyle issues in order to promote enrollee responsibility for
health care decisions, enhance productivity, prepare enrollees to reenter the workforce,
and reduce future health care expenditures;

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Article 5 Sec. 53.
(2) use high-quality and cost-effective integrated disease management that includes
the best practices of traditional and complementary and alternative medicine;
(3) incorporate holistic medical care, appropriate nutrition, exercise, medications,
and conflict resolution techniques;
(4) include a provider education component that makes use of professional
organizations representing chiropractors, nurses, and other primary care providers
and provides appropriate educational materials and activities in order to improve the
integration of traditional medical care with licensed chiropractic services and other
alternative health care services and achieve program enrollment objectives; and
(5) provide to the commissioner the information and data necessary for the
commissioner to prepare the annual reports required under subdivision 6.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the
commissioner from current enrollees in the prepaid medical assistance program who
have, or are determined to be at significant risk of developing, neck and back problems.
Participation in the demonstration project shall be voluntary. The commissioner shall
seek to enroll, over the term of the demonstration project, ten percent of current and
future medical assistance enrollees who have, or are determined to be at significant risk
of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and
approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic and research
institution selected, federally qualified health centers, and federally qualified health center
look-alikes to fund all costs of the demonstration project. Amounts received under
subdivision 2 are appropriated to the commissioner for the purposes of this section.

Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner
of health, beginning December 15, 2011, and each December 15 thereafter through
December 15, 2015, shall report annually to the legislature on the functional and mental
improvements of the populations served by the demonstration project, patient satisfaction,
and the cost-effectiveness of the program. The reports must also include data on hospital
admissions, days in hospital, rates of outpatient surgery and other services, and drug
utilization. The report, due December 15, 2015, must include recommendations on
whether the demonstration project should be continued and expanded.

Sec. 54. [256B.841] MINNESOTA CHOICE WAIVER APPLICATION AND
PROCESS.

Subdivision 1. **Intent.** It is the intent of the legislature that medical assistance be:
(1) a sustainable, cost-effective, person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; and

(2) a results-oriented system of coordinated care that focuses on independence and choice, promotes accountability and transparency, encourages and rewards healthy outcomes and responsible choices, and promotes efficiency.

Subd. 2. Waiver application. (a) By September 1, 2011, the commissioner of human services shall apply for a waiver and any necessary state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., or other provisions of federal law that provide program flexibility and under which Minnesota will operate all facets of the state's medical assistance program. For purposes of this section, and 256B.842, and 256B.843, this waiver shall be known as the Minnesota Consumer Health Opportunities and Innovative Care Excellence (CHOICE) waiver.

(b) The commissioner of human services shall provide the legislative committees with jurisdiction over health and human services finance and policy with the CHOICE waiver application and financial and other related materials, at least ten days prior to submitting the application and materials to the federal Centers for Medicare and Medicaid Services.

(c) If the state's CHOICE waiver application is approved, the commissioner of human services shall:

(1) notify the chairs of the legislative committees with jurisdiction over health and human services finance and policy and allow the legislative committees with jurisdiction over health and human services finance and policy to review the terms of the CHOICE waiver; and

(2) not implement the CHOICE waiver until ten legislative days have passed following notification of the chairs.

Subd. 3. Rulemaking; legislative proposals. Upon acceptance of the terms of the CHOICE waiver, the commissioner of human services shall:

(1) adopt rules to implement the CHOICE waiver; and

(2) propose any legislative changes necessary to implement the terms of the CHOICE waiver.

Subd. 4. Joint commission on waiver implementation. (a) After acceptance of the terms of the CHOICE waiver, the governor shall establish a joint commission on CHOICE waiver implementation. The commission shall consist of eight members; four of whom...
shall be members of the senate, not more than three from the same political party, to be
appointed by the Subcommittee on Committees of the senate Committee on Rules and
Administration, and four of whom shall be members of the house of representatives, not
more than three from the same political party, to be appointed by the speaker of the house.

(b) The commission shall:

(1) oversee implementation of the CHOICE waiver;

(2) confer as necessary with state agency commissioners;

(3) make recommendations on services covered under the medical assistance
program;

(4) monitor and make recommendations on quality and access to care under the
CHOICE waiver; and

(5) make recommendations for the efficient and cost-effective administration of the
medical assistance program under the terms of the CHOICE waiver.

Sec. 55. [256B.842] PRINCIPLES AND GOALS FOR MEDICAL ASSISTANCE

REFORM.

Subdivision 1. Goals for reform. In developing the CHOICE waiver application
and implementing the CHOICE waiver, the commissioner of human services shall ensure
that the reformed medical assistance program is a person-centered, financially sustainable,
and cost-effective program.

Subd. 2. Reformed medical assistance criteria. The reformed medical assistance
program established through the CHOICE waiver must:

(1) empower consumers to make informed and cost-effective choices about their
health and offer consumers rewards for healthy decisions;

(2) ensure adequate access to needed services;

(3) enable consumers to receive individualized health care that is outcome-oriented
and focused on prevention, disease management, recovery, and maintaining independence;

(4) promote competition between health care providers to ensure best value
purchasing, leverage resources, and to create opportunities for improving service quality
and performance;

(5) redesign purchasing and payment methods and encourage and reward
high-quality and cost-effective care by incorporating and expanding upon current payment
reform and quality of care initiatives including, but not limited to, those initiatives
authorized under chapter 62U; and
(6) continually improve technology to take advantage of recent innovations and advances that help decision makers, consumers, and providers make informed and cost-effective decisions regarding health care.

Subd. 3. Annual report. The commissioner of human services shall annually submit a report to the governor and the legislature, beginning December 1, 2012, and each December 1 thereafter, describing the status of the administration and implementation of the CHOICE waiver.

Sec. 56. [256B.843] CHOICE WAIVER APPLICATION REQUIREMENTS.

Subdivision 1. Requirements for CHOICE waiver request. The commissioner shall seek federal approval to:

(1) enter into a five-year agreement with the United States Department of Health and Human Services and Centers for Medicaid and Medicare Services (CMS) under section 1115a to waive, as part of the CHOICE waiver, provisions of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., requiring:

(i) statewideness to allow for the provision of different services in different areas or regions of the state;

(ii) comparability of services to allow for the provision of different services to members of the same or different coverage groups;

(iii) no prohibitions restricting the amount, duration, and scope of services included in the medical assistance state plan;

(iv) no prohibitions limiting freedom of choice of providers; and

(v) retroactive payment for medical assistance, at the state's discretion;

(2) waive the applicable provisions of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., in order to:

(i) expand cost sharing requirements above the five percent of income threshold for beneficiaries in certain populations;

(ii) establish health savings or power accounts that encourage and reward beneficiaries who reach certain prevention and wellness targets; and

(iii) implement a tiered set of parameters to use as the basis for determining long-term service care and setting needs;

(3) modify income and resource rules in a manner consistent with the goals of the reformed program;

(4) provide enrollees with a choice of appropriate private sector health coverage options, with full federal financial participation;
(5) treat payments made toward the cost of care as a monthly premium for beneficiaries receiving home and community-based services when applicable;

(6) provide health coverage and services to individuals over the age of 65 that are limited in scope and are available only in the home and community-based setting;

(7) consolidate all home and community-based services currently provided under title XIX of the federal Social Security Act, United States Code, title 42, section 1915(c), into a single program of home and community-based services that include options for consumer direction and shared living;

(8) expand disease management, care coordination, and wellness programs for all medical assistance recipients; and

(9) empower and encourage able-bodied medical assistance recipients to work, whenever possible.

Subd. 2. Agency coordination. The commissioner shall establish an intraagency assessment and coordination unit to ensure that decision making and program planning for recipients who may need long-term care, residential placement, and community support services are coordinated. The assessment and coordination unit shall determine level of care, develop service plans and a service budget, make referrals to appropriate settings, provide education and choice counseling to consumers and providers, track utilization, and monitor outcomes.

Sec. 57. Minnesota Statutes 2010, section 256D.03, subdivision 3, is amended to read:

Subd. 3. General assistance medical care; eligibility. (a) Beginning April 1, 2010 October 1, 2011, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated, except for outpatient prescription drug coverage, which shall continue to be administered under this section and funded under section 256D.031, subdivision 9, beginning June 1, 2010.

(b) Outpatient prescription drug coverage under general assistance medical care is limited to prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Outpatient prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13h.
(c) Outpatient prescription drug coverage does not include drugs administered in a
clinic or other outpatient setting.

(d) For the period beginning April 1, 2010, to May 31, 2010, general assistance
medical care covers the services listed in subdivision 4:

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 58. Minnesota Statutes 2010, section 256D.031, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general
assistance medical care may be paid for any individual who is not eligible for medical
assistance under chapter 256B, including eligibility for medical assistance based on a
spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children
who are eligible under the Minnesota family investment program (MFIP), or who is
having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75
percent of federal poverty guidelines for the family size, using a six-month budget period;
and whose equity in assets is not in excess of $1,000 per assistance unit;

(2) is a resident of Minnesota and has gross countable income that is equal to or less
than 125 percent of the federal poverty guidelines for the family size, using a six-month
budget period, and who meets the asset limit specified in section 256L.17, subdivision 2.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must
conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d,
except that the maximum amount of undistributed funds in a trust that could be distributed
to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's
discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July
1 by the annual update of the federal poverty guidelines following publication by the
United States Department of Health and Human Services.

Sec. 59. Minnesota Statutes 2010, section 256D.031, subdivision 6, is amended to read:

Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010 October
1, 2011, the commissioner shall contract with hospitals or groups of hospitals, or
county-based purchasing plans, that qualify under paragraph (b) and agree to deliver
services according to this subdivision. Contracting hospitals or plans shall develop
and implement a coordinated care delivery system to provide health care services to
individuals who are eligible for general assistance medical care under this section and who
either choose to receive services through the coordinated care delivery system or who are
enrolled by the commissioner under paragraph (c). The health care services provided by
the system must include: (1) the services described in subdivision 4 with the exception
of outpatient prescription drug coverage but shall include drugs administered in a clinic
or other outpatient setting; or (2) a set of comprehensive and medically necessary health
services that the recipients might reasonably require to be maintained in good health and
that has been approved by the commissioner, including at a minimum, but not limited
to, emergency care, medical transportation services, inpatient hospital and physician
care, outpatient health services, preventive health services, mental health services,
and prescription drugs administered in a clinic or other outpatient setting. Outpatient
prescription drug coverage is covered on a fee-for-service basis in accordance with section
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, or July 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 excluding
outpatient prescription drug coverage 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 system may seek services from
a hospital eligible for reimbursement under the temporary uncompensated care pool
established under subdivision 8. After February 28, 2011, services are available only
through a coordinated care delivery system:

(d) The hospital or plan may contract and coordinate with providers and clinics
for the delivery of services and shall contract with essential community providers as
defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the
extent practicable. When contracting with providers and clinics, the hospital or plan
shall give preference to providers and clinics certified as health care homes under section
256B.0751. The hospital or plan must contract with federally qualified health centers or
federally qualified health center look-alikes, as defined in section 145.9269, subdivision 1,
and essential community providers as defined in section 62Q.19, that agree to accept the
terms, conditions, and payment rates offered by the hospital or plan to similarly situated
providers, except that reimbursement to federally qualified health centers and federally
qualified health center look-alikes must comply with federal law. If a provider or clinic or
health center contracts with a hospital or plan to provide services through the coordinated
care delivery system, the provider may not refuse to provide services to any recipient
enrolled in the system, and payment for services shall be negotiated with the hospital or
plan and paid by the hospital or plan from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled
in the coordinated care delivery system, and comply with the requirements of subdivision
4, paragraphs (b) to (g);
(2) establish a process to monitor enrollment and ensure the quality of care provided;
(3) in cooperation with counties, coordinate the delivery of health care services with
existing homeless prevention, supportive housing, and rent subsidy programs and funding
administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination,
which may include the use of allied health professionals, telemedicine, patient educators,
care coordinators, and community health workers.

(f) The hospital or plan may require a recipient to designate a primary care provider
or a primary care clinic. The hospital or plan may limit the delivery of services to a
network of providers who have contracted with the hospital or plan to deliver services in
accordance with this subdivision, and require a recipient to seek services only within this
network. The hospital or plan may also require a referral to a provider before the service
is eligible for payment. A coordinated care delivery system is not required to provide
payment to a provider who is not employed by or under contract with the system for
services provided to a recipient enrolled in the system, except in cases of an emergency.
For purposes of this section, emergency services are defined in accordance with Code of
Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal
to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred
by the coordinated care delivery system.

(i) The hospital or plan must provide the commissioner with data necessary for
assessing enrollment, quality of care, cost, and utilization of services. Each hospital or
plan must provide, on a quarterly basis on a form prescribed by the commissioner for each
recipient served by the coordinated care delivery system, the services provided, the cost of
services provided, and the actual payment amount for the services provided and any other
information the commissioner deems necessary to claim federal Medicaid match. The
commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010; The provisions of section 256.9695, subdivision 2,
paragraph (b), do not apply to general assistance medical care provided under this section.

(k) Notwithstanding any other provision in this section to the contrary, for
participation beginning September 1, 2010, the commissioner shall offer the same contract
terms related to shall negotiate an enrollment threshold formula and financial liability
protections to with a hospital or group of hospitals or plan qualified under this subdivision
to develop and implement a coordinated care delivery system as those contained in the
coordinated care delivery system contracts effective June 1, 2010.
(1) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 60. Minnesota Statutes 2010, section 256D.031, subdivision 7, is amended to read:

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system. (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals or plans participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010 October 1, 2011. The payment shall be allocated among all hospitals or plans qualified to participate on the allocation date as follows: based upon the enrollment thresholds negotiated with the commissioner,

(1) each hospital or group of hospitals shall be allocated an initial amount based on the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for general assistance medical care services to all participating hospitals;

(2) the initial allocations to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and the University of Minnesota Medical Center, Fairview, shall be increased to 110 percent of the value determined in clause (1);

(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata amount in order to keep the allocations within the limit of available appropriations; and

(4) the amounts determined under clauses (1) to (3) shall be allocated to participating hospitals:

The commissioner may prospectively reallocate payments to participating hospitals or plans on a biennial basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2014.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

(c) (b) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals or plans described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the hospital or plan. The hospital or plan shall
reimburse bills submitted by nonhospital providers participating under this paragraph at a
rate negotiated between the hospital or plan and the nonhospital provider.

(d) (e) The commissioner shall apply for federal matching funds under section
256B.199, paragraphs (a) to (d), for expenditures under this subdivision.
(e) (d) Outpatient prescription drug coverage is provided in accordance with section
256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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

Sec. 61. Minnesota Statutes 2010, section 256D.031, subdivision 9, is amended to read:
Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient
prescription drug pool, effective June 1, 2010 October 1, 2011. Money in the pool must
be used to reimburse pharmacies and other pharmacy service providers as defined in
Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed
to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates
established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage
is subject to the availability of funds in the pool. If the commissioner forecasts that
expenditures under this subdivision will exceed the appropriation for this purpose, the
commissioner may bring recommendations to the Legislative Advisory Commission on
methods to resolve the shortfall.

(b) Effective June 1, 2010 January 1, 2012, coordinated care delivery systems
established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an
assessment equal to 20 percent of payments for the prescribed drugs for recipients of
services through that coordinated care delivery system, as calculated by the commissioner
based on the most recent available data.

Sec. 62. Minnesota Statutes 2010, section 256D.031, subdivision 10, is amended to read:
Subd. 10. Assistance for veterans. Hospitals and plans participating in the
coordinated care delivery system under subdivision 6 shall consult with counties, county
veterans service officers, and the Veterans Administration to identify other programs for
which general assistance medical care recipients enrolled in their system are qualified.

Sec. 63. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:
Subd. 4a. Gross individual or gross family income. (a) "Gross individual or gross
family income" for nonfarm self-employed means income calculated for the 42-month
six-month period of eligibility using as a baseline the adjusted gross income reported
on the applicant's federal income tax form for the previous year and adding back in
depreciation, and carryover net operating loss amounts that apply to the business in which
the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means
income calculated for the 42-month six-month period of eligibility using as the baseline
the adjusted gross income reported on the applicant's federal income tax form for the
previous year.

(c) "Gross individual or gross family income" means the total income for all family
members, calculated for the 42-month six-month period of eligibility.

Sec. 64. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. Financial management. (a) The commissioner shall manage spending for
the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
each state revenue and expenditure forecast, the commissioner must make an assessment
of the expected expenditures for the covered services for the remainder of the current
biennium and for the following biennium. The estimated expenditure, including the
reserve, shall be compared to an estimate of the revenues that will be available in the health
care access fund. Based on this comparison, and after consulting with the chairs of the
house of representatives Ways and Means Committee and the senate Finance Committee,
and the Legislative Commission on Health Care Access, the commissioner shall, as
necessary, make the adjustments specified in paragraph (b) to ensure that expenditures
remain within the limits of available revenues for the remainder of the current biennium
and for the following biennium. The commissioner shall not hire additional staff using
appropriations from the health care access fund until the commissioner of management
and budget makes a determination that the adjustments implemented under paragraph (b)
are sufficient to allow MinnesotaCare expenditures to remain within the limits of available
revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order:
first, stop enrollment of single adults and households without children; second, upon 45
days' notice, stop coverage of single adults and households without children already
enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium
subsidy amounts by ten percent for families with gross annual income above 200 percent
of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium
subsidy amounts by ten percent for families with gross annual income at or below 200
percent; and fifth, require applicants to be uninsured for at least six months prior to
eligibility in the MinnesotaCare program. If these measures are insufficient to limit the
expenditures to the estimated amount of revenue, the commissioner shall further limit
enrollment or decrease premium subsidies.

Sec. 65. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:
 Subd. 5. Co-payments and coinsurance Cost-sharing. (a) Except as provided in paragraphs (b) and (c), and (h), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance cost-sharing requirements for all enrollees:
 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;
 (2) $3 per prescription for adult enrollees;
 (3) $25 for eyeglasses for adult enrollees;
 (4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and
 (5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and
 (6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.
 (b) Paragraph (a), clause (1), does and paragraph (e) do not apply to parents and relative caretakers of children under the age of 21.
 (c) Paragraph (a) does not apply to pregnant women and children under the age of 21.
 (d) Paragraph (a), clause (4), does not apply to mental health services.
 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.
 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.
 (g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.
(h) Effective January 1, 2012, the following co-payments for nonpreventive visits shall apply to enrollees who are adults without children eligible under section 256L.04, subdivision 7:

1. $3 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same type;

2. $6 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

3. $10 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county-based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph using a methodology that has been approved by the commissioner.

Sec. 66. [256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. Defined contributions to enrollees. (a) Beginning January 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income greater than 125 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Beginning January 1, 2012, the commissioner shall provide each MinnesotaCare adult enrollee eligible under section 256L.04, subdivision 1, with family income greater than 133 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3, offered by a health plan company as defined in section 62Q.01, subdivision 4.

(c) Enrollees eligible under paragraph (a) or (b) shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(d) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under paragraph (a) or (b) unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under paragraph (a) shall be as provided under the terms of the health plan purchased by the enrollee.
(c) 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; health plan requirements. (a) 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.

(b) An enrollee must select a health plan within three calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria.

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

1. provide coverage for mental health and chemical dependency treatment services;
and

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

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 the lowest eligible household income with a defined contribution of 110 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 or income level 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).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Defined Contribution</th>
</tr>
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<tbody>
<tr>
<td>Under 19</td>
<td>$105</td>
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<tr>
<td>19-29</td>
<td>$125</td>
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<tr>
<td>30-34</td>
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<td>35-39</td>
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<td>40-44</td>
<td>$175</td>
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<tr>
<td>45-49</td>
<td>$215</td>
</tr>
<tr>
<td>50-54</td>
<td>$295</td>
</tr>
</tbody>
</table>
(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who are denied coverage under an individual health plan by a health plan company and who purchase coverage through the Minnesota Comprehensive Health Association.

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

1. calculate and process defined contributions for enrollees; and
2. pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA), Beginning January 1, 2012.** MinnesotaCare enrollees who are denied coverage in the individual health market by a health plan company in accordance with section 62A.65 are eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association and may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and covered losses to the MCHA related to implementation of this section shall be paid to the MCHA from the health care access fund.

Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers and approvals necessary to implement coverage under this section for MinnesotaCare enrollees eligible under subdivision 1. The commissioner shall seek the continuation of federal financial participation for the adult enrollees eligible under section 256L.04, subdivision 1.

Sec. 67. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All
other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children,
if the children are eligible. Children may be enrolled separately without enrollment by
parents. However, if one parent in the household enrolls, both parents must enroll, unless
other insurance is available. If one child from a family is enrolled, all children must
be enrolled, unless other insurance is available. If one spouse in a household enrolls,
the other spouse in the household must also enroll, unless other insurance is available.

Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies
to the MinnesotaCare program. These persons are no longer counted in the parental
household and may apply as a separate household.

(d) Beginning July 1, 2010, or upon federal approval, whichever is later, Parents are
not eligible for MinnesotaCare if their gross income exceeds $55,500 $50,000.

(e) Children formerly enrolled in medical assistance and automatically deemed
eligible for MinnesotaCare according to section 256B.057, subdivision 2e, are exempt
from the requirements of this section until renewal.

(f) [Reserved.]

Sec. 68. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

Subd. 7. Single adults and households with no children. (a) The definition of
eligible persons, through September 30, 2011, includes all individuals and households
with no children who have gross family incomes that are equal to or less than 200 250
percent of the federal poverty guidelines.

(b) Effective July 1, 2009 October 1, 2011, the definition of eligible persons includes
all individuals and households with no children who have gross family incomes that are
greater than 125 percent of the federal poverty guidelines and equal to or less than 250
percent of the federal poverty guidelines.

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 69. Minnesota Statutes 2010, section 256L.04, subdivision 10, is amended to read:

Subd. 10. Citizenship requirements. Eligibility for MinnesotaCare is limited to
citizens or nationals of the United States, qualified noncitizens, and other persons residing
lawfully in the United States as described in section 256D.06, subdivision 4, paragraphs
(a) to (e) and (f) who are eligible for medical assistance with federal participation
according to United States Code, title 8, section 1612. Undocumented noncitizens and
nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a
nonimmigrant is an individual in one or more of the classes listed in United States Code,
title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides
in the United States without the approval or acquiescence of the United States Citizenship
and Immigration Services. Families with children who are citizens or nationals of
the United States must cooperate in obtaining satisfactory documentary evidence of
citizenship or nationality according to the requirements of the federal Deficit Reduction

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

Sec. 70. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner’s duties.** (a) The commissioner or county agency shall
use electronic verification as the primary method of income verification. If there is a
discrepancy between reported income and electronically verified income, an individual
may be required to submit additional verification. In addition, the commissioner shall
perform random audits to verify reported income and eligibility. The commissioner
may execute data sharing arrangements with the Department of Revenue and any other
governmental agency in order to perform income verification related to eligibility and
premium payment under the MinnesotaCare program.

(b) In determining eligibility for MinnesotaCare, the commissioner shall require
applicants and enrollees seeking renewal of eligibility to verify both earned and unearned
income. The commissioner shall also require applicants and enrollees , and their spouses
or parents, who are age 21 and over and employed 20 or more hours per week by any one
employer, to verify that they do not have access to employer-subsidized coverage as
described in section 256L.07, subdivision 2. Data collected is nonpublic data as defined
in section 13.02, subdivision 9.

Sec. 71. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007-2011, an enrollee's
eligibility must be renewed every 42 six months. The 12-month period begins in the
month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in
circumstances that impact eligibility and premium amount. An enrollee must provide all
the information needed to redetermine eligibility by the first day of the month that ends
the eligibility period. If there is no change in circumstances, the enrollee may renew
eligibility at designated locations that include community clinics and health care providers'
Sec. 72. Minnesota Statutes 2010, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

Sec. 73. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines the limits described in section 256L.04, subdivision 1, are no longer eligible for the program and shall be disenrolled by the commissioner. **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, 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 (b), 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), 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.

Sec. 74. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

Subd. 7. Critical access dental providers. Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, July 1, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 75. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing.
plan payments under this section pending completion of performance targets. Each
performance target must be quantifiable, objective, measurable, and reasonably attainable,
except in the case of a performance target based on a federal or state law or rule. Criteria
for assessment of each performance target must be outlined in writing prior to the
contract effective date. The managed care plan must demonstrate, to the commissioner's
satisfaction, that the data submitted regarding attainment of the performance target is
accurate. The commissioner shall periodically change the administrative measures used
as performance targets in order to improve plan performance across a broader range of
administrative services. The performance targets must include measurement of plan
efforts to contain spending on health care services and administrative activities. The
commissioner may adopt plan-specific performance targets that take into account factors
affecting only one plan, such as characteristics of the plan's enrollee population. The
withheld funds must be returned no sooner than July 1 and no later than July 31 of the
following calendar year if performance targets in the contract are achieved.

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

(d) Effective for services rendered on or after January 1, 2011, the commissioner
shall include as part of the performance targets described in paragraph (b) a reduction in
the plan's emergency room utilization rate for state health care program enrollees by a
measurable rate of five percent from the plan's utilization rate for the previous calendar
year.

The withheld funds must be returned no sooner than July 1 and no later than July 31
of the following calendar year if the managed care plan demonstrates to the satisfaction of
the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive
contract period until the plan's emergency room utilization rate for state health care
program enrollees is reduced by 25 percent of the plan's emergency room utilization rate
for state health care program enrollees for calendar year 2009. Hospitals shall cooperate
with the health plans in meeting this performance target and shall accept payment
withholds that may be returned to the hospitals if the performance target is achieved. The
commissioner shall structure the withhold so that the commissioner returns a portion of
the withheld funds in amounts commensurate with achieved reductions in utilization less
170.1 than the targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.

170.3 (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.

170.9 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.

170.13 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.

170.23 (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.

170.26 Sec. 76. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

170.27 Subd. 1a. Payment options. The commissioner may offer the following payment options to an enrollee:

170.29 (1) payment by check;

170.30 (2) payment by credit card;

170.31 (3) payment by recurring automatic checking withdrawal;

170.32 (4) payment by onetime electronic transfer of funds;

170.33 (5) payment by wage withholding with the consent of the employer and the employee; or

170.35 (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. 77. 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. 78. REGULATORY SIMPLIFICATION AND REDUCTION OF PROVIDER REPORTING AND DATA SUBMITTAL REQUIREMENTS.

Subdivision 1. Regulatory simplification and report reduction work group. The commissioner of management and budget shall convene a regulatory simplification and report reduction work group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittal requirements for health care providers or group purchasers related to health care costs, quality, utilization, access, or patient encounters or related to provider or group purchaser, monitoring, finances, and regulation. For purposes of this section, the term "health care providers or group purchasers" has the meaning provided in Minnesota Statutes, section 62J.03, subdivisions 6 and 8, except that it also includes nursing homes.
Subd. 2. Plan development and other duties. (a) The commissioner of management and budget, in consultation with the work group, shall develop a plan for regulatory simplification and report reduction activities of the commissioners of health, human services, and commerce that considers collection and regulation of the following in a coordinated manner:

(1) encounter data;
(2) group purchaser provider network data;
(3) financial reporting;
(4) reporting and documentation requirements relating to member communications and marketing materials;
(5) state regulation and oversight of group purchasers;
(6) requirements and procedures for denial, termination, or reduction of services and member appeals and grievances; and
(7) state performance improvement projects, requirements, and procedures.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, shall present to the legislature by January 1, 2012, proposals to implement their recommendations.

Subd. 3. New reporting and other duties. (a) The commissioner of management and budget, in consultation with the work group and the commissioners of health, human services, and commerce, shall develop criteria to be used by the commissioners in determining whether to establish new reporting and data submittal requirements. These criteria must support the establishment of new reporting and data submittal requirements only:

(1) if required by a federal agency or state statute;
(2) if needed for a state regulatory audit or corrective action plan;
(3) if needed to monitor or protect public health;
(4) if needed to manage the cost and quality of Minnesota's public health insurance programs; or
(5) if a review and analysis by the commissioner of the relevant agency has documented the necessity, importance, and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, may propose to the legislature new provider and group purchaser reporting and data submittal requirements to take effect on or after July 1, 2012.
These proposals shall include an analysis of the extent to which the requirements meet
the criteria developed under paragraph (a).

Sec. 79. SPECIALIZED MAINTENANCE THERAPY.

The commissioner of human services shall evaluate whether providing medical
assistance coverage for specialized maintenance therapy for enrollees with serious and
persistent mental illness who are at risk of hospitalization will improve the quality of
care and lower medical assistance spending by reducing rates of hospitalization. The
commissioner shall present findings and recommendations to the chairs and ranking
minority members of the legislative committees with jurisdiction over health and human
services finance and policy by December 15, 2011.

Sec. 80. BENEFIT SET OPTIONS.

The commissioner of human services shall analyze and provide recommendations
for state plan amendments that would provide different benefits for different demographic
populations under the medical assistance program as permitted under federal law, with the
goal of tailoring more cost-effective coverage based on unique needs of the demographic
population. The commissioner shall report these recommendations to the chairs and
ranking minority members of the senate and house health and human services committees

Sec. 81. REDUCING HOSPITALIZATION RATES.

The commissioner of human services, by January 15, 2012, shall present
recommendations to the legislature to reduce hospitalization rates for state health care
program enrollees who are children with high-cost medical conditions.

Sec. 82. MEDICAID FRAUD PREVENTION AND DETECTION.

Subdivision 1. Request for proposals. By October 31, 2011, the commissioner
of human services shall issue a request for proposals to prevent and detect Medicaid
fraud and mispayment. The request for proposals shall require the vendor to provide
data analytics capabilities, including, but not limited to, predictive modeling techniques
and other forms of advanced analytics, technical assistance, claims review, and medical
record and documentation investigations, to detect and investigate improper payments
both before and after payments are made.
Subd. 2. **Proof of concept phase.** The selected vendor, at no cost to the state, shall be required to apply its analytics and investigations on a subset of data provided by the commissioner to demonstrate the direct recoveries of the solution.

Subd. 3. **Data confidentiality.** Data provided by the commissioner to the vendor under this section must maintain the confidentiality of the information.

Subd. 4. **Full implementation phase.** The request for proposal must require the commissioner to implement the recommendations provided by the vendor if the work done under the requirements of subdivision 2 provides recoveries directly related to the investigations to the state. After full implementation, the vendor shall be paid from recoveries directly attributable to the work done by the vendor, according to the terms and performance measures negotiated in the contract.

Subd. 5. **Selection of vendor.** The commissioner of human services shall select a vendor from the responses to the request for proposal by January 31, 2012.

Subd. 6. **Progress report.** The commissioner shall provide a report describing the progress made under this section to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over the Department of Human Services by June 15, 2012. The report shall provide a dynamic scoring analysis of the work described in the report.

Sec. 83. **WOUND CARE TREATMENT.**

The commissioner of human services, through the health services policy committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall study the effectiveness of new strategies for wound care treatment for medical assistance and MinnesotaCare enrollees with diabetes, including but not limited to the use of new wound care technologies, assessment tools, and reporting programs. The commissioner shall present recommendations by December 15, 2011, to the legislature on whether these new strategies for wound care treatment should be covered under medical assistance and MinnesotaCare.

Sec. 84. **PROHIBITION OF STATE FUNDS TO IMPLEMENT CERTAIN FEDERAL HEALTH CARE REFORMS.**

State funds must not be expended in the planning or implementation of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Affordability and Reconciliation Act of 2010, Public Law 111-152, and no provisions of the act may be implemented, until the constitutionality of the act has been affirmed by the United States Supreme Court.
EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 85. COMMISSIONER'S ACTIONS; REPEAL OF EARLY MEDICAL
ASSISTANCE EXPANSION.
(a) Effective October 1, 2011, 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,
(b) The commissioner shall seek all federal approvals and waivers necessary
to implement Minnesota Statutes, section 256D.031, and to ensure federal financial
participation for the population covered under Minnesota Statutes, section 256D.031.

Sec. 86. 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 October 1, 2011:
(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, 9,
and 10; and
(3) Laws 2010, chapter 200, article 1, section 18.

Sec. 87. REPEALER.
(a) Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, are repealed.
(b) Minnesota Statutes 2010, section 256L.07, subdivision 7, exempting eligibility
for children formally under medical assistance, is repealed retroactively from October
1, 2008, and federal approval is no longer necessary.
(c) The amendment in Laws 2009, chapter 79, article 5, section 55, as amended by
Laws 2009, chapter 173, article 1, section 36, (256L.04, subdivision 1, children deemed
eligible are exempt from eligibility requirements) is repealed retroactively from January
1, 2009, and federal approval is no longer necessary.
(d) Laws 2009, chapter 79, article 5, section 56, (256L.04, subdivision 1b,
exemption from income limit for children) is repealed retroactively from July 1, 2009,
and federal approval is no longer necessary.
(e) Laws 2009, chapter 79, article 5, section 60, (256L.05, subdivision 1c, open enrollment and streamlined application) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(f) Laws 2009, chapter 79, article 5, section 66, (256L.07, subdivision 8, automatic eligibility certain children) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(g) The amendment in Laws 2009, chapter 79, article 5, section 57, (256L.04, subdivision 7a, ineligibility for adults with certain income) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(h) The amendment in Laws 2009, chapter 79, article 5, section 61, (256L.05, subdivision 3, children eligibility following termination from foster care) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(i) The amendment in Laws 2009, chapter 79, article 5, section 62, (256L.05, subdivision 3a, exemption from cancellation for nonrenewal for children) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(j) The amendment in Laws 2009, chapter 79, article 5, section 63, (256L.07, subdivision 1, children whose gross family income is greater than 275 percent FPG may remain enrolled) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(k) The amendment in Laws 2009, chapter 79, article 5, section 64, (256L.07, subdivision 2, exempts children from requirement not to have employer-subsidized coverage) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(l) The amendment in Laws 2009, chapter 79, article 5, section 65, (256L.07, subdivision 3, requires children with family gross income over 200 percent of FPG to have had no health coverage for four months prior to application) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(m) The amendment in Laws 2009, chapter 79, article 5, section 68, (256L.15, subdivision 2, children in families with income less than 200 percent FPG pay no premium) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(n) The amendment in Laws 2009, chapter 79, article 5, section 69, (256L.15, subdivision 3, exempts children with family income below 200 percent FPG from sliding fee scale) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.
(o) Laws 2009, chapter 79, article 5, section 79, (uncoded federal approval) is repealed the day following final enactment.

(p) Minnesota Statutes 2010, section 256B.057, subdivision 2c, (extended medical assistance for certain children) is repealed.

(q) The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9, (renewal rolling month and premium grace month) are repealed.

Sec. 88. REPEALER.

Minnesota Statutes 2010, sections 256B.055, subdivision 15; and 256B.0756, are repealed effective October 1, 2011.

ARTICLE 6

CONTINUING CARE

Section 1. [15.996] PERFORMANCE-BASED ORGANIZATIONS.

Subdivision 1. Designation. The governor may designate one or more programs within the Department of Human Services and within up to two other executive branch state agencies whose missions involve people with disabilities as performance-based organizations. The goal of the performance-based organization designation is to provide the best services in the most cost-effective manner to people with disabilities. For a program that is designated as a performance-based organization, the agency providing services or another governmental or private organization under contract with the agency may enter into a performance-based agreement that allows the agency or the entity under contract with the agency more flexibility in its operations in exchange for a greater level of accountability. With any required legislative approval, a performance-based organization agreement may exempt an agency or an outside entity providing services from one or more procedural laws, rules, or policies that otherwise would govern the program.

Subd. 2. Performance-based organization agreement. Designation of a performance-based organization must be implemented through a performance-based organization agreement. A performance-based organization agreement may be between the governor and an agency, if an agency is to provide services under the agreement, or between an agency and an outside entity, if the outside entity is to provide the services. A performance-based organization agreement must:

(1) describe the programs subject to the agreement;

(2) specify the procedural laws, rules, or policies that will not apply to the performance-based organization, why waiver or variance from these laws, rules, or
policies is necessary to achieve desired outcomes, and a description of alternative means
of accomplishing the purposes of those laws, rules, or policies;

(3) contain procedures for oversight of the performance-based organization,
including requirements and procedures for program and financial audits;

(4) if the performance-based organization involves a nonstate entity, contain
provisions governing assumption of liability, and types and amounts of insurance coverage
to be obtained;

(5) specify the duration of the agreement; and

(6) specify measurable performance-based outcomes for achieving program
goals, time periods during which these outcomes will be measured and reported, and
consequences for not meeting the performance-based outcomes.

Subd. 3. Duration; legislative approval; reporting. (a) A performance-based
organization agreement may be up to three years and may be renewed.

(b) The chief executive of the state agency whose program is subject to a
performance-based organization must report to the chairs and ranking minority members
of legislative policy and finance committees with jurisdiction over the program on the
proposed content of the performance-based organization, and specifically describing
any procedural laws, rules, and policies that will not apply. The legislature must
approve a performance-based organization before the state agency may enter into a
performance-based agreement.

Sec. 2. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. Contribution amount. (a) The natural or adoptive parents of a minor
child, including a child determined eligible for medical assistance without consideration of
parental income, must contribute to the cost of services used by making monthly payments
on a sliding scale based on income, unless the child is married or has been married,
parental rights have been terminated, or the child's adoption is subsidized according to
section 259.67 or through title IV-E of the Social Security Act. The parental contribution
is a partial or full payment for medical services provided for diagnostic, therapeutic,
curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
defined in United States Code, title 26, section 213, needed by the child with a chronic
illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent
of federal poverty guidelines, the parental contribution shall be computed by applying the
following schedule of rates to the adjusted gross income of the natural or adoptive parents:
(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 $4,525 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 $4,525 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than $4,525 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 $9,750 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 $9,750 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than $9,750 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.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form,
except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility
for services is being determined. The contribution shall be made on a monthly basis
effective with the first month in which the child receives services. Annually upon
redetermination or at termination of eligibility, if the contribution exceeded the cost of
services provided, the local agency or the state shall reimburse that excess amount to
the parents, either by direct reimbursement if the parent is no longer required to pay a
contribution, or by a reduction in or waiver of parental fees until the excess amount is
exhausted. All reimbursements must include a notice that the amount reimbursed may be
taxable income if the parent paid for the parent's fees through an employer's health care
flexible spending account under the Internal Revenue Code, section 125, and that the
parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months;
when there is a change in household size; and when there is a loss of or gain in income
from one month to another in excess of ten percent. The local agency shall mail a written
notice 30 days in advance of the effective date of a change in the contribution amount.
A decrease in the contribution amount is effective in the month that the parent verifies a
reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the
contribution required under paragraph (a). An amount equal to the annual court-ordered
child support payment actually paid on behalf of the child receiving services shall be
deducted from the adjusted gross income of the parent making the payment prior to
calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five
percent if the local agency determines that insurance coverage is available but not
obtained for the child. For purposes of this section, "available" means the insurance is a
benefit of employment for a family member at an annual cost of no more than five percent
of the family's annual income. For purposes of this section, "insurance" means health
and accident insurance coverage, enrollment in a nonprofit health service plan, health
maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required
to pay more than the amount for the child with the highest expenditures. There shall
be no resource contribution from the parents. The parent shall not be required to pay
a contribution in excess of the cost of the services provided to the child, not counting
payments made to school districts for education-related services. Notice of an increase in
fee payment must be given at least 30 days before the increased fee is due.
(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if,
in the 12 months prior to July 1:
(1) the parent applied for insurance for the child;
(2) the insurer denied insurance;
(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
a complaint or appeal, in writing, to the commissioner of health or the commissioner of
commerce, or litigated the complaint or appeal; and
(4) as a result of the dispute, the insurer reversed its decision and granted insurance.
For purposes of this section, "insurance" has the meaning given in paragraph (h).
A parent who has requested a reduction in the contribution amount under this
paragraph shall submit proof in the form and manner prescribed by the commissioner or
county agency, including, but not limited to, the insurer's denial of insurance, the written
letter or complaint of the parents, court documents, and the written response of the insurer
approving insurance. The determinations of the commissioner or county agency under this
paragraph are not rules subject to chapter 14.

(1) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,
2013, the parental contribution shall be computed by applying the following contribution
schedule to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal
poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal
poverty guidelines and less than or equal to 525 percent of federal poverty guidelines;
the parental contribution shall be determined using a sliding fee scale established by the
commissioner of human services which begins at one percent of adjusted gross income
at 175 percent of federal poverty guidelines and increases to eight percent of adjusted
gross income for those with adjusted gross income up to 525 percent of federal poverty
guidelines;

(3) if the adjusted gross income is greater than 525 percent of federal poverty
guidelines and less than 675 percent of federal poverty guidelines, the parental contribution
shall be 9.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal
poverty guidelines and less than 900 percent of federal poverty guidelines; the parental
contribution shall be determined using a sliding fee scale established by the commissioner
of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

Sec. 3. Minnesota Statutes 2010, section 256.01, subdivision 24, is amended to read:

Subd. 24. Disability Linkage Line. The commissioner shall establish the Disability Linkage Line, 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;
(3) provide benefits and options counseling;
(2) makes (4) make referrals to appropriate support entities;
(3) delivers information and assistance based on national and state standards;
(4) assists (5) educate people to on their options so they can make well-informed decisions; choices; and
(5) supports (6) help support the timely resolution of service access and benefit issues;
(7) inform people of their long-term community services and supports;
(8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; and
(9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org.

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

Sec. 4. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:
Subd. 29. **State medical review team.** (a) To ensure the timely processing of
determinations of disability by the commissioner's state medical review team under
sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, paragraph
and 256B.055, subdivision 12, the commissioner shall review all medical evidence
submitted by county agencies with a referral and seek additional information from
providers, applicants, and enrollees to support the determination of disability where
necessary. Disability shall be determined according to the rules of title XVI and title
XIX of the Social Security Act and pertinent rules and policies of the Social Security
Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due
to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
necessary and appropriate to a determination of disability, and (2) assist applicants and
enrollees to obtain the evidence, including, but not limited to, medical examinations
and electronic medical records.

c) The commissioner shall provide the chairs of the legislative committees with
jurisdiction over health and human services finance and budget the following information
on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied,
approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date
the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization
history within three months of application, and whether an application for Social Security
or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials
of the person or persons performing the medical review determinations and length of
time in that position.

d) Any appeal made under section 256.045, subdivision 3, of a disability
determination made by the state medical review team must be decided according to the
timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is
not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the
appeal must be immediately reviewed by the chief appeals referee.

**EFFECTIVE DATE.** This section is effective July 1, 2011.
Sec. 5. Minnesota Statutes 2010, section 256B.04, is amended by adding a subdivision to read:

Subd. 20. Money Follows the Person Rebalancing demonstration project. In accordance with federal law governing Money Follows the Person Rebalancing funds, amounts equal to the value of enhanced federal funding resulting from the operation of the demonstration project grant must be transferred from the medical assistance account in the general fund to an account in the special revenue fund. Funds in the special revenue fund account do not cancel and are appropriated to the commissioner to carry out the goals of the Money Follows the Person Rebalancing demonstration project as required under the approved federal plan for the use of the funds, and may be transferred to the medical assistance account if applicable.

Sec. 6. Minnesota Statutes 2010, section 256B.05, is amended by adding a subdivision to read:

Subd. 5. Obligation of local agency to process medical assistance applications within established timelines. The local agency must act on an application for medical assistance within ten working days of receipt of all information needed to act on the application but no later than required under Minnesota Rules, part 9505.0090, subparts 2 and 3.

Sec. 7. 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 (e) (d).
(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

**EFFECTIVE DATE.** This section is effective January 1, 2014.

Sec. 8. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (e) (d); and

(4) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(b)(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or
(2) Effective January 1, 2004, loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(c)(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer;

(4) spousal assets, including spouse's share of jointly held assets.

(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(e)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. (e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under section 256.01, subdivision 18b.

(1) An enrollee must pay the greater of a $65 premium or the premium shall be calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (f):
(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one half of one percent of unearned income in addition to the premium amount, except as provided under section 256.01, subdivision 18b.

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256D.0625, subdivision 15, paragraph (a).

(5) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.
(k) For enrollees whose income does not exceed 200 percent of the federal poverty
guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
paragraph (a).

**EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or
closer, and October 1, 2019, for children age 16 to before the child's 21st birthday.

Sec. 9. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to
read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
must meet the following requirements:

1. be at least 18 years of age with the exception of persons who are 16 or 17 years
   of age with these additional requirements:

2. supervision by a qualified professional every 60 days; and
3. employment by only one personal care assistance provider agency responsible
   for compliance with current labor laws;
4. be employed by a personal care assistance provider agency;
5. enroll with the department as a personal care assistant after clearing a background
   study. Except as provided in subdivision 11a, before a personal care assistant provides
   services, the personal care assistance provider agency must initiate a background study on
   the personal care assistant under chapter 245C, and the personal care assistance provider
   agency must have received a notice from the commissioner that the personal care assistant
   is:

4. not disqualified under section 245C.14; or
5. is disqualified, but the personal care assistant has received a set aside of the
   disqualification under section 245C.22;
6. be able to effectively communicate with the recipient and personal care
   assistance provider agency;
7. be able to provide covered personal care assistance services according to the
   recipient's personal care assistance care plan, respond appropriately to recipient needs,
   and report changes in the recipient's condition to the supervising qualified professional
   or physician;
8. not be a consumer of personal care assistance services;
9. maintain daily written records including, but not limited to, time sheets under
   subdivision 12;
(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 275 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, Persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

**EFFECTIVE DATE.** This section is effective October 1, 2011.

Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.**

(a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:
(i) applications for employment;
(ii) background study requests and results;
(iii) orientation records about the agency policies;
(iv) trainings completed with demonstration of competence;
(v) supervisory visits;
(vi) evaluations of employment; and
(vii) signature on fraud statement;
(2) recipient files, including:
(i) demographics;
(ii) emergency contact information and emergency backup plan;
(iii) personal care assistance service plan;
(iv) personal care assistance care plan;
(v) month-to-month service use plan;
(vi) all communication records;
(vii) start of service information, including the written agreement with recipient; and
(viii) date the home care bill of rights was given to the recipient;
(3) agency policy manual, including:
(i) policies for employment and termination;
(ii) grievance policies with resolution of consumer grievances;
(iii) staff and consumer safety;
(iv) staff misconduct; and
(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
resolution of consumer grievances;
(4) time sheets for each personal care assistant along with completed activity sheets
for each recipient served; and
(5) agency marketing and advertising materials and documentation of marketing
activities and costs; and
(6) for each personal care assistant, whether or not the personal care assistant is
providing care to a relative as defined in subdivision 11.
(b) The commissioner may assess a fine of up to $500 on provider agencies that do
not consistently comply with the requirements of this subdivision.

Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to
read:
Subd. 1a. Definitions. For purposes of this section, the following definitions apply:
(a) "Long-term care consultation services" means:
(1) assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations on cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated screening to determine the need for an institutional level of care under subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support plan development with appropriate referrals, including the option for consumer-directed community self-directed supports;

(8) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(9) assistance to transition people back to community settings after facility admission; and

(10) providing notice to the individual or legal representative of the annual and monthly average authorized amount for traditional agency services and self-directed services under section 256B.0657 for which the recipient is found eligible.

(b) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(c) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

**EFFECTIVE DATE.** This section is effective January 1, 2012.
Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. Assessment and support planning. (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 45 calendar 20 calendar days after the date on which an assessment was requested or recommended. After January 1, 2011, these requirements also apply to personal care assistance services, private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, and with the permission of the person being assessed or the persons' designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining their recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed self-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of
this requirement, "cost-effective alternatives" means community services and living
arrangements that cost the same as or less than institutional care. For persons determined
eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the
community support plan must also include the estimated annual and monthly average
authorized budget amount for those services.

(f) If the person chooses to use community-based services, the person or the
person's legal representative must be provided with a written community support plan,
regardless of whether the individual is eligible for Minnesota health care programs. The
written community support plan must include:

(i) a summary of assessed needs as defined in paragraphs (c) and (d);

(ii) the individual's options and choices to meet identified needs, including all
available options for case management services and providers;

(iii) identification of health and safety risks and how those risks will be addressed,
including personal risk management strategies;

(iv) referral information; and

(v) informal caregiver supports, if applicable.

(2) For persons determined eligible for services defined under subdivision 1a,
paragraph (a), clauses (7) to (10), the community support plan must also include:

(i) identification of individual goals;

(ii) identification of short-term and long-term service outcomes. Short-term service
outcomes are defined as achievable within six months;

(iii) a recommended schedule for case management visits. When achievement of
short-term service outcomes may affect the amount of service required, the schedule must
be at least every six months and must reflect evaluation and progress toward identified
short-term service outcomes; and

(iv) the estimated annual and monthly budget amount for services.

(3) In addition, for persons determined eligible for state plan home care under
subdivision 1a, paragraph (a), clause (8), the person or person's representative must also
receive a copy of the home care service plan developed by a certified assessor.

(4) A person may request assistance in identifying community supports without
participating in a complete assessment. Upon a request for assistance identifying
community support, the person must be transferred or referred to the services available
under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone
assistance and follow up.
(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The team must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

1. the need for and purpose of preadmission screening if the person selects nursing facility placement;
2. the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;
3. information about Minnesota health care programs;
4. the person's freedom to accept or reject the recommendations of the team;
5. the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;
6. the long-term care consultant's decision regarding the person's need for institutional level of care as determined under criteria established in section 144.0724, subdivision 11, or 256B.092; and
7. the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). The updated assessment may be completed by face-to-face visit, written communication, or telephone as determined by the commissioner to establish statewide consistency. The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

**EFFECTIVE DATE.** This section is effective January 1, 2012.
Sec. 13. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. Eligibility for funding for services for nonmedical assistance recipients.

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program. Effective January 1, 2011, this determination must be made according to the criteria established in section 144.0724, subdivision 11;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) only one dependency up to two dependencies in bathing, dressing, grooming,
or walking, or (iii) a dependency score of less than three if eating is the only dependency
and eating when the dependency score in eating is three or greater as determined by
an assessment performed under section 256B.0911, the monthly cost of alternative
care services funded by the program cannot exceed $593 per month for all new
participants enrolled in the program on or after July 1, 2011. This monthly limit
shall be applied to all other participants who meet this criteria at reassessment. This
monthly limit shall be increased annually as described in section 256B.0915, subdivision
3a, paragraph (a). This monthly limit does not prohibit the alternative care client from
payment for additional services, but in no case may the cost of additional services
purchased exceed the difference between the client's monthly service limit defined in this
clause and the limit described in clause (6) for case mix classification A; and
(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person
agrees to:
(i) the appointment of a representative payee;
(ii) automatic payment from a financial account;
(iii) the establishment of greater family involvement in the financial management of
payments; or
(iv) another method acceptable to the lead agency to ensure prompt fee payments.
The lead agency may extend the client's eligibility as necessary while making
arrangements to facilitate payment of past-due amounts and future premium payments.
Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person
who is a medical assistance recipient or who would be eligible for medical assistance
without a spenddown or waiver obligation. A person whose initial application for medical
assistance and the elderly waiver program is being processed may be served under the
alternative care program for a period up to 60 days. If the individual is found to be eligible
for medical assistance, medical assistance must be billed for services payable under the
federally approved elderly waiver plan and delivered from the date the individual was
found eligible for the federally approved elderly waiver plan. Notwithstanding this
provision, alternative care funds may not be used to pay for any service the cost of which:
(i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
to participate in the federally approved elderly waiver program under the special income
standard provision.
(c) Alternative care funding is not available for a person who resides in a licensed
nursing home, certified boarding care home, hospital, or intermediate care facility, except
for case management services which are provided in support of the discharge planning
process for a nursing home resident or certified boarding care home resident to assist with
a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater
than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
year for which alternative care eligibility is determined, who would be eligible for the
erly waiver with a waiver obligation.

Sec. 14. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to
read:

Subd. 3a. Elderly waiver cost limits. (a) The monthly limit for the cost of
waivered services to an individual elderly waiver client except for individuals described
in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
mix resident class to which the elderly waiver client would be assigned under Minnesota
Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
which the resident assessment system as described in section 256B.438 for nursing home
rate determination is implemented. Effective on the first day of the state fiscal year in
which the resident assessment system as described in section 256B.438 for nursing home
rate determination is implemented and the first day of each subsequent state fiscal year, the
monthly limit for the cost of waivered services to an individual elderly waiver client shall
be the rate of the case mix resident class to which the waiver client would be assigned
under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the
previous state fiscal year, adjusted by the greater of any legislatively adopted home and
community-based services percentage rate increase or the average statewide percentage
increase in nursing facility payment rates adjustment.

(b) The monthly limit for the cost of waivered 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 1, 2008, per month for all new participants enrolled in the program on or after July 1, 2009. 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 waivered services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) or (b).

Sec. 15. 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 waivered services, a monthly conversion budget limit for the cost of elderly waivered 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 the 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

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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 waivered 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 waivered 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. 16. Minnesota Statutes 2010, section 256B.0915, subdivision 3e, is amended to
read:

Subd. 3e. Customized living service rate. (a) Payment for customized living
services shall be a monthly rate authorized by the lead agency within the parameters
established by the commissioner. The payment agreement must delineate the amount of
each component service included in the recipient's customized living service plan. The
lead agency shall ensure that there is a documented need within the parameters established
by the commissioner for all component customized living services authorized.
(b) The payment rate must be based on the amount of component services to be
provided utilizing component rates established by the commissioner. Counties and tribes
shall use tools issued by the commissioner to develop and document customized living
service plans and rates.
(c) Component service rates must not exceed payment rates for comparable elderly
waiver or medical assistance services and must reflect economies of scale. Customized
living services must not include rent or raw food costs.
(d) With the exception of individuals described in subdivision 3a, paragraph (b), the
individualized monthly authorized payment for the customized living service plan shall
not exceed 50 percent of the greater of either the statewide or any of the geographic
groups' weighted average monthly nursing facility rate of the case mix resident class
to which the elderly waiver eligible client would be assigned under Minnesota Rules,
parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described.
in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(c) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 17. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. Service rate limits; 24-hour customized living services. (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each 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. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.
(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

1. intermittent assistance with toileting, positioning, or transferring;
2. cognitive or behavioral issues;
3. a medical condition that requires clinical monitoring; or
4. for all new participants enrolled in the program on or after January 1, 2011, and all other participants at their first reassessment after January 1, 2011, dependency in at least two of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in
housing with services establishments which are freestanding buildings with a capacity of
16 or fewer, by applying a single hourly rate for covered component services provided
in either:

(1) licensed corporate adult foster homes; or
(2) specialized dementia care units which meet the requirements of section 144D.065
and in which:

(i) each resident is offered the option of having their own apartment; or
(ii) the units are licensed as board and lodge establishments with maximum capacity
of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
subparts 1, 2, 3, and 4, item A.

(h) A provider may not bill or otherwise charge an elderly waiver participant or their
family for additional units of any allowable component service beyond those available
under the service rate limits described in paragraph (e), nor for additional units of any
allowable component service beyond those approved in the service plan by the lead agency.

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to
read:

Subd. 10. Waiver payment rates; managed care organizations. The
commissioner shall adjust the elderly waiver capitation payment rates for managed care
organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum
service rate limits for customized living services and 24-hour customized living services
under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical
assistance rates paid to customized living providers by managed care organizations under
this section shall not exceed the maximum service rate limits and component rates as
determined by the commissioner under subdivisions 3e and 3h.

Sec. 19. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to
read:

Subd. 6a. Statewide availability of consumer-directed community self-directed
support services. (a) The commissioner shall submit to the federal Health Care Financing
Administration by August 1, 2001, an amendment to the home and community-based
waiver for persons with developmental disabilities under section 256B.092 and by April 1,
2005, for waivers under sections 256B.0915 and 256B.49, to make consumer directed
community self-directed support services available in every county of the state by January
1, 2002.
(b) Until the waiver amendment for self-directed community supports is effective, if a county declines to meet the requirements for provision of consumer-directed community
self-directed supports, the commissioner shall contract with another county, a group of
counties, or a private agency to plan for and administer consumer-directed community
self-directed supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative
entities under contract to participate in the implementation and administration of the home
and community-based waiver for persons with developmental disabilities, shall not be
liable for damages, injuries, or liabilities sustained through the purchase of support by the
individual, the individual's family, legal representative, or the authorized representative
with funds received through the consumer-directed community self-directed support
service under this section. Liabilities include but are not limited to: workers' compensation
liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment
Tax Act (FUTA).

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

Sec. 20. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
read:

Subd. 1b. Individual service Coordinated services and support plan. The
individual service Each recipient of case management services and any legal representative
shall be provided a written copy of the coordinated services and support plan must, which:
(1) include is developed within ten working days after the case manager receives the
community support plan from the certified assessor under section 256B.0911;
(2) includes the results of the assessment information on the person's need for
service, including identification of service needs that will be or that are met by the person's
services, friends, and others, as well as community services used by the general public;
(3) reasonably assures the health, safety, and welfare of the recipient;
(4) identifies the person's preferences for services as stated by the person,
who the person's legal guardian or conservator, or the parent if the person is a minor;
(5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
paragraph (o), of service and support providers;
(6) identifies long- and short-range goals for the person;
(7) identifies specific services and the amount and frequency of the
services to be provided to the person based on assessed needs, preferences, and available
resources. The individual service plan shall also specify other services the person needs
that are not available, and other services the person needs that are not available. The
individual coordinated services and support plan shall also specify service outcomes and
the provider's responsibility to monitor the achievement of the service outcomes;

(5) identify (8) identifies the need for an individual program individual's provider
plan to be developed by the provider according to the respective state and federal licensing
and certification standards, and additional assessments to be completed or arranged by the
provider after service initiation;

(6) identify (9) identifies provider responsibilities to implement and make
recommendations for modification to the individual service coordinated services and
support plan;

(7) include (10) includes notice of the right to have assessments completed and
service plans developed within specified time periods, the right to appeal action or
inaction, and the right to request a reconciliation conference or a hearing an appeal under
section 256.045;

(8) be (11) is agreed upon and signed by the person, the person's legal guardian
or conservator, or the parent if the person is a minor, and the authorized county
representative; and

(9) be (12) is reviewed by a health professional if the person has overriding medical
needs that impact the delivery of services.

Service planning formats developed for interagency planning such as transition,
vocational, and individual family service plans may be substituted for service planning
formats developed by county agencies.

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

Sec. 21. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
read:

Subd. 1e. Case management service monitoring, coordination, and evaluation;
and monitoring of services duties. (a) If the individual service coordinated services and
support plan identifies the need for individual program provider plans for authorized
services, the case manager management service provider shall assure that individual
program the individual provider plans are developed by the providers according to clauses
(2) to (5). The providers shall assure that the individual program provider plans:

(1) are developed according to the respective state and federal licensing and
certification requirements;

(2) are designed to achieve the goals of the individual service plan;

(3) are consistent with other aspects of the individual service coordinated services
and support plan;
(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services and service outcomes among the various service providers.

(b) The case management service provider shall monitor the provision of services:

(1) to assure that the individual service coordinated services and support plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the individual service coordinated services and support plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the individual service coordinated services and support plan.

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

Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of individual service coordinated services and support plan.** Unless otherwise required by federal law, the county agency is not required to complete an individual service coordinated services and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.
EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

Subd. 3. Authorization and termination of services. County agency case managers lead agencies, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to individual service coordinated services and support plans. Services provided to persons with developmental disabilities may only be authorized and terminated by case managers according to (1) rules of the commissioner and (2) the individual service coordinated services and support plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county lead agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

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

Sec. 24. 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) 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. 25. [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
receiving disability services is enacted. This system is a partnership between the
Department of Human Services and the State Quality Council established under
subdivision 3.
(b) This system is a result of the recommendations from the Department of Human
Services' licensing and alternative quality assurance study mandated under Laws 2005,
First Special Session chapter 4, article 7, section 57, and presented to the legislature
in February 2007.
(c) The disability services eligible under this section include:
(1) the home and community-based services waiver programs for persons with
developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
including traumatic brain injuries and services for those who qualify for nursing facility
level of care or hospital facility level of care;
(2) home care services under section 256B.0651;
(3) family support grants under section 252.32;
(4) consumer support grants under section 256.476;
(5) semi-independent living services under section 252.275; and
(6) services provided through an intermediate care facility for the developmentally
disabled.
(d) For purposes of this section, the following definitions apply:

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

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. Duties of the commissioner of human services. (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012 to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. State Quality Council. (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;
(2) during the first two years of the State Quality Council, there must be at least three 
members from the Region 10 stakeholders. As regional quality councils are formed under 
subdivision 4, each regional quality council shall appoint one member; 
(3) disability service providers; 
(4) disability advocacy groups; and 
(5) county human services agencies and staff from the Department of Human 
Services and Ombudsman for Mental Health and Developmental Disabilities. 
(c) Members of the council who do not receive a salary or wages from an employer 
for time spent on council duties may receive a per diem payment when performing council 
duties and functions. 
(d) The State Quality Council shall: 
(1) assist the Department of Human Services in fulfilling federally mandated 
 obligations by monitoring disability service quality and quality assurance and 
improvement practices in Minnesota; and 
(2) establish state quality improvement priorities with methods for achieving results 
and provide an annual report to the legislative committees with jurisdiction over policy 
and funding of disability services on the outcomes, improvement priorities, and activities 
undertaken by the commission during the previous state fiscal year. 
(e) The State Quality Council, in partnership with the commissioner, shall: 
(1) approve and direct implementation of the community-based, person-directed 
system established in this section; 
(2) recommend an appropriate method of funding this system, and determine the 
feasibility of the use of Medicaid, licensing fees, as well as other possible funding options; 
(3) approve measurable outcomes in the areas of health and safety, consumer 
evaluation, education and training, providers, and systems; 
(4) establish variable licensure periods not to exceed three years based on outcomes 
achieved; and 
(5) in cooperation with the Quality Assurance Commission, design a transition plan 
for licensed providers from Region 10 into the alternative licensing system by July 1, 2013. 
(f) The State Quality Council shall notify the commissioner of human services that a 
facility, program, or service has been reviewed by quality assurance team members under 
subdivision 4, paragraph (b), clause (13), and qualifies for a license. 
(g) The State Quality Council, in partnership with the commissioner, shall establish 
an ongoing review process for the system. The review shall take into account the 
comprehensive nature of the system which is designed to evaluate the broad spectrum of
licensed and unlicensed entities that provide services to persons with disabilities. The
review shall address efficiencies and effectiveness of the system.

(b) The State Quality Council may recommend to the commissioner certain
variances from the standards governing licensure of programs for persons with disabilities
in order to improve the quality of services so long as the recommended variances do
not adversely affect the health or safety of persons being served or compromise the
qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under
subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
recommendations to the commissioner or to the legislature in the report required under
paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this
subdivision.

Subd. 4. Regional quality councils. (a) The commissioner shall establish, as
selected by the State Quality Council, regional quality councils of key stakeholders,
including regional representatives of:

(1) disability service recipients and their family members;
(2) disability service providers;
(3) disability advocacy groups; and
(4) county human services agencies and staff from the Department of Human
Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance
system in this section;

(2) approve a training program for quality assurance team members under clause
(13);

(3) review summary reports from quality assurance team reviews and make
recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers,
persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting
incidents of life safety concerns immediately to the Department of Human Services
licensing division;
(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;
(8) disseminate information and resources developed to other regional quality councils;
(9) respond to state-level priorities;
(10) establish regional priorities for quality improvement;
(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;
(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and
(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service.

Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.
(g) A facility, program, or service may contest a licensing decision of the regional
quality council as permitted under chapter 245A.

Subd. 5. Annual survey of service recipients. The commissioner, in consultation
with the State Quality Council, shall conduct an annual independent statewide survey
of service recipients, randomly selected, to determine the effectiveness and quality
of disability services. The survey must be consistent with the system performance
expectations of the Centers for Medicare and Medicaid Services (CMS) Quality
Framework. The survey must analyze whether desired outcomes for persons with different
demographic, diagnostic, health, and functional needs, who are receiving different types
of services in different settings and with different costs, have been achieved. Annual
statewide and regional reports of the results must be published and used to assist regions,
counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. Mandated reporters. Members of the State Quality Council under
subdivision 3, the regional quality councils under subdivision 4, and quality assurance
team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as
defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are effective July 1, 2011.

(b) The jurisdictions of the regional quality councils in subdivision 4 must be
defined, with implementation dates, by July 1, 2012. During the biennium beginning July
1, 2011, the Quality Assurance Commission shall continue to implement the alternative
licensing system under this section.

Sec. 26. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to
read:

Subd. 2r. Payment restrictions on leave days. (a) Effective July 1, 1993, the
commissioner shall limit payment for leave days in a nursing facility to 79 percent of that
nursing facility's total payment rate for the involved resident.

(b) For services rendered on or after July 1, 2003, for facilities reimbursed under this
section or section 256B.434, the commissioner shall limit payment for leave days in a
nursing facility to 60 percent of that nursing facility's total payment rate for the involved
resident.

(c) For services rendered on or after July 1, 2011, for facilities reimbursed under
this chapter, the commissioner shall limit payment for leave days in a nursing facility
to 30 percent of that nursing facility's total payment rate for the involved resident, and
shall allow this payment only when the occupancy of the nursing facility, inclusive of
bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415.

Sec. 27. Minnesota Statutes 2010, section 256B.431, subdivision 32, is amended to read:

Subd. 32. Payment during first 90 days. (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 paid days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class;

(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class;

(3) beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(4) payments under this paragraph apply to admissions occurring on or after July 1, 2004, and before July 1, 2003, and to resident days occurring before July 30, 2003.

(b) For rate years beginning on or after July 1, 2003, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section shall be:

(1) for the first 30 calendar days after admission, the rate shall be 120 percent of the facility's medical assistance rate for each RUG class;

(2) beginning with the 31st calendar day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(3) payments under this paragraph apply to admissions occurring on or after July 1, 2003.

(c) Effective January 1, 2004. (b) The enhanced rates under this subdivision shall not be allowed if a resident has resided during the previous 30 calendar days in:

(1) the same nursing facility;

(2) a nursing facility owned or operated by a related party; or

(3) a nursing facility or part of a facility that closed or was in the process of closing.

Sec. 28. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

Subd. 4. Alternate rates for nursing facilities. (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.
(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, October 1, 2011, and October 1, 2012, this paragraph shall apply only to the property-related payment rate; except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided. For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:
(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;
(3) improved quality as measured in the Nursing Home Report Card;
(4) reduced acute care costs; and
(5) any additional outcomes proposed by a nursing facility that the commissioner
finds desirable.
(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
take action to come into compliance with existing or pending requirements of the life
safety code provisions or federal regulations governing sprinkler systems must receive
reimbursement for the costs associated with compliance if all of the following conditions
are met:
(1) the expenses associated with compliance occurred on or after January 1, 2005,
and before December 31, 2008;
(2) the costs were not otherwise reimbursed under subdivision 4f or section
144A.071 or 144A.073; and
(3) the total allowable costs reported under this paragraph are less than the minimum
threshold established under section 256B.431, subdivision 15, paragraph (e), and
subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying
nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
2008. Nursing facilities that have spent money or anticipate the need to spend money
to satisfy the most recent life safety code requirements by (1) installing a sprinkler
system or (2) replacing all or portions of an existing sprinkler system may submit to the
commissioner by June 30, 2007, on a form provided by the commissioner the actual
costs of a completed project or the estimated costs, based on a project bid, of a planned
project. The commissioner shall calculate a rate adjustment equal to the allowable
costs of the project divided by the resident days reported for the report year ending
September 30, 2006. If the costs from all projects exceed the appropriation for this
purpose, the commissioner shall allocate the money appropriated on a pro rata basis
to the qualifying facilities by reducing the rate adjustment determined for each facility
by an equal percentage. Facilities that used estimated costs when requesting the rate
adjustment shall report to the commissioner by January 31, 2009, on the use of this
money on a form provided by the commissioner. If the nursing facility fails to provide
the report, the commissioner shall recoup the money paid to the facility for this purpose.
If the facility reports expenditures allowable under this subdivision that are less than
the amount received in the facility's annualized rate adjustment, the commissioner shall
recoup the difference.

Sec. 29. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

Subd. 6. Planned closure rate adjustment. (a) The commissioner of human
services shall calculate the amount of the planned closure rate adjustment available under
subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):
(1) the amount available is the net reduction of nursing facility beds multiplied
by $2,080;
(2) the total number of beds in the nursing facility or facilities receiving the planned
closure rate adjustment must be identified;
(3) capacity days are determined by multiplying the number determined under
clause (2) by 365; and
(4) the planned closure rate adjustment is the amount available in clause (1), divided
by capacity days determined under clause (3).
(b) A planned closure rate adjustment under this section is effective on the first day
of the month following completion of closure of the facility designated for closure in the
application and becomes part of the nursing facility's total operating payment rate.
(c) Applicants may use the planned closure rate adjustment to allow for a property
payment for a new nursing facility or an addition to an existing nursing facility or as an
operating payment rate adjustment. Applications approved under this subdivision are
exempt from other requirements for moratorium exceptions under section 144A.073,
subdivisions 2 and 3.
(d) Upon the request of a closing facility, the commissioner must allow the facility a
closure rate adjustment as provided under section 144A.161, subdivision 10.
(e) A facility that has received a planned closure rate adjustment may reassign it
to another facility that is under the same ownership at any time within three years of its
effective date. The amount of the adjustment shall be computed according to paragraph (a).
(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
the commissioner shall recalculate planned closure rate adjustments for facilities that
delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
bed dollar amount. The recalculated planned closure rate adjustment shall be effective
from the date the per bed dollar amount is increased.
(g) For planned closures approved after June 30, 2009, the commissioner of human
services shall calculate the amount of the planned closure rate adjustment available under
subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).
(h) Beginning July 16, 2011, the commissioner shall no longer accept applications for planned closure rate adjustments under subdivision 3.

Sec. 30. Minnesota Statutes 2010, section 256B.441, subdivision 50a, is amended to read:

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

1. determine the difference between the limits;
2. determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;
3. subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and
4. increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Sec. 31. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 61. **Rate increase for low-rate facilities.** Effective October 1, 2011, operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased for a resource utilization group rate with a weight of 1.00 by up to 2.45 percent, but not to exceed for the same resource utilization group weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's operating payment rate on the preceding September 30.

Sec. 32. Minnesota Statutes 2010, section 256B.48, subdivision 1, is amended to read:
Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances:

1. the nursing facility may;
2. charge private paying residents a higher rate for a private room; and
3. charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner; or

2. effective for rate years beginning October 1, 2012, and after, nursing facilities may charge private paying residents rates greater than the allowable medical assistance payment rate determined by the commissioner for the RUGS group currently assigned to the resident; and

3. effective for rate years beginning October 1, 2012, and after, nursing facilities may charge private paying residents rates up to two percent higher than the allowable medical assistance payment rate determined by the commissioner for the RUGS group currently assigned to the resident by up to two percent more than the differential in effect on the prior September 30. Nothing in this section precludes a nursing facility from charging a rate allowable under the facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11, or the enhanced rates under section 256B.431, subdivision 32.

Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this clause paragraph is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this clause paragraph. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private
paying resident or the resident's legal representative, the state, subdivision or agency, or a
nursing facility may request a hearing to determine the allowed rate or rates at issue in
the cause of action. Within 15 calendar days after receiving a request for such a hearing,
the commissioner shall request assignment of an administrative law judge under sections
14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by
the parties. The administrative law judge shall issue a report within 15 calendar days
following the close of the hearing. The prohibition set forth in this clause paragraph shall
not apply to facilities licensed as boarding care facilities which are not certified as skilled
or intermediate care facilities level I or II for reimbursement through medical assistance.

(b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission
to the facility, or from anyone acting in behalf of the applicant, as a condition of admission,
expediting the admission, or as a requirement for the individual's continued stay, any fee,
deposit, gift, money, donation, or other consideration not otherwise required as payment
under the state plan. For residents on medical assistance, medical assistance payments
according to the state plan must be accepted as payment in full for continued stay, except
where otherwise provided for under statute;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan
any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise
to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of
admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in
accordance with state and federal regulations.

c) Requiring any resident of the nursing facility to utilize a vendor of health care
services chosen by the nursing facility. A nursing facility may require a resident to use
pharmacies that utilize unit dose packing systems approved by the Minnesota Board of
Pharmacy, and may require a resident to use pharmacies that are able to meet the federal
regulations for safe and timely administration of medications such as systems with specific
number of doses, prompt delivery of medications, or access to medications on a 24-hour
basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict
a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit
dose drug packing.

d) Providing differential treatment on the basis of status with regard to public
assistance.
(e) Discriminating in admissions, services offered, or room assignment on the
basis of status with regard to public assistance or refusal to purchase special services.

Discrimination in admissions, services offered, or room assignment shall
include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing
facility, or the applicant's guardian or conservator, that the applicant is neither eligible for
nor will seek information or assurances regarding current or future eligibility for public
assistance for payment of nursing facility care costs; and

(2) engaging in preferential selection from waiting lists based on an applicant's
ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing facility of financial information of any applicant
pursuant to a preadmission screening program established by law shall not raise an
inference that the nursing facility is utilizing that information for any purpose prohibited
by this paragraph.

(f) Requiring any vendor of medical care as defined by section 256B.02, subdivision
7, who is reimbursed by medical assistance under a separate fee schedule, to pay any
amount based on utilization or service levels or any portion of the vendor's fee to the
nursing facility except as payment for renting or leasing space or equipment or purchasing
support services from the nursing facility as limited by section 256B.433. All agreements
must be disclosed to the commissioner upon request of the commissioner. Nursing
facilities and vendors of ancillary services that are found to be in violation of this provision
shall each be subject to an action by the state of Minnesota or any of its subdivisions or
agencies for treble civil damages on the portion of the fee in excess of that allowed by
this provision and section 256B.433. Damages awarded must include three times the
excess payments together with costs and disbursements including reasonable attorney's
fees or their equivalent.

(g) Refusing, for more than 24 hours, to accept a resident returning to the same
bed or a bed certified for the same level of care, in accordance with a physician's order
authorizing transfer, after receiving inpatient hospital services.

(h) For a period not to exceed 180 days, the commissioner may continue to make
medical assistance payments to a nursing facility or boarding care home which is in
violation of this section if extreme hardship to the residents would result. In these cases
the commissioner shall issue an order requiring the nursing facility to correct the violation.
The nursing facility shall have 20 days from its receipt of the order to correct the violation.
If the violation is not corrected within the 20-day period the commissioner may reduce
the payment rate to the nursing facility by up to 20 percent. The amount of the payment
rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 33. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. Case management. (a) Each recipient of a home and community-based waiver under this section shall be provided case management services according to section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:

1. assessing the needs of the individual within 20 working days of a recipient's request;
2. developing the written individual service plan within ten working days after the assessment is completed;
3. informing the recipient or the recipient's legal guardian or conservator of service options;
4. assisting the recipient in the identification of potential service providers;
5. assisting the recipient to access services;
6. coordinating, evaluating, and monitoring of the services identified in the service plan;
7. completing the annual reviews of the service plan; and
8. informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case
manager may not delegate those aspects which require professional judgment including
assessments, reassessments, and care plan development.

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

Sec. 34. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
strengths, informal support systems, and need for services shall be completed within 20
working days of the recipient's request as provided in section 256B.0911. Reassessment
of each recipient's strengths, support systems, and need for services shall be conducted
at least every 12 months and at other times when there has been a significant change in
the recipient's functioning.

(b) There must be a determination that the client requires a hospital level of care or a
nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
appropriate to determine nursing facility level of care for purposes of medical assistance
payment for nursing facility services, only face-to-face assessments conducted according
to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
determination or a nursing facility level of care determination must be accepted for
purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing
facility level waiver programs shall be screened for the appropriate level of care according
to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under
this section before their 65th birthday may remain eligible for these services after their
65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify recipients whose level of
functioning is reasonably expected to improve and reassess these recipients to establish
a baseline assessment. Recipients who meet these criteria must have a comprehensive
transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
reassessed every six months until there has been no significant change in the recipient's
functioning for at least 12 months. After there has been no significant change in the
recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
informal support systems, and need for services shall be conducted at least every 12
months and at other times when there has been a significant change in the recipient's

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functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

**EFFECTIVE DATE.** This section is effective January 1, 2012, except for paragraph (f), which is effective July 1, 2013.

Sec. 35. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service Coordinated services and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written service coordinated services and support plan which complies with the requirements of section 256B.092, subdivisions 1b and 1e.

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater
natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(ė) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

**EFFECTIVE DATE.** This section is effective January 1, 2012, except for paragraphs (b), (c), and (d), which are effective July 1, 2013.
Sec. 36. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/MR rate increase.** Effective July 1, 2011, the commissioner shall increase the daily rate to $138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

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

Sec. 37. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 10. **ICF/MR rate adjustment.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 38. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(b) any period an applicant spends on a placement basis in a training and habilitation program, including a rehabilitation facility or work or employment program as defined in section 268A.01; or receiving personal care assistance services pursuant to section 256B.0659; or semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.
EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 39. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

Subd. 8. Continuing Care Grants

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Aging and Adult Services Grants  13,499,000  15,805,000

Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.

Information and Assistance

Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant

Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant

Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.
(b) Alternative Care Grants

Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.

(d) Medical Assistance Long-Term Care Waivers and Home Care Grants

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing
facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

**Manage Growth in DD Waiver.** The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

**Adjustment to Lead Agency Waiver Allocations.** Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate 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

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<th>Appropriations by Fund</th>
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<tr>
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<tr>
<td>Lottery Prize</td>
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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

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(g) Chemical Dependency Entitlement Grants

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<td></td>
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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

(2) 160 percent of the average rate on January
1, 2009, for each group of vendors with
similar attributes.

Rates for fiscal years 2010 and 2011 must
not exceed 160 percent of the average rate on
January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, the statewide aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the projected aggregate payment under the rates in effect for fiscal year 2011 excluding the rate reduction for rates that were below the average on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008,
to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants

(i) Other Continuing Care Grants

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 40. ESTABLISHMENT OF RATES FOR SHARED HOME AND COMMUNITY-BASED WAIVER SERVICES.

By January 1, 2012, the commissioner shall establish rates to begin paying for in-home services and personal supports under all of the home and community-based
waiver services programs consistent with the standards in Minnesota Statutes, section
256B.4912, subdivision 2.

Sec. 41. ESTABLISHMENT OF RATE FOR CASE MANAGEMENT SERVICES.
By July 1, 2012, the commissioner shall establish the rate to be paid for case
management services under Minnesota Statutes, sections 256B.0621, subdivision 2, clause
(4), 256B.092, and 256B.49, consistent with the standards in Minnesota Statutes, section
256B.4912, subdivision 2.

Sec. 42. RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.
By February 1, 2012, the commissioner of human services shall develop a legislative
report with specific recommendations and language for proposed legislation to be effective
July 1, 2012, for the following:

1. definitions of service and consolidation of standards and rates to the extent
appropriate for all types of medical assistance case management services, including
targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625;
subdivision 20; and 256B.0924; mental health case management services for children
and adults, all types of home and community-based waiver case management, and case
management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be
completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

2. recommendations on county of financial responsibility requirements and quality
assurance measures for case management;

3. identification of county administrative functions that may remain entwined in
case management service delivery models; and

4. implementation of a methodology to fully fund county case management
administrative functions.

Sec. 43. MY LIFE, MY CHOICES TASK FORCE.
Subdivision 1. Establishment. The My Life, My Choices Task Force is established
to create a system of supports and services for people with disabilities governed by the
following principles:

1. freedom to act as a consumer of services in the marketplace;

2. freedom to choose to take as much risk as any other citizen;

3. more choices in levels of service that may vary throughout life;
(4) opportunity to work with a trusted advocate and fiscal support entity to manage a
personal budget and to be accountable for reporting spending and personal outcomes;
(5) opportunity to live with minimal constraints instead of minimal freedoms; and
(6) ability to consolidate funding streams into an individualized budget.

Subd. 2. Membership. The My Life, My Choices Task Force shall consist of:
(1) the lieutenant governor;
(2) the commissioner of human services, or the commissioner's designee;
(3) a representative of the Minnesota Chamber of Commerce;
(4) a county representative appointed by the Association of Minnesota Counties;
(5) seven members appointed by the governor as follows: one administrative law
judge, one labor representative, two family members of people with disabilities, and three
individual members with different disabilities;
(6) two members appointed by the speaker of the house as follows: a representative
of a disability advocacy organization, and a representative of a disability legal services
advocacy organization; and
(7) three members appointed by the majority leader of the senate, including two
representatives from nonprofit organizations, one of which serves all 87 counties and
one that serves persons with disabilities and employs fewer than 50 people, and a
representative of a philanthropic organization.

Appointed nongovernmental members of the task force shall serve as staff for the
task force and take on responsibilities of coordinating meetings, reporting on committee
recommendations, and providing other staff support as needed to meet the responsibilities
of the task force as described in subdivision 3. The chairs and ranking minority members
of the legislative committees with jurisdiction over health and human services policy and
finance shall serve as ex officio members.

Subd. 3. Duties. The task force shall make recommendations, including proposed
legislation, and report to the legislative committees with jurisdiction over health and
human services policy and finance by November 15, 2011, on creating a system of
supports and services for people with disabilities by July 1, 2012, as governed by the
principles under subdivision 1. In making recommendations and proposed legislation, the
council shall work in conjunction with the Consumer-Directed Community Supports Task
Force and shall include self-directed planning, individual budgeting, choice of trusted
partner, self-directed purchasing of services and supports, reporting of outcomes, ability to
share in any savings, and any additional rules or laws that may need to be waived.

Subd. 4. Expense reimbursement. The members of the task force shall not be
reimbursed by the state for expenses related to the duties of the task force. The task force

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shall be independently staffed and coordinated by nongovernmental appointees who
serve on the task force, and no state dollars shall be appropriated for expenses related to
the task force under this section.

Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

**Sec. 44. DIRECTION TO OMBUDSMAN FOR LONG-TERM CARE.**

The Office of Ombudsman for Long-Term Care shall develop a work group to
address issues about, but not limited to: housing with services fees, staffing, and quality
assurance. The work group shall include, but not be limited to: consumers, relatives of
consumers, advocates, and providers. The Office of Ombudsman for Long-Term Care
shall present a report with recommendations related to housing with services fees, staffing,
and quality assurance to the legislative committees with jurisdiction over health and

**Sec. 45. DIRECTION TO COUNTIES.**

Counties must inform individuals who have had a level of service reduction of
their right to request an informal review conference with their case worker and any other
relevant county staff.

**Sec. 46. NURSING FACILITY PILOT PROJECT.**

Subdivision 1. **Report.** The commissioner of human services, in consultation with
the commissioner of health, stakeholders, and experts, shall provide to the legislature
recommendations by November 15, 2011, on how to develop a project to demonstrate a
new approach to caring for certain individuals in nursing facilities.

Subd. 2. **Contents of report.** The recommendations shall address the:

1) nature of the demonstration in terms of timing, size, qualifications to participate,
participation selection criteria and postdemonstration options for the demonstration and
for participating facilities;

2) nature of needed new form of licensure;

3) characteristics of the individuals the new model is intended to serve and
comparison of these characteristics with those individuals served by existing models of
care;

4) quality standards for licensure addressing management, types and amounts of
staffing, safety, infection control, care processes, quality improvement, and resident rights;

5) characteristics of inspection process;

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235.1 (6) funding for inspection process;
235.2 (7) enforcement authorities;
235.3 (8) role of Medicare;
235.4 (9) participation in the elderly waiver program, including rate setting;
235.5 (10) nature of any federal approval or waiver requirements and the method and
235.6 timing of obtaining them;
235.7 (11) consumer rights; and
235.8 (12) methods and resources needed to evaluate the effectiveness of the model with
235.9 regards to cost and quality.

ARTICLE 7

CHEMICAL AND MENTAL HEALTH

235.12 Section 1. Minnesota Statutes 2010, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

235.14 The civilly committed sex offender's county shall pay to the state a portion of the
235.15 cost of care provided in the Minnesota sex offender program to a civilly committed sex
235.16 offender who has legally settled in that county. A county's payment must be made from
235.17 the county's own sources of revenue and payments must equal ten 25 percent of the cost of
235.18 care, as determined by the commissioner, for each day or portion of a day, that the civilly
235.19 committed sex offender spends at the facility. If payments received by the state under this
235.20 chapter exceed 90 75 percent of the cost of care, the county is responsible for paying the
235.21 state the remaining amount. The county is not entitled to reimbursement from the civilly
235.22 committed sex offender, the civilly committed sex offender's estate, or from the civilly
235.23 committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. This section is effective for all individuals who are civilly
235.25 committed to the Minnesota sex offender program on or after August 1, 2011.

235.26 Sec. 2. Minnesota Statutes 2010, section 252.025, subdivision 7, is amended to read:

Subd. 7. Minnesota extended treatment options. The commissioner shall develop
235.28 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who
235.29 have developmental disabilities and exhibit severe behaviors which present a risk to
235.30 public safety. This program is statewide and must provide specialized residential services
235.31 in Cambridge and an array of community-based services with sufficient levels of care
235.32 and a sufficient number of specialists to ensure that individuals referred to the program
235.33 receive the appropriate care. The individuals working in the community-based services
under this section are state employees supervised by the commissioner of human services.

No midcontract layoffs shall occur as a result of restructuring under this section, but
layoffs may occur as a normal consequence of a low census or closure of the facility
due to decreased census.

Sec. 3. 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 or 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
treatment report shall be filed with the Indian Health Service within six months of the
patient's admission to the facility or prior to discharge, whichever comes first. Provisional
discharge or transfer of the patient may be authorized by the head of the treatment facility
only with the consent of the Indian Health Service. Discharge from the facility to the
Indian Health Service may be authorized by the head of the treatment facility after notice
to and consultation with the Indian Health Service.

Sec. 4. Minnesota Statutes 2010, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. Local agency duties. (a) Every local agency shall provide chemical
dependency services to persons residing within its jurisdiction who meet criteria
established by the commissioner for placement in a chemical dependency residential
or nonresidential treatment service subject to the limitations on residential chemical
dependency treatment in section 254B.04, subdivision 1. Chemical dependency money
must be administered by the local agencies according to law and rules adopted by the
commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible
vendors of chemical dependency services who can provide economical and appropriate
treatment. Unless the local agency is a social services department directly administered by
a county or human services board, the local agency shall not be an eligible vendor under
section 254B.05. The commissioner may approve proposals from county boards to provide
services in an economical manner or to control utilization, with safeguards to ensure that
necessary services are provided. If a county implements a demonstration or experimental
medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) A culturally specific vendor that provides assessments under a variance under
Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
persons not covered by the variance.

Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

Subd. 4. Division of costs. Except for services provided by a county under
section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
subdivision 4, paragraph (b), the county shall, out of local money, pay the state for

16.44 22.95 percent of the cost of chemical dependency services, including those services
provided to persons eligible for medical assistance under chapter 256B and general
assistance medical care under chapter 256D. Counties may use the indigent hospitalization
levy for treatment and hospital payments made under this section. 16.44 22.95 percent
of any state collections from private or third-party pay, less 15 percent for the cost of
payment and collections, must be distributed to the county that paid for a portion of the
treatment under this section.

**EFFECTIVE DATE.** This section is effective for claims processed beginning
July 1, 2011.

Sec. 6. Minnesota Statutes 2010, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. Eligibility. (a) Persons eligible for benefits under Code of Federal
Regulations, title 25, part 20, persons eligible for medical assistance benefits under
sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet
the income standards of section 256B.056, subdivision 4, and persons eligible for general
assistance medical care under section 256D.03, subdivision 3, are entitled to chemical
dependency fund services subject to the following limitations: (1) no more than three
residential chemical dependency treatment episodes for the same person in a four-year
period of time unless the person meets the criteria established by the commissioner of
human services; and (2) no more than four residential chemical dependency treatment
episodes in a lifetime unless the person meets the criteria established by the commissioner
of human services. For purposes of this section, "episode" means a span of treatment
without interruption of 30 days or more. State money appropriated for this paragraph must
be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical
dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
local agency to access needed treatment services. Treatment services must be appropriate
for the individual or family, which may include long-term care treatment or treatment in a
facility that allows the dependent children to stay in the treatment facility. The county
shall pay for out-of-home placement costs, if applicable.

(b) A person not entitled to services under paragraph (a), but with family income
that is less than 215 percent of the federal poverty guidelines for the applicable family
size, shall be eligible to receive chemical dependency fund services within the limit
of funds appropriated for this group for the fiscal year. If notified by the state agency
of limited funds, a county must give preferential treatment to persons with dependent
children who are in need of chemical dependency treatment pursuant to an assessment
under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
6, or 260C.212. A county may spend money from its own sources to serve persons under
this paragraph. State money appropriated for this paragraph must be placed in a separate
account established for this purpose.

c) Persons whose income is between 215 percent and 412 percent of the federal
poverty guidelines for the applicable family size shall be eligible for chemical dependency
services on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

**EFFECTIVE DATE.** This section is effective for all chemical dependency residential treatment beginning on or after July 1, 2011.

1  Sec. 7. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision to read:
2  **Subd. 2a. Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, and recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

Sec. 8. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

**Subd. 2. Allocation of collections.** The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate 33.3% 77.05 percent of patient payments and third-party payments to the special revenue account and 46.14 22.95 percent to the county financially responsible for the patient.

**EFFECTIVE DATE.** This section is effective for claims processed beginning

July 1, 2011.
Sec. 9. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to read:

Subd. 41. Residential services for children with severe emotional disturbance. Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county or an American Indian tribe through a residential facility, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

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

Sec. 10. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. Payment rates. (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective October 1, 2011.
Sec. 11. COMMUNITY MENTAL HEALTH SERVICES; USE OF BEHAVIORAL HEALTH HOSPITALS.

The commissioner shall issue a written report to the chairs and ranking minority members of the house and senate committees with jurisdiction of health and human services by December 31, 2011, on how the community behavioral health hospital facilities will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The commissioner must consult with the regional planning work groups for adult mental health and must include the recommendations of the work groups in the legislative report. The report must address future use of community behavioral health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65 percent licensed bed occupancy rate, and using the facilities for another purpose that will meet the mental health needs of residents of the region. The regional planning work groups shall work with the commissioner to prioritize the needs of their regions. These priorities, by region, must be included in the commissioner's report to the legislature.

Sec. 12. INTEGRATED DUAL DIAGNOSIS TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments or mental health diagnostic assessments to use screening tools approved by the commissioner in order to identify whether an individual who is the subject of the assessment screens positive for co-occurring mental health or chemical dependency disorders. Screening for co-occurring disorders must begin no later than December 31, 2011.

(b) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(c) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 13. REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.

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. 14. 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. 15. 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 8
REDESIGNING SERVICE DELIVERY

Section 1. Minnesota Statutes 2010, section 256.01, subdivision 14, is amended to read:
shall encourage local reforms in the delivery of child welfare services, within available
appropriations, and is authorized to approve local pilot programs which focus on reforming
the child protection and child welfare systems in Minnesota. Authority to approve pilots
includes authority to waive existing state rules as needed to accomplish reform efforts.
Notwithstanding section 626.556, subdivision 10, 10b, or 10d, the commissioner may
authorize programs to use alternative methods of investigating and assessing reports of
child maltreatment, provided that the programs 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. Pilot programs must
be required to address responsibility for safety and protection of children, be time limited,
and include evaluation of the pilot program.

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;
3. have a substantial number of children for whom determinations of maltreatment have occurred;
4. have capacity to respond to reports of abuse and neglect under section 626.556;
5. provide a wide range of services to families in need of child welfare services; and
6. have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

1. assessment and prevention of child abuse and neglect;
2. family preservation;
3. facilitative, supportive, and reunification services;
4. out-of-home placement for children removed from the home for child protective purposes; and
5. other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under...
this section, the affected county social service agency is relieved of responsibility for
responding to reports of abuse and neglect under section 626.556 for those children
during the time within which the tribal project is in effect and funded. The commissioner
shall work with tribes and affected counties to develop procedures for data collection,
evaluation, and clarification of ongoing role and financial responsibilities of the county
and tribe for child welfare services prior to initiation of the project. Children who have not
been identified by the tribe as participating in the project shall remain the responsibility
of the county. Nothing in this section shall alter responsibilities of the county for law
enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section
245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the
initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;
(2) the child must be in foster care; or
(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings.
Nothing in this section shall alter responsibilities of the county for providing services
under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In
establishing a local child mortality review panel, the tribe agrees to conduct local child
mortality reviews for child deaths or near-fatalities occurring on the reservation under
subdivision 12. Tribes with established child mortality review panels shall have access
to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c)
to (e). The tribe shall provide written notice to the commissioner and affected counties
when a local child mortality review panel has been established and shall provide data upon
request of the commissioner for purposes of sharing nonpublic data with members of the
state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety,
permanency, and well-being of American Indian children who are served in the projects.
Participating tribes must provide information to the state in a format and completeness
deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop
and submit to the chairs and ranking minority members of the legislative committees
with jurisdiction over health and human services a plan to transfer legal responsibility
for providing child protective services to White Earth Band member children residing in
Hennepin County to the White Earth Band. The plan shall include a financing proposal,
definitions of key terms, statutory amendments required, and other provisions required to
implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 3. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
to read:

Subd. 30. **Provision of required materials in alternative formats.** (a) For the
purposes of this subdivision, "alternative format" means a medium other than paper and
"prepaid health plan" means managed care plans and county-based purchasing plans.
(b) A prepaid health plan may provide in an alternative format a provider directory
and certificate of coverage, or materials otherwise required to be available in writing
under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's
contract with the prepaid health plan, if the following conditions are met:
(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the
enrollee that:
   (i) an alternative format is available and the enrollee affirmatively requests of
the prepaid health plan that the provider directory, certificate of coverage, or materials
otherwise required under Code of Federal Regulations, title 42, section 438.10, or under
the commissioner's contract with the prepaid health plan be provided in an alternative
format; and
   (ii) a record of the enrollee request is retained by the prepaid health plan in the
form of written direction from the enrollee or a documented telephone call followed by a
confirmation letter to the enrollee from the prepaid health plan that explains that the
enrollee may change the request at any time;
   (2) the materials are sent to a secure electronic mailbox and are made available at a
password-protected secure electronic Web site or on a data storage device if the materials
contain enrollee data that is individually identifiable;
   (3) the enrollee is provided a customer service number on the enrollee's membership
card that may be called to request a paper version of the materials provided in an
alternative format; and
   (4) the materials provided in an alternative format meets all other requirements of
the commissioner regarding content, size of the typeface, and any required time frames
for distribution. "Required time frames for distribution" must permit sufficient time for
prepaid health plans to distribute materials in alternative formats upon receipt of enrollees'
requests for the materials.

(c) A prepaid health plan may provide in an alternative format its primary care
network list to the commissioner and to local agencies within its service area. The
commissioner or local agency, as applicable, shall inform a potential enrollee of the
availability of a prepaid health plan's primary care network list in an alternative format. If
the potential enrollee requests an alternative format of the prepaid health plan's primary
care network list, a record of that request shall be retained by the commissioner or local
agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary
care network list to the commissioner and to local agencies within its service area to
accommodate potential enrollee requests for paper versions of the primary care network
list.

(d) A prepaid health plan may provide in an alternative format materials otherwise
required to be available in writing under Code of Federal Regulations, title 42, section
438.10, or under the commissioner's contract with the prepaid health plan, if the conditions
of paragraphs (b), (c), and (e), are met for persons who are eligible for enrollment in
managed care.

(e) The commissioner shall seek any federal Medicaid waivers within 90 days after
the effective date of this subdivision that are necessary to provide alternative formats of
required material to enrollees of prepaid health plans as authorized under this subdivision.

(f) The commissioner shall consult with managed care plans, county-based
purchasing plans, counties, and other interested parties to determine how materials
required to be made available to enrollees under Code of Federal Regulations, title 42,
section 438.10, or under the commissioner's contract with a prepaid health plan may
be provided in an alternative format on the basis that the enrollee has not opted in to
receive the alternative format. The commissioner shall consult with managed care
plans, county-based purchasing plans, counties, and other interested parties to develop
recommendations relating to the conditions that must be met for an opt-out process
to be granted.

Sec. 4. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:
Subd. 6. Recovery of overpayments. (a) If an amount of general assistance or
family general assistance is paid to a recipient in excess of the payment due, it shall be
recoverable by the county agency. The agency shall give written notice to the recipient of
its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision
5, when an overpayment occurs, the county agency shall recover the overpayment
from a current recipient by reducing the amount of aid payable to the assistance unit of
which the recipient is a member, for one or more monthly assistance payments, until
the overpayment is repaid. All county agencies in the state shall reduce the assistance
payment by three percent of the assistance unit’s standard of need in nonfraud cases and
ten percent where fraud has occurred, or the amount of the monthly payment, whichever is
less, for all overpayments.
(c) In cases when there is both an overpayment and underpayment, the county
agency shall offset one against the other in correcting the payment.
(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
in addition to the aid reductions provided in this subdivision, to include further voluntary
reductions in the grant level agreed to in writing by the individual, until the total amount
of the overpayment is repaid.
(e) The county agency shall make reasonable efforts to recover overpayments to
persons no longer on assistance under standards adopted in rule by the commissioner
of human services. The county agency need not attempt to recover overpayments of
less than $35 paid to an individual no longer on assistance if the individual does not
receive assistance again within three years, unless the individual has been convicted of
violating section 256.98.
(f) 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. 5. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

Subd. 3. Overpayment of monthly grants and recovery of ATM errors. (a) When
the county agency determines that an overpayment of the recipient's monthly payment
of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment
to the recipient. If the person is no longer receiving Minnesota supplemental aid, the
county agency may request voluntary repayment or pursue civil recovery. If the person is
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. Establishment of an overpayment is limited to 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. 6. 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. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Sec. 7. 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, number of cases pending, length of time required to process each application and deliver benefits, number of applicants eligible for expedited issuance, length of time required to process and deliver expedited issuance, number of terminations and reasons for terminations, client profiles by age, household composition and income level and sources, and the use of phone certification and home visits. The commissioner shall determine the county-by-county and statewide participation rate.
(b) On July 1 of each year, the commissioner of human services shall determine a
statewide and county-by-county food stamp program participation rate. The commissioner
may designate a different agency to administer the food stamp program in a county if the
agency administering the program fails to increase the food stamp program participation
rate among families or eligible individuals, or comply with all federal laws and regulations
governing the food stamp program. The commissioner shall review agency performance
annually to determine compliance with this paragraph.

(c) A person who commits any of the following acts has violated section 256.98 or
609.821, or both, and is subject to both the criminal and civil penalties provided under
those sections:

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
willful statement or misrepresentation, or intentional concealment of a material fact, food
stamps or vouchers issued according to sections 145.891 to 145.897 to which the person
is not entitled or in an amount greater than that to which that person is entitled or which
specify nutritional supplements to which that person is not entitled; or

(2) presents or causes to be presented, coupons or vouchers issued according to
sections 145.891 to 145.897 for payment or redemption knowing them to have been
received, transferred or used in a manner contrary to existing state or federal law; or

(3) willfully uses, possesses, or transfers food stamp coupons, authorization to
purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner
contrary to existing state or federal law, rules, or regulations; or

(4) buys or sells food stamp coupons, authorization to purchase cards, other
assistance transaction devices, vouchers issued according to sections 145.891 to 145.897,
or any food obtained through the redemption of vouchers issued according to sections
145.891 to 145.897 for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps,
authorization to purchase cards, or other assistance transaction devices found in the
possession of any person who is neither a recipient of the food stamp program nor
otherwise authorized to possess and use such materials. Confiscated property shall be
disposed of as the commissioner may direct and consistent with state and federal food
stamp law. The confiscated property must be retained for a period of not less than 30 days
to allow any affected person to appeal the confiscation under section 256.045.

(e) Food stamp overpayment claims which are due in whole or in part to client error
shall be established by the county agency for a period of six years from the date of any
resultant overpayment Establishment of an overpayment is limited to 12 months prior to
the month of discovery due to agency error. Establishment of an overpayment is limited
to six years prior to the month of discovery due to client error or an intentional program
violation determined under section 256.046.

(f) With regard to the federal tax revenue offset program only, recovery incentives
authorized by the federal food and consumer service shall be retained at the rate of 50
percent by the state agency and 50 percent by the certifying county agency.

(g) A peace officer, welfare fraud investigator, federal law enforcement official,
or the commissioner of health may confiscate vouchers found in the possession of any
person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise
authorized to possess and use such vouchers. Confiscated property shall be disposed of
as the commissioner of health may direct and consistent with state and federal law. The
confiscated property must be retained for a period of not less than 30 days.

(h) The commissioner of human services may seek a waiver from the United States
Department of Agriculture to allow the state to specify foods that may and may not be
purchased in Minnesota with benefits funded by the federal Food Stamp Program. The
commissioner shall consult with the members of the house of representatives and senate
policy committees having jurisdiction over food support issues in developing the waiver.
The commissioner, in consultation with the commissioners of health and education, shall
develop a broad public health policy related to improved nutrition and health status. The
commissioner must seek legislative approval prior to implementing the waiver.

Sec. 8. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

Subd. 4. Essential human services or essential services. "Essential human
services" or "essential services" means assistance and services to recipients or potential
recipients of public welfare and other services delivered by counties or tribes that are
mandated in federal and state law that are to be available in all counties of the state.

Sec. 9. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

Subd. 5. Service delivery authority. "Service delivery authority" means a single
county, or group consortium of counties operating by execution of a joint powers
agreement under section 471.59 or other contractual agreement, that has voluntarily
chosen by resolution of the county board of commissioners to participate in the redesign
under this chapter or has been assigned by the commissioner pursuant to section 402A.18.
A service delivery authority includes an Indian tribe or group of tribes that have voluntarily
chosen by resolution of tribal government to participate in redesign under this chapter.
Sec. 10. Minnesota Statutes 2010, section 402A.15, is amended to read:

**402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME REFORMS.**

Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome

Reforms shall develop a uniform process to establish and review performance and outcome standards for all essential human services based on the current level of resources available, and to develop appropriate reporting measures and a uniform accountability process for responding to a county's or human service delivery authority's failure to make adequate progress on achieving performance measures. The accountability process shall focus on the performance measures rather than inflexible implementation requirements.

(b) The steering committee shall:

(1) by November 1, 2009, establish an agreed-upon list of essential services;

(2) by February 15, 2010, develop and recommend to the legislature a uniform, graduated process, in addition to the remedies identified in section 402A.18, for responding to a county's failure to make adequate progress on achieving performance measures; and

(3) by December 15, 2012, for each essential service, make recommendations to the legislature regarding (i) performance measures and goals based on those measures for each essential service, (ii) a system for reporting on the performance measures and goals, and (iii) appropriate resources, including funding, needed to achieve those performance measures and goals. The resource recommendations shall take into consideration program demand and the unique differences of local areas in geography and the populations served. Priority shall be given to services with the greatest variation in availability and greatest administrative demands. By January 15 of each year starting January 15, 2011, the steering committee shall report its recommendations to the governor and legislative committees with jurisdiction over health and human services. As part of its report, the steering committee shall, as appropriate, recommend statutory provisions, rules and requirements, and reports that should be repealed or eliminated.

(c) As far as possible, the performance measures, reporting system, and funding shall be consistent across program areas. The development of performance measures shall consider the manner in which data will be collected and performance will be reported. The steering committee shall consider state and local administrative costs related to collecting data and reporting outcomes when developing performance measures. The steering committee shall correlate the performance measures and goals to available levels of resources, including state and local funding. The steering committee shall also identify and incorporate federal performance measures in its recommendations for those program areas where federal funding is contingent on meeting federal performance standards. The
steering committee shall take into consideration that the goal of implementing changes
to program monitoring and reporting the progress toward achieving outcomes is to
significantly minimize the cost of administrative requirements and to allow funds freed
by reduced administrative expenditures to be used to provide additional services, allow
flexibility in service design and management, and focus energies on achieving program
and client outcomes.

(d) In making its recommendations, the steering committee shall consider input from
the council established in section 402A.20. The steering committee shall review the
measurable goals established in a memorandum of understanding entered into under
section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied
as statewide performance outcomes.

(e) The steering committee shall form work groups that include persons who provide
or receive essential services and representatives of organizations who advocate on behalf
of those persons.

(f) By December 15, 2009, the steering committee shall establish a three-year
schedule for completion of its work. The schedule shall be published on the Department of
Human Services Web site and reported to the legislative committees with jurisdiction over
health and human services. In addition, the commissioner shall post quarterly updates on
the progress of the steering committee on the Department of Human Services Web site.

Subd. 2. Composition. (a) The steering committee shall include:

(1) the commissioner of human services, or designee, and two additional
representatives of the department;

(2) two county commissioners, representative of rural and urban counties, selected
by the Association of Minnesota Counties;

(3) two county directors of human services, representative of rural and urban
counties, selected by the Minnesota Association of County Social Service Administrators;
and

(4) three clients or client advocates representing different populations receiving
services from the Department of Human Services, who are appointed by the commissioner.

(b) The commissioner, or designee, and a county commissioner shall serve as
cochairs of the committee. The committee shall be convened within 60 days of May

(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 (2), must also serve as a representative
on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).

Sec. 11. 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 remediying 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 remediying 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 remediying performance outcome
deficiencies;

(2) mandatory incorporation of the administration and operation of the specific
essential service services with an existing service delivery authority or another county.
A service delivery authority or county incorporating an underperforming county shall
not be financially liable for the costs associated with remediying performance outcome
deficiencies; or
(3) transfer of authority for program administration and operation of the specific essential service services to the commissioner.

Subd. 2a. Financial responsibility of underperforming county. A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the essential service or essential services the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. Conditions prior to imposing remedies. Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:

(1) the county or service delivery authority determined by the commissioner to be deficient in achieving minimum performance outcomes has the opportunity, in coordination with the council, to develop a program outcome improvement plan. The program outcome improvement plan must be developed no later than six months from the date of the deficiency determination; and

(2) the council has conducted an assessment of the program outcome improvement plan to determine if the county or service delivery authority has made satisfactory progress toward performance outcomes and has made a recommendation about remedies to the commissioner. The review assessment and recommendation must be made to the commissioner within 12 months from the date of the deficiency determination.

Sec. 12. Minnesota Statutes 2010, section 402A.20, is amended to read:

402A.20 COUNCIL.

Subdivision 1. Council. (a) The State-County Results, Accountability, and Service Delivery Redesign Council is established. Appointed council members must be appointed by their respective agencies, associations, or governmental units by November 1, 2009.

The council shall be cochaired by the commissioner of human services, or designee, and a county representative from paragraph (b), clause (4) or (5), appointed by the Association of Minnesota Counties. Recommendations of the council must be approved by a majority of the voting council members. The provisions of section 15.059 do not apply to this council, and this council does not expire.

(b) The council must consist of the following members:

(1) two legislators appointed by the speaker of the house, one from the minority and one from the majority;

(2) two legislators appointed by the Senate Rules Committee, one from the majority and one from the minority;

(3) the commissioner of human services, or designee, and three employees from the department;
(4) two county commissioners appointed by the Association of Minnesota Counties;
(5) two county representatives appointed by the Minnesota Association of County
Social Service Administrators;
(6) one representative appointed by AFSCME as a nonvoting member; and
(7) one representative appointed by the Teamsters as a nonvoting member.
(c) Administrative support to the council may be provided by the Association of
Minnesota Counties and affiliates.
(d) Member agencies and associations are responsible for initial and subsequent
appointments to the council.

Subd. 2. Council duties. The council shall:
(1) provide review of the service delivery redesign process, including proposed
memoranda of understanding to establish a service delivery authority to conduct and
administer experimental projects to test new methods and procedures of delivering
services;
(2) certify, in accordance with section 402A.30, subdivision 4, the formation of
a service delivery authority, including the memorandum of understanding in section
402A.30, subdivision 2, paragraph (b);
(3) ensure the consistency of the memorandum of understanding entered into
under section 402A.30, subdivision 2, paragraph (b), with the performance standards
recommended by the steering committee and enacted by the legislature;
(4) ensure the consistency of the memorandum of understanding, to the extent
appropriate, or with other memorandum of understanding entered into by other service
delivery authorities;
(3) review and make recommendations on applications from a service delivery
authority for waivers of statutory or rule program requirements that are needed for
flexibility to determine the most cost-effective means of achieving specified measurable
goals in a redesign of human services delivery;
(4) establish a process to take public input on the service delivery framework
specified in the memorandum of understanding in section 402A.30, subdivision 2,
paragraph (b) scope of essential services over which a service delivery authority has
jurisdiction;
(5) form work groups as necessary to carry out the duties of the council under the
redesign;
(6) serve as a forum for resolving conflicts among participating counties and
tribes or between participating counties or tribes and the commissioner of human services,
provided nothing in this section is intended to create a formal binding legal process;
(8) (7) engage in the program improvement process established in section 402A.18, subdivision 3; and

(9) (8) identify and recommend incentives for counties and tribes to participate in human services service delivery authorities.

Subd. 3. Program evaluation. By December 15, 2014, the council shall request consideration by the legislative auditor for a reevaluation under section 3.971, subdivision 7, of those aspects of the program evaluation of human services administration reported in January 2007 affected by this chapter.

Sec. 13. [402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.

Subdivision 1. Requirements for establishing a service delivery authority.

(a) A county, tribe, or consortium of counties is eligible to establish a service delivery authority if:

(1) the county, tribe, or consortium of counties is:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more;

(iii) a consortium of four or more counties in reasonable geographic proximity without regard to population; or

(iv) one or more tribes with a total combined population of 25,000 or more.

The council may recommend that the commissioner of human services exempt a single county, tribe, or consortium of counties from the minimum population standard if the county, tribe, or consortium of counties can demonstrate that it can otherwise meet the requirements of this chapter.

(b) A service delivery authority shall:

(1) comply with current state and federal law, including any existing federal or state performance measures and performance measures under section 402A.15 when they are enacted into law, except where waivers are approved by the commissioner. Nothing in this subdivision requires the establishment of performance measures under section 402A.15 prior to a service delivery authority participating in the service delivery redesign under this chapter;

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of those services included in a proposal for a redesigned service or services and identify a single administrative agent for purposes of contact and communication with the department;
(4) identify the waivers from statutory or rule program requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals that the participating service delivery authority is expected to achieve;

(5) set forth a reasonable level of targeted reductions in overhead and administrative costs for each service delivery authority participating in the service delivery redesign;

(6) set forth the terms under which a county, tribe, or consortium of counties may withdraw from participation. In the case of withdrawal of any or all parties or the dissolution of the service delivery authority, the employees shall continue to be represented by the same exclusive representative or representatives and continue to be covered by the same collective bargaining union agreement until a new agreement is negotiated or the collective bargaining agreement term ends; and

(7) set forth a structure for managing the terms and conditions of employment of the employees as provided in section 402A.40.

(c) Once a county, tribe, or consortium of counties establishes a service delivery authority, no county, tribe, or consortium of counties that is a member of the service delivery authority may participate as a member of any other service delivery authority. The service delivery authority may allow an additional county, a tribe, or a consortium of counties to join the service delivery authority subject to the approval of the council and the commissioner.

(d) Nothing in this chapter precludes local governments from using sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Nothing in this chapter limits the authority of a county board or tribal council to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Subd. 2. Relief from statutory requirements. (a) Unless otherwise identified in the memorandum of understanding, any county, tribe, or consortium of counties forming a service delivery authority is exempt from the provisions of sections 245.465; 245.4835; 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph (b); and 256M.30.

(b) This subdivision does not preclude any county, tribe, or consortium of counties forming a service delivery authority from requesting additional waivers from statutory and rule requirements to ensure greater local control and flexibility.

Subd. 3. Duties. The service delivery authority shall:
(1) within the scope of essential services set forth in the memorandum of understanding establishing the authority, carry out the responsibilities required of local agencies under chapter 393 and human services boards under chapter 402;
(2) manage the public resources devoted to human services and other public services delivered or purchased by the counties or tribes that are subsidized or regulated by the Department of Human Services under chapters 245 to 261;
(3) employ staff to assist in carrying out its duties;
(4) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human services functions in the event of any business interruption according to local, state, and federal emergency planning requirements;
(5) receive and expend funds received for the redesign process under the memorandum of understanding;
(6) plan and deliver services directly or through contract with other governmental, tribal, or nongovernmental providers;
(7) rent, purchase, sell, and otherwise dispose of real and personal property as necessary to carry out the redesign; and
(8) carry out any other service designated as a responsibility of a county.

Subd. 4. Process for establishing a service delivery authority. (a) The county, tribe, or consortium of counties meeting the requirements of section 402A.30 and proposing to establish a service delivery authority shall present to the council:
(1) in conjunction with the commissioner, a proposed memorandum of understanding meeting the requirements of subdivision 1, paragraph (b), and outlining:
(i) the details of the proposal;
(ii) the state, tribal, and local resources, which may include, but are not limited to, funding, administrative and technology support, and other requirements necessary for the service delivery authority; and
(iii) the relief available to the service delivery authority if the resource commitments identified in item (ii) are not met; and
(2) a board resolution from the board of commissioners of each participating county stating the county's intent to participate, or in the case of a tribe, a resolution from tribal government, stating the tribe's intent to participate.
(b) After the council has considered and recommended approval of a proposed memorandum of understanding, the commissioner may finalize and execute the memorandum of understanding.

Subd. 5. Commissioner authority to seek waivers. The commissioner may use the authority under section 256.01, subdivision 2, paragraph (l), to grant waivers identified as
part of a proposed service delivery authority under subdivision 1, paragraph (b), clause
(4), except that waivers granted under this section must be approved by the council under
section 402A.20 rather than the Legislative Advisory Committee.

Sec. 14. [402A.40] TRANSITION TO NEW BARGAINING UNIT STRUCTURE.

Subdivision 1. Application of section. Notwithstanding the provisions of section
179A.12 or any other law, this section governs, where contrary to other law, the initial
certification and decertification, if any, of exclusive representatives for service delivery
authorities. Employees of a service delivery authority are public employees under section
179A.03, subdivision 14. Service delivery authorities are public employers under section
179A.03, subdivision 15.

Subd. 2. Existing majority. The commissioner of the Minnesota Bureau of
Mediation Services shall certify an employee organization for employees of a service
delivery authority as exclusive representative for an appropriate unit upon a petition
filed with the commissioner by the organization demonstrating that the petitioner is
certified pursuant to section 179A.12 as the exclusive representative of a majority of the
employees included within the unit as of that date. Two or more employee organizations
that represent the employees in a unit may petition jointly under this subdivision, provided
that any organization may withdraw from a joint certification in favor of the remaining
organizations on 30 days' notice to the remaining organizations, the employer, and the
commissioner, without affecting the rights and obligations of the remaining organizations
or the employer. The commissioner shall make a determination on a timely petition within
45 days of its receipt.

Subd. 3. No existing majority. (a) If no exclusive representative is certified under
subdivision 2, the commissioner shall certify an employee organization as exclusive
representative for an appropriate unit established upon a petition filed by the organization
within the time period provided in subdivision 2 demonstrating that the petitioner is
certified under section 179A.12 as the exclusive representative of fewer than a majority
of the employees included within the unit if no other employee organization so certified
has filed a petition within the time period provided in subdivision 2 and a majority of the
employees in the unit are represented by employee organizations under section 179A.12
on the date of the petition. Two or more employee organizations, each of which represents
employees included in the unit may petition jointly under this paragraph, provided that
any organization may withdraw from a joint certification in favor of the remaining
organizations on 30 days' notice to the remaining organizations, the employer, and the
commissioner without affecting the rights and obligations of the remaining organizations
260.1 or the employer. The commissioner shall make a determination on a timely petition within
260.2 45 days of its receipt.
260.3 (b) If no exclusive representative is certified under paragraph (a) or subdivision 2,
260.4 and an employee organization petitions the commissioner within 90 days of the creation of
260.5 the service delivery authority demonstrating that a majority of the employees included
260.6 within an appropriate unit wish to be represented by the petitioner, where this majority
260.7 is evidenced by current dues deduction rights, signed statements from employees in
260.8 counties within the service delivery authority that are not currently represented by any
260.9 employee organization plainly indicating that the signatories wish to be represented for
260.10 collective bargaining purposes by the petitioner rather than by any other organization,
260.11 or a combination of those, the commissioner shall certify the petitioner as exclusive
260.12 representative of the employees in the unit. The commissioner shall make a determination
260.13 on a timely petition within 45 days of its receipt.
260.14 (c) If no exclusive representative is certified under paragraph (a) or (b) or subdivision
260.15 2, and an employee organization petitions the commissioner subsequent to the creation
260.16 of the service delivery authority demonstrating that at least 30 percent of the employees
260.17 included within an appropriate unit wish to be represented by the petitioner, where this 30
260.18 percent is evidenced by current dues deduction rights, signed statements from employees
260.19 in counties within the service delivery authority that are not currently represented by any
260.20 employee organization plainly indicating that the signatories wish to be represented for
260.21 collective bargaining purposes by the petitioner rather than by any other organization, or a
260.22 combination of those, the commissioner shall conduct a secret ballot election to determine
260.23 the wishes of the majority. The election must be conducted within 45 days of receipt or
260.24 final decision on any petitions filed pursuant to subdivision 2, whichever is later. The
260.25 election is governed by section 179A.12, where not inconsistent with other provisions
260.26 of this section.

Subd. 4. Decertification. The commissioner may not consider a petition for
decertification of an exclusive representative certified under this section for one year after
certification, unless section 179A.20, subdivision 6, applies.

Subd. 5. Continuing contract. (a) The terms and conditions of collective
bargaining agreements covering the employees of service delivery authorities remain in
effect until a successor agreement becomes effective or, if no employee organization
petitions to represent the employees of the service delivery authority, until six months
after the establishment of the service delivery authority.

(b) Any accrued leave, including but not limited to sick leave, vacation time,
compensatory leave or paid time off, or severance pay benefits accumulated under policies
of the previously employing county or a collective bargaining agreement between the
previously employing county and an exclusive representative shall continue to apply in the
newly created service delivery authority for the employees of the previously employing
county. An employee who was eligible for the benefits of the Family and Medical Leave
Act at the previously employing county shall continue to be eligible at the newly created
service delivery authority.

(c) If it is necessary, prior to the negotiation of a new collective bargaining
agreement, to lay off an employee of a service delivery authority and if two or more
employees previously performed the work, seniority based on continuous length of
service with a service delivery authority member county shall be the determining factor
in determining which qualified employee shall be offered the job by the service delivery
authority. An employee whose work is being transferred to the service delivery authority
shall have the option of being laid off.

Subd. 6. Contract and representation responsibilities. (a) The exclusive
representatives of units of employees certified prior to the creation of the service delivery
authority remain responsible for administration of their contracts and for other contractual
duties and have the right to dues and fair share fee deduction and other contractual
privileges and rights until a contract is agreed upon with the service delivery authority.
Exclusive representatives of service delivery authority employees certified after the
creation of the service delivery authority are immediately upon certification responsible
for bargaining on behalf of employees within the unit. They are also responsible for
administering grievances arising under previous contracts covering employees included
within the unit that remain unresolved upon agreement with the service delivery authority
on a contract. Where the employer does not object, these responsibilities may be varied by
agreement between the outgoing and incoming exclusive representatives. All other rights
and duties of representation begin upon the creation of a service delivery authority, except
that exclusive representatives certified upon or after the creation of the service delivery
authority shall immediately, upon certification, have the right to all employer information
and all forms of access to employees within the bargaining unit which would be permitted
to the current contract holder, including the rights in section 179A.07, subdivision 6. This
section does not affect an existing collective bargaining contract. Incoming exclusive
representatives are immediately, upon certification, responsible for bargaining on behalf of
all previously unrepresented employees assigned to their units.

(b) Nothing in this section prevents an exclusive representative certified after
the effective dates of these provisions from assessing fair share or dues deductions
immediately upon certification if the employees were unrepresented for collective
bargaining purposes before that certification.

Sec. 15. COUNTY ELECTRONIC VERIFICATION PROCEDURES.

The commissioner of human services shall define which public assistance program
requirements may be electronically verified for the purposes of determining eligibility,
and shall also define procedures for electronic verification. The commissioner of human
services shall report back to the chairs and ranking minority members of the legislative
committees with jurisdiction over these issues by January 15, 2012, with draft legislation
to implement the procedures if legislation is necessary for purposes of implementation.

Sec. 16. ALIGNMENT OF PROGRAM POLICY AND PROCEDURES.

The commissioner of human services, in consultation with counties and other key
stakeholders, shall analyze and develop recommendations to align program policy and
procedures across all public assistance programs to simplify and streamline program
eligibility and access. The commissioner shall report back to the chairs and ranking
minority members of the legislative committees with jurisdiction over these issues by
January 15, 2013, with draft legislation to implement the recommendations.

Sec. 17. ALTERNATIVE STRATEGIES FOR CERTAIN REDETERMINATIONS.

The commissioner of human services shall develop and implement by January 15,
2012, a simplified process to redetermine eligibility for recipient populations in the medical
assistance, Minnesota supplemental aid, food support, and group residential housing
programs who are eligible based upon disability, age, or chronic medical conditions, and
who are expected to experience minimal change in income or assets from month to month.
The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 18. SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT PROCESS.

(a) The commissioner of human services shall issue a request for information for an
integrated service delivery system for health care programs, food support, cash assistance,
and child care. The commissioner shall determine, in consultation with partners in
paragraph (c), if the products meet departments' and counties' functions. The request for
information may incorporate a performance-based vendor financing option in which the
vendor shares the risk of the project's success. The health care system must be developed

Article 8 Sec. 18. 262
in phases with the capacity to integrate food support, cash assistance, and child care
programs as funds are available. The request for information must require that the system:

(1) streamline eligibility determinations and case processing to support statewide
eligibility processing;

(2) enable interested persons to determine eligibility for each program, and to apply
for programs online in a manner that the applicant will be asked only those questions
relevant to the programs for which the person is applying;

(3) leverage technology that has been operational in other state environments with
similar requirements; and

(4) include Web-based application, worker application processing support, and the
opportunity for expansion.

(b) The commissioner shall issue a final report, including the implementation plan,
to the chairs and ranking minority members of the legislative committees with jurisdiction
over health and human services no later than October 31, 2011.

(c) The commissioner shall partner with counties, a service delivery authority
established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology,
other state agencies, and service partners to develop an integrated service delivery
framework, which will simplify and streamline human services eligibility and enrollment
processes. The primary objectives for the simplification effort include significantly
improved eligibility processing productivity resulting in reduced time for eligibility
determination and enrollment, increased customer service for applicants and recipients of
services, increased program integrity, and greater administrative flexibility.

(d) The commissioner, along with a county representative appointed by the
Association of Minnesota Counties, shall report specific implementation progress to the

(e) The commissioner shall work with the Minnesota Association of County Social
Service Administrators and the Office of Enterprise Technology to develop collaborative
task forces, as necessary, to support implementation of the service delivery components
under this paragraph. The commissioner must evaluate, develop, and include as part
of the integrated eligibility and enrollment service delivery framework, the following
minimum components:

(1) screening tools for applicants to determine potential eligibility as part of an
online application process;

(2) the capacity to use databases to electronically verify application and renewal
data as required by law;

(3) online accounts accessible by applicants and enrollees:
(4) an interactive voice response system, available statewide, that provides case
information for applicants, enrollees, and authorized third parties;
(5) an electronic document management system that provides electronic transfer of
all documents required for eligibility and enrollment processes; and
(6) a centralized customer contact center that applicants, enrollees, and authorized
third parties can use statewide to receive program information, application assistance,
and case information, report changes, make cost-sharing payments, and conduct other
eligibility and enrollment transactions.
(f) Subject to a legislative appropriation, the commissioner of human services shall
issue a request for proposal for the appropriate phase of an integrated service delivery
system for health care programs, food support, cash assistance, and child care.

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

Sec. 19. WHITE EARTH BAND OF OJIBWE HUMAN SERVICES PROJECT.
(a) The commissioner of human services, in consultation with the White Earth Band
of Ojibwe, shall transfer legal responsibility to the tribe for providing human services to
tribal members and their families who reside on or off the reservation in Mahnomen
County. The transfer shall include:
(1) financing, including federal and state funds, grants, and foundation funds; and
(2) services to eligible tribal members and families defined as it applies to state
programs being transferred to the tribe.
(b) The determination as to which programs will be transferred to the tribe and
the timing of the transfer of the programs shall be made by a consensus decision of the
governing body of the tribe and the commissioner. The commissioner shall waive existing
rules and seek all federal approvals and waivers as needed to carry out the transfer.
(c) When the commissioner approves transfer of programs and the tribe assumes
responsibility under this section, Mahnomen County is relieved of responsibility for
providing program services to tribal members and their families who live on or off the
reservation while the tribal project is in effect and funded, except that a family member
who is not a White Earth member may choose to receive services through the tribe or the
county. The commissioner shall have authority to redirect funds provided to Mahnomen
County for these services, including administrative expenses, to the White Earth Band
of Ojibwe Indians.
(d) Upon the successful transfer of legal responsibility for providing human services
for tribal members and their families who reside on and off the reservation in Mahnomen
County, the commissioner and the White Earth Band of Ojibwe shall develop a plan to
transfer legal responsibility for providing human services for tribal members and their
families who reside on or off reservation in Clearwater and Becker Counties.

(e) No later than January 15, 2012, the commissioner shall submit a written
report detailing the transfer progress to the chairs and ranking minority members of the
legislative committees with jurisdiction over health and human services. If legislation is
needed to fully complete the transfer of legal responsibility for providing human services,
the commissioner shall submit proposed legislation along with the written report.

Sec. 20. REPEALER.
(a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.
(b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

ARTICLE 9
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
General (381,869,000)
Health Care Access 169,514,000
Federal TANF (23,108,000)

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

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<td>Federal TANF</td>
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#### (a) MFIP/DWP Grants

#### Appropriations by Fund

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<td>Federal TANF</td>
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#### (b) MFIP Child Care Assistance Grants

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#### (c) General Assistance Grants

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#### (d) Minnesota Supplemental Aid Grants

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#### (e) Group Residential Housing Grants

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### Subd. 4. Basic Health Care Grants

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<tr>
<td>Health Care Access</td>
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#### (a) MinnesotaCare Grants

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This appropriation is from the health care access fund.

#### (b) Medical Assistance Basic Health Care - Families and Children

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#### (c) Medical Assistance Basic Health Care - Elderly and Disabled

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#### (d) Medical Assistance Basic Health Care - Adults without Children

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### Subd. 5. Continuing Care Grants

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<tbody>
<tr>
<td>(39,721,000)</td>
</tr>
</tbody>
</table>

#### (a) Medical Assistance Long-Term Care Facilities

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(14,627,000)</td>
</tr>
</tbody>
</table>

#### (b) Medical Assistance Long-Term Care Waivers

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(44,718,000)</td>
</tr>
</tbody>
</table>
(c) Chemical Dependency Entitlement Grants  19,624,000

Sec. 3. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6, is amended to read:

Subd. 6. Health Care Grants

(a) MinnesotaCare Grants  998,000  (13,376,000)

This appropriation is from the health care access fund.

Health Care Access Fund Transfer to General Fund. The commissioner of management and budget shall transfer the following amounts in the following years from the health care access fund to the general fund: $998,000 in fiscal year 2010; $141,041,000 in fiscal year 2011; $141,041,000 in fiscal year 2012; and $286,150,000 in fiscal year 2013. If at any time the governor issues an executive order not to participate in early medical assistance expansion, no funds shall be transferred from the health care access fund to the general fund until early medical assistance expansion takes effect. This paragraph is effective the day following final enactment.

MinnesotaCare Ratable Reduction.

Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by 15 percent. Effective
for services provided from July 1, 2010, to
June 30, 2011, this reduction shall apply to
all services. Effective for services provided
from July 1, 2011, to December 31, 2013, this
reduction shall apply to all services except
inpatient hospital services. Notwithstanding
any contrary provision of this article, this
paragraph shall expire on December 31,
2013.

(b) Medical Assistance Basic Health Care
Grants - Families and Children

Critical Access Dental. Of the general
fund appropriation, $731,000 in fiscal year
2011 is to the commissioner for critical
access dental provider reimbursement
payments under Minnesota Statutes, section
256B.76 subdivision 4. This is a onetime
appropriation.

Nonadministrative Rate Reduction. For
services rendered on or after July 1, 2010,
to December 31, 2013, the commissioner
shall reduce contract rates paid to managed
care plans under Minnesota Statutes,
sections 256B.69 and 256L.12, and to
county-based purchasing plans under
Minnesota Statutes, section 256B.692, by
three percent of the contract rate attributable
to nonadministrative services in effect on
June 30, 2010. Notwithstanding any contrary
provision in this article, this rider expires on
December 31, 2013.

(c) Medical Assistance Basic Health Care
Grants - Elderly and Disabled

(d) General Assistance Medical Care Grants
The reduction to general assistance medical care grants is contingent upon the effective date in Laws 2010, First Special Session chapter 1, article 16, section 48. The reduction shall be reestimated based upon the actual effective date of the law. The commissioner of management and budget shall make adjustments in fiscal year 2011 to general assistance medical care appropriations to conform to the total expected expenditure reductions specified in this section.

(e) Other Health Care Grants

Cobra Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel and are available to the commissioner for fiscal year 2011 COBRA grant expenditures. Up to $111,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner for costs related to administration of the COBRA grants.

Sec. 4. EFFECTIVE DATE.

This article is effective the day following final enactment.

ARTICLE 10

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. SUMMARY OF APPROPRIATIONS.

The amounts shown in this section summarize direct appropriations, by fund, made in this article.
S.F. No. 760, 4th Engrossment - 87th Legislative Session (2011-2012) [S0760-4]

270.1 2012 2013 Total
270.2 General $5,564,457,000 $5,407,093,000 $10,971,550,000
270.3 State Government Special Revenue 63,700,000 63,475,000 127,175,000
270.5 Health Care Access 317,467,000 306,733,000 624,200,000
270.6 Federal TANF 286,744,000 258,466,000 545,210,000
270.7 Lottery Prize Fund 1,665,000 1,665,000 3,330,000
270.8 Total $6,234,032,000 $6,037,432,000 $12,271,464,000

Sec. 2. HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal year 2013. "The biennium" is fiscal years 2012 and 2013.

Sec. 3. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation $6,078,510,000 $5,891,475,000

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>5,489,816,000</td>
<td>5,337,566,000</td>
</tr>
<tr>
<td>State Government Special Revenue</td>
<td>565,000</td>
<td>565,000</td>
</tr>
<tr>
<td>Health Care Access</td>
<td>306,086,000</td>
<td>299,578,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>280,378,000</td>
<td>252,101,000</td>
</tr>
<tr>
<td>Lottery Prize Fund</td>
<td>1,665,000</td>
<td>1,665,000</td>
</tr>
</tbody>
</table>

Receipts for Systems Projects.

Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money
appropriated for computer projects approved
by the Minnesota Office of Enterprise
Technology, funded by the legislature,
and approved by the commissioner
of management and budget, may be
transferred from one project to another
and from development to operations as the
commissioner of human services considers
necessary. Any unexpended balance in
the appropriation for these projects does
not cancel but is available for ongoing
development and operations.

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

TANF Maintenance of Effort.

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

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

(2) the child care assistance programs
under Minnesota Statutes, sections 119B.03
and 119B.05, and county child care
administrative costs under Minnesota
Statutes, section 119B.15;
(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

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

(5) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671; and

(6) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

c) For fiscal years beginning with state fiscal year 2003, the commissioner shall assure that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

d) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct...
appropriations provided by law, do not apply
if the grants or aids are federal TANF funds.
(e) For the federal fiscal years beginning on
or after October 1, 2007, the commissioner
may not claim an amount of TANF/MOE in
excess of the 75 percent standard in Code
of Federal Regulations, title 45, section
263.1(a)(2), except:
(1) to the extent necessary to meet the 80
percent standard under Code of Federal
Regulations, title 45, section 263.1(a)(1),
if it is determined by the commissioner
that the state will not meet the TANF work
participation target rate for the current year;
(2) to provide any additional amounts
under Code of Federal Regulations, title 45,
section 264.5, that relate to replacement of
TANF funds due to the operation of TANF
penalties; and
(3) to provide any additional amounts that
may contribute to avoiding or reducing
TANF work participation penalties through
the operation of the excess MOE provisions
of Code of Federal Regulations, title 45,
section 261.43(a)(2).
For the purposes of clauses (1) to (3),
the commissioner may supplement the
MOE claim with working family credit
expenditures or other qualified expenditures
to the extent such expenditures are otherwise
available after considering the expenditures
allowed in this subdivision.
(f) Notwithstanding any contrary provision
in this article, paragraphs (a) to (e) expire
June 30, 2015.
Working Family Credit Expenditures

as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year of working family credit expenditures for fiscal years 2012 and 2013.

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2012, $37,517,000;
(2) fiscal year 2013, $28,171,000;
(3) fiscal year 2014, $34,097,000; and
(4) fiscal year 2015, $34,100,000.

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

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

(1) fiscal year 2012, $25,020,000;
(2) fiscal year 2013, $12,020,000;
(3) fiscal year 2014, $15,818,000; and
(4) fiscal year 2015, $15,818,000.

(b) The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.
Food Stamps Employment and Training

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

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

ARRA Food Support Benefit Increases.
The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Supplemental Security Interim Assistance

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

Transfer. By June 30, 2012, the commissioner of management and budget
must transfer $49,694,000 from the health
care access fund to the general fund. By June
30, 2013, the commissioner of management
and budget must transfer $5,000,000 from the
health care access fund to the general fund.

Subd. 2. Central Office Operations

The amounts that may be spent from this
appropriation for each purpose are as follows:

(a) Operations

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>General</th>
<th>72,547,000</th>
<th>71,077,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Access</td>
<td>11,508,000</td>
<td>11,508,000</td>
<td></td>
</tr>
<tr>
<td>State Government</td>
<td>440,000</td>
<td>440,000</td>
<td></td>
</tr>
<tr>
<td>Special Revenue</td>
<td>222,000</td>
<td>222,000</td>
<td></td>
</tr>
<tr>
<td>Federal TANF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DHS Receipt Center Accounting. The
commissioner is authorized to transfer
appropriations to, and account for DHS
receipt center operations in, the special
revenue fund.

Administrative Recovery; Set-Aside. The
commissioner may invoice local entities
through the SWIFT accounting system as an
alternative means to recover the actual cost
of administering the following provisions:

(1) Minnesota Statutes, section 125A.744,
subdivision 3;

(2) Minnesota Statutes, section 245.495,
paragraph (b);

(3) Minnesota Statutes, section 256B.0625,
subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924,
subdivision 6, paragraph (g);
(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and
(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

Payments for Cost Settlements. The commissioner is authorized to use amounts repaid to the general assistance medical care program under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, to pay cost settlements for claims for services provided prior to June 1, 2010. Notwithstanding any contrary provision in this article, this provision does not expire.

Base Adjustment. The general fund base for fiscal year 2014 shall be increased by $68,000 and decreased by $11,000 in fiscal year 2015.

(b) Children and Families

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>9,457,000</td>
<td>9,337,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>2,160,000</td>
<td>2,160,000</td>
</tr>
</tbody>
</table>

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2012 and 2013 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Base Adjustment. The general fund base is decreased by $47,000 in fiscal years 2014 and 2015.
(c) **Health Care**

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>16,376,000</td>
<td>16,278,000</td>
</tr>
<tr>
<td>Health Care Access</td>
<td>22,623,000</td>
<td>26,926,000</td>
</tr>
</tbody>
</table>

**Minnesota Senior Health Options**

**Reimbursement.** Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

**Utilization Review.** Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to the commissioner for these purposes. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

**Base Adjustment.** The general fund base shall be decreased by $2,000 in fiscal year 2014 and $114,000 in fiscal year 2015.

The health care access fund base is decreased by $411,000 in fiscal year 2014 and $880,000 in fiscal year 2015.

(d) **Continuing Care**

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>18,078,000</td>
<td>17,864,000</td>
</tr>
<tr>
<td>State Government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Revenue</td>
<td>125,000</td>
<td>125,000</td>
</tr>
</tbody>
</table>

**Region 10 Administrative Expenses.** $100,000 is appropriated each fiscal year, beginning in fiscal year 2012, for the administration of the State Quality Improvement and Licensing System under Minnesota Statutes, section 256B.0961.
Base Adjustment. The general fund base is decreased by $662,000 in fiscal year 2014 and $762,000 in fiscal year 2015.

(c) Chemical and Mental Health

Appropriations by Fund

<table>
<thead>
<tr>
<th>Fund</th>
<th>Fiscal Year 1</th>
<th>Fiscal Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>4,194,000</td>
<td>4,194,000</td>
</tr>
<tr>
<td>Lottery Prize</td>
<td>157,000</td>
<td>157,000</td>
</tr>
</tbody>
</table>

Subd. 3. Forecasted Programs

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP Grants

Appropriations by Fund

<table>
<thead>
<tr>
<th>Fund</th>
<th>Fiscal Year 1</th>
<th>Fiscal Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>83,986,000</td>
<td>88,187,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>84,425,000</td>
<td>75,417,000</td>
</tr>
</tbody>
</table>

(b) MFIP Child Care Assistance Grants 39,012,000 44,805,000

(c) General Assistance Grants and Adult Assistance 48,774,000 44,003,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54. This paragraph expires September 30, 2012.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,089,812 in fiscal year 2012 and $1,682,453 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method...
specified in Minnesota Statutes, section 256D.06. This paragraph expires September 30, 2012.

**Base Adjustment.** The general fund base for adult assistance is $44,512,000 in fiscal years 2014 and 2015.

| (d) Minnesota Supplemental Aid Grants | 34,460,000 | 33,532,000 |

**Emergency Minnesota Supplemental Aid Funds.** The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $367,000 in fiscal year 2012. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46. This paragraph expires September 30, 2012.

| (e) Group Residential Housing Grants | 121,080,000 | 129,238,000 |
| (f) MinnesotaCare Grants | 271,430,000 | 260,619,000 |

This appropriation is from the health care access fund.

| (g) G AMC Grants | 174,150,000 | 232,200,000 |

**General Assistance Medical Care Payments.** For general assistance medical care payments under Minnesota Statutes, section 256D.031:

- $120,150,000 in fiscal year 2012 and $160,200,000 in fiscal year 2013 are for payments to coordinated care delivery systems under Minnesota Statutes, section 256D.031, subdivision 7; and
- $54,000,000 in fiscal year 2012 and $72,000,000 in fiscal year 2013 are for payments for prescription drugs under
Minnesota Statutes, section 256D.031,
subdivision 9.

Any amount under paragraph (g) that is not
spent in the first year does not cancel and is
available for payments in the second year.
The commissioner may transfer any
unexpended amount under Minnesota
Statutes, section 256D.031, subdivision 9,
after the final allocation in fiscal year 2011 to
make payments under Minnesota Statutes,
section 256D.031, subdivision 7.

(h) Medical Assistance Grants
4,175,592,000 3,938,873,000

Managed Care Incentive Payments. The
commissioner shall not make managed care
incentive payments for expanding preventive
services. This provision does not expire.

Capitation Payment Delay. The
commissioner shall delay 71 percent of the
medical assistance capitation payment for
families with children to managed care plans
and county-based purchasing plans due in
May of 2013 until July of 2013.

Reduction of Rates for Congregate
Living for Individuals with Lower Needs.
Beginning October 1, 2011, lead agencies
must reduce rates in effect on January 1,
2011, by ten percent for individuals with
lower needs living in foster care settings
where the license holder does not share the
residence with recipients on the CADI, DD,
and TBI waivers and customized living
settings for CADI and TBI. Lead agencies
must adjust contracts within 60 days of the
effective date.
Reduction of Lead Agency Waiver

Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI, DD, and TBI waivers and customized living settings for CADI and TBI.

Manage Elderly Waiver Growth.

Beginning July 1, 2011, and ending on June 30, 2013, the commissioner shall manage the elderly waiver so that the number of people does not exceed the number on June 30, 2011.

Reduce customized living and 24-hour customized living component rates.

Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by ten percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012, To implement the reduction specified in
this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a 20 percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a ten percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental

Disability Waiver. For the biennium beginning July 1, 2011, the commissioner shall limit the developmental disability waiver to the number of recipients served in March 2010. If necessary to achieve this level, the commissioner shall not refill waiver openings until the number of waiver recipients reaches the March 2010 level. Once the March 2010 enrollment level is reached, the commissioner shall refill vacated openings to maintain the March 2010 enrollment level. To the extent possible, waiver allocations shall be available to individuals who meet the priorities for accessing waiver services described in Minnesota Statutes, section 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. When implementing the waiver enrollment limits under this provision, it is an absolute defense to an appeal under Minnesota Statutes, section 256.045, if the commissioner or lead agency proves that it followed the established written procedures and criteria and determined that home and community-based services could
not be provided to the person within the
appropriations or lead agency's allocation of
home and community-based services money.

Limit Growth in the Community
Alternatives for Disabled Individuals
Waiver. For the biennium beginning
July 1, 2011, the commissioner shall limit
the community alternatives for disabled
individuals waiver to the number of
recipients served in March 2010. If necessary
to achieve this level, the commissioner shall
not refill waiver openings until the number
of waiver recipients reaches the March 2010
level. Once the March 2010 enrollment
level is reached, the commissioner shall
refill vacated openings to maintain the
March 2010 enrollment level. To the
extent possible, waiver allocations shall
be available to individuals who meet the
priorities for accessing waiver services
described in Minnesota Statutes, section
256B.49, subdivision 11a. The limits include
conversions and diversions, unless the
commissioner has approved a plan to convert
funding due to the closure or downsizing
of a residential facility or nursing facility
to serve directly affected individuals on
the community alternatives for disabled
individuals waiver. When implementing
the waiver enrollment limits under this
provision, it is an absolute defense to an
appeal under Minnesota Statutes, section
256.045, if the commissioner or lead agency
proves that it followed the established written
procedures and criteria and determined that
home and community-based services could
not be provided to the person within the
appropriations or lead agency's allocation of
home and community-based services money.

Limit Growth in the Waiver for

Individuals with Traumatic Brain Injury.

For the biennium beginning July 1, 2011, the
commissioner shall limit the traumatic brain
injury waiver to the number of recipients
served in March 2010. If necessary to
achieve this level, the commissioner shall
not refill waiver openings until the number
of waiver recipients reaches the March 2010
level. Once the March 2010 enrollment
level is reached, the commissioner shall
refill vacated openings to maintain the
March 2010 enrollment level. To the
extent possible, waiver allocations shall
be available to individuals who meet the
priorities for accessing waiver services
described in Minnesota Statutes, section
256B.49, subdivision 11a. The limits include
conversions and diversions, unless the
commissioner has approved a plan to convert
funding due to the closure or downsizing of a
residential facility or nursing facility to serve
directly affected individuals on the traumatic
brain injury waiver. When implementing
the waiver enrollment limits under this
provision, it is an absolute defense to an
appeal under Minnesota Statutes, section
256.045, if the commissioner or lead agency
proves that it followed the established written
procedures and criteria and determined that
home and community-based services could
not be provided to the person within the
appropriations or lead agency's allocation of
home and community-based services money.

**Personal Care Assistance Relative**

**Care.** The commissioner shall adjust the
capitation payment rates for managed care
organizations paid under Minnesota Statutes,
section 256B.69, to reflect the rate reductions
for personal care assistance provided by
a relative pursuant to Minnesota Statutes,
section 256B.0659, subdivision 11.

(i) **Alternative Care Grants** 45,727,000 47,877,000

**Alternative Care Transfer.** Any money
allocated to the alternative care program that
is not spent for the purposes indicated does
not cancel but shall be transferred to the
medical assistance account.

(j) **Chemical Dependency Entitlement Grants** 108,568,000 123,095,000

**Subd. 4. Grant Programs**

The amounts that may be spent from this
appropriation for each purpose are as follows:

(a) **Support Services Grants**

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>8,715,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>100,525,000</td>
</tr>
</tbody>
</table>

**MFIP Consolidated Fund Grants.** The
TANF fund base is reduced by $10,000,000
each year beginning in fiscal year 2012.

**Subsidized Employment Funding Through**

**ARRA.** The commissioner is authorized to
apply for TANF emergency fund grants for
subsidized employment activities. Growth
in expenditures for subsidized employment
within the supported work program and the
MFIP consolidated fund over the amount

Article 10 Sec. 3.
287.1 expended in the calendar year quarters in
287.2 the TANF emergency fund base year shall
287.3 be used to leverage the TANF emergency
287.4 fund grants for subsidized employment and
287.5 to fund supported work. The commissioner
287.6 shall develop procedures to maximize
287.7 reimbursement of these expenditures over the
287.8 TANF emergency fund base year quarters,
287.9 and may contract directly with employers
287.10 and providers to maximize these TANF
287.11 emergency fund grants.
287.12 (b) Basic Sliding Fee Child Care Assistance
287.13 Grants
287.14 $36,067,000 $37,342,000

287.15 Base Adjustment. The general fund base is
287.16 decreased by $1,490,000 in fiscal year 2014
287.17 and $867,000 in fiscal year 2015.

287.18 Child Care and Development Fund
287.19 Unexpended Balance. In addition to
287.20 the amount provided in this section, the
287.21 commissioner shall expend $5,000,000
287.22 in fiscal year 2012 from the federal child
287.23 care and development fund unexpended
287.24 balance for basic sliding fee child care under
287.25 Minnesota Statutes, section 119B.03. The
287.26 commissioner shall ensure that all child
287.27 care and development funds are expended
287.28 according to the federal child care and
287.29 development fund regulations.
287.30 (c) Child Care Development Grants
287.31 $232,000 $232,000

287.32 Base Adjustment. The general fund base is
287.33 increased by $1,255,000 is fiscal years 2014
287.34 and 2015.

287.35 (d) Child Support Enforcement Grants
287.36 $50,000 $50,000

287.37 Federal Child Support Demonstration
287.38 Grants. Federal administrative
reimbursement resulting from the federal
child support grant expenditures authorized
under section 1115a of the Social Security
Act is appropriated to the commissioner for
this activity.

(c) Children's Services Grants

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>45,654,000</td>
<td>45,654,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>140,000</td>
<td>140,000</td>
</tr>
</tbody>
</table>

Adoption Assistance and Relative Custody

Assistance Payments. $1,661,000 each

year is for continuation of current payments
for adoption assistance and relative custody
assistance.

Adoption Assistance and Relative Custody

Assistance Transfer. The commissioner
may transfer unencumbered appropriation
balances for adoption assistance and relative
custody assistance between fiscal years and
between programs.

Privatized Adoption Grants. Federal
reimbursement for privatized adoption grant
and foster care recruitment grant expenditures
is appropriated to the commissioner for
adoption grants and foster care and adoption
administrative purposes.

Adoption Assistance Incentive Grants.

Federal funds available during fiscal year
2012 and fiscal year 2013 for adoption
incentive grants are appropriated to the
commissioner for these purposes.

Base Adjustment. The general fund base is
increased by $1,134,000 is fiscal years 2014
and 2015.
(f) Children and Community Services Grants 54,301,000 52,301,000

(g) Children and Economic Support Grants

Appropriations by Fund

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>15,770,000</td>
<td>15,772,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>700,000</td>
<td>0</td>
</tr>
</tbody>
</table>

Long-Term Homeless Services. $700,000

is appropriated from the federal TANF fund for the biennium beginning July 1, 2011, to the commissioner of human services for long-term homeless services for low-income homeless families under Minnesota Statutes, section 256K.26. This is a onetime appropriation and is not added to the base.

Base Adjustment. The general fund base is increased by $42,000 in fiscal year 2014 and $43,000 in fiscal year 2015.

(h) Health Care Grants 150,000 150,000

This appropriation is from the health care access fund.

Surplus Appropriation Canceled. Of the health care access fund appropriation in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (e), for the COBRA premium state subsidy program, $11,750,000 must be canceled in fiscal year 2011. This provision is effective the day following final enactment.

(i) Aging and Adult Services Grants 18,734,000 18,910,000

Aging Grants Reduction. Effective July 1, 2011, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $3,600,000 for each year of the biennium.
These reductions are onetime and do not affect base funding for the 2014-2015 biennium. Grants made during the 2012-2013 biennium under Minnesota Statutes, section 256B.9754, must not be used for new construction or building renovation.

**Base Level Adjustment.** The general fund base is increased by $3,600,000 in fiscal year 2014 and increased by $3,600,000 in fiscal year 2015.

(i) **Deaf and Hard-of-Hearing Grants**

| 1,936,000 | 1,767,000 |

(k) **Disabilities Grants**

| 15,438,000 | 18,432,000 |

**HIV Grants.** The general fund appropriation for the HIV drug and insurance grant program shall be reduced by $2,425,000 in fiscal year 2012 and increased by $2,425,000 in fiscal year 2014. These adjustments are onetime and shall not be applied to the base.

Notwithstanding any contrary provision, this provision expires June 30, 2014. Money appropriated for the HIV drug and insurance grant program in fiscal year 2014 may be used in either year of the biennium.

**Region 10.** Any unspent allocation for Region 10 Quality Assurance from the biennium beginning on July 1, 2009, may be carried over into the biennium beginning on July 1, 2011.

**Base Level Adjustment.** The general fund base is increased by $2,425,000 in fiscal year 2014 only.

**Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs.** The
291.1 commissioner shall make available a total
291.2 of $250,000 per year in local planning
291.3 grants, beginning July 1, 2011, to assist
291.4 lead agencies and provider organizations in
291.5 developing alternatives to congregate living
291.6 within the available level of resources for the
291.7 home and community-based services waivers
291.8 for persons with disabilities.
291.9 (l) Adult Mental Health Grants
291.10
291.11 Appropriations by Fund
291.12
291.13
291.14 Funding Usage. Up to 75 percent of a fiscal
291.15 year's appropriation for adult mental health
291.16 grants may be used to fund allocations in that
291.17 portion of the fiscal year ending December
291.18
291.19 Base Adjustment. The general fund base is
291.20 increased by $813,000 in fiscal years 2014
291.21 and 2015. The health care access fund base
291.22 is increased by $375,000 in fiscal years 2014
291.23 and 2015.
291.24 (m) Children's Mental Health Grants
291.25 Funding Usage. Up to 75 percent of a fiscal
291.26 year's appropriation for children's mental
291.27 health grants may be used to fund allocations
291.28 in that portion of the fiscal year ending
291.29 December 31.
291.30 Base Adjustment. The general fund base is
291.31 increased by $2,431,000 in fiscal years 2014
291.32 and 2015.
291.33 (n) Chemical Dependency Nonentitlement
291.34 Grants
291.35
291.36 Subd. 5. State-Operated Services

[Table of Appropriations]

<table>
<thead>
<tr>
<th>Fund</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>69,957,000</td>
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<tr>
<td>Health Care Access</td>
<td>375,000</td>
<td>375,000</td>
</tr>
<tr>
<td>Lottery Prize Fund</td>
<td>1,508,000</td>
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</table>

14,251,000
14,251,000

1,336,000
1,336,000

Article 10 Sec. 3. 291
Transfer Authority Related to

State-Operated Services. Money
appropriated for state-operated services
may be transferred between fiscal years
of the biennium with the approval of the
commissioner of management and budget.

(a) State-Operated Services Mental Health
115,286,000 115,135,000

The commissioner shall close the Community
Behavioral Health Hospital-Willmar on or
before June 30, 2011. The commissioner
shall relocate the Child and Adolescent
Behavioral Health Hospital located in
the former Willmar Regional Treatment
Center to the facility previously housing
the Community Behavioral Health
Hospital-Willmar.

(b) Minnesota Security Hospital
69,582,000 69,582,000

Subd. 6. Sex Offender Program
70,416,000 67,570,000

Transfer Authority Related to Minnesota Sex Offender Program. Money
appropriated for the Minnesota sex offender
program may be transferred between fiscal
years of the biennium with the approval
of the commissioner of management and
budget.

Minnesota Sex Offender Program
Reduction. The fiscal year 2011 general
fund appropriation for Minnesota sex
offender services under Laws 2009, chapter
79, article 13, section 3, subdivision 10,
paragraph (b), is reduced by $3,000,000.
This paragraph is effective the day following
final enactment.

Subd. 7. Technical Activities
92,206,000 79,551,000
This appropriation is from the federal TANF fund.

**Base Level Adjustment.** The TANF fund base is increased by $4,155,000 in fiscal year 2014 and increased by $4,582,000 in fiscal year 2015.

**Sec. 4. COMMISSIONER OF HEALTH**

**Subdivision 1. Total Appropriation** $132,589,000 $123,237,000

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>69,455,000</td>
<td>64,341,000</td>
</tr>
<tr>
<td>State Government</td>
<td>45,387,000</td>
<td>45,376,000</td>
</tr>
<tr>
<td>Health Care Access</td>
<td>11,381,000</td>
<td>7,155,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>6,366,000</td>
<td>6,365,000</td>
</tr>
</tbody>
</table>

The amounts that may be spent for each purpose are specified in the following subdivisions.

**Subd. 2. Community and Family Health**

**Promotion**

<table>
<thead>
<tr>
<th>Appropriations by Fund</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>43,539,000</td>
<td>38,799,000</td>
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<tr>
<td>State Government</td>
<td>1,033,000</td>
<td>1,033,000</td>
</tr>
<tr>
<td>Health Care Access</td>
<td>1,719,000</td>
<td>1,719,000</td>
</tr>
<tr>
<td>Federal TANF</td>
<td>6,366,000</td>
<td>6,365,000</td>
</tr>
</tbody>
</table>

**TANF Appropriations.** (1) $578,000 of the TANF funds is appropriated each year to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $1,790,000 of the TANF funds is appropriated each year to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7).

Funds must be distributed to community.
health boards according to Minnesota
Statutes, section 145A.131, subdivision 1.

(3) $1,000,000 of the TANF funds is
appropriated each year to the commissioner
for decreasing infant mortality rates under
Minnesota Statutes, section 145.928,
subdivision 7.

(4) $2,998,000 of the TANF funds is
appropriated each year to the commissioner
for the family home visiting grant program
according to Minnesota Statutes, section
145A.17. $2,000,000 of the funding must
be distributed to community health boards
according to Minnesota Statutes, section
145A.131, subdivision 1. $998,000 of
the funding must be distributed to tribal
governments based on Minnesota Statutes,
section 145A.14, subdivision 2a.

(5) The commissioner may use up to 7.06
percent of the funds appropriated each fiscal
year to conduct the ongoing evaluations
required under Minnesota Statutes, section
145A.17, subdivision 7, and training and
technical assistance as required under
Minnesota Statutes, section 145A.17,
subdivisions 4 and 5.

TANF Carryforward. Any unexpended
balance of the TANF appropriation in the
first year of the biennium does not cancel but
is available for the second year.

Base Level Adjustment. The general fund
base is decreased by $5,000 in fiscal years
2014 and 2015.

Subd. 3. Policy Quality and Compliance
Appropriations by Fund

<table>
<thead>
<tr>
<th>Appropriation</th>
<th>First Year</th>
<th>Second Year</th>
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<tr>
<td>General</td>
<td>10,395,000</td>
<td>10,023,000</td>
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<tr>
<td>State Government</td>
<td>14,026,000</td>
<td>14,083,000</td>
</tr>
<tr>
<td>Special Revenue</td>
<td>9,662,000</td>
<td>5,436,000</td>
</tr>
</tbody>
</table>

Medical Education and Research

Costs (MERC) Fund Transfers. The commissioner of management and budget shall transfer $9,800,000 from the MERC fund to the general fund by October 1, 2011.

White Earth Clinic. Of the general fund appropriation, $500,000 in the first year and $200,000 in the second year is for a grant to the White Earth Band of Ojibwe Indians.

If the White Earth Band of Ojibwe Indians accepts this grant, funds must be used for the White Earth Clinic under Minnesota Statutes, section 145.9271. The base for this program is $200,000 for each of fiscal years 2014 and 2015.

Comprehensive Advanced Life Support.

Of the general fund appropriation, $31,000 each year is added to the base of the comprehensive advanced life support (CALS) program under Minnesota Statutes, section 144.6062.

Unused Federal Match Funds. Of the funds appropriated in Laws 2009, chapter 79, article 13, section 4, subdivision 3, for state matching funds for the federal Health Information Technology for Economic and Clinical Health Act, $2,800,000 is transferred to the health care access fund by October 1, 2011.
Loan Forgiveness. $1,014,000 is appropriated from the health care access fund in fiscal year 2012 for the department to fulfill existing obligations of loan forgiveness agreements. This funding is available through fiscal year 2014. In addition, prior year funds appropriated for loan forgiveness and required to fulfill existing obligations do not expire and are available until expended.

Administrative Reports. Of the general fund appropriation, $82,000 in fiscal year 2012 and $10,000 in fiscal year 2013 are for transfer to the commissioner of management and budget for the reduction of the administrative report study.

Base Level Adjustment. The state government special revenue fund base shall be reduced by $141,000 in fiscal years 2014 and 2015. The health care access base shall be increased by $600,000 in fiscal year 2014.

Subd. 4. Health Protection

| Appropriations by Fund | General | 9,370,000 | State Government | 30,328,000 | Special Revenue | 30,260,000 |

Subd. 5. Administrative Support Services

Sec. 5. COUNCIL ON DISABILITY $ 524,000 $ 524,000

Sec. 6. OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES $ 1,655,000 $ 1,655,000

Funds appropriated for fiscal year 2011 are available until expended.

Sec. 7. OMBUDSPERSON FOR FAMILIES $ 265,000 $ 265,000
Sec. 8. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$17,748,000</td>
<td>$17,534,000</td>
</tr>
</tbody>
</table>

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. Board of Chiropractic Examiners

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Dentistry</td>
<td>469,000</td>
<td>469,000</td>
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</table>

Subd. 3. Board of Dentistry

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
</table>
| 8. Health Professional Services Program. Of this appropriation, $704,000 in fiscal year 2012 and $704,000 in fiscal year 2013 from the state government special revenue fund are for the health professional services program.

Subd. 4. Board of Dietetic and Nutrition Practice

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
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</thead>
<tbody>
<tr>
<td>Board of Dietetic and Nutrition Practice</td>
<td>110,000</td>
<td>110,000</td>
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</table>

Subd. 5. Board of Marriage and Family Therapy

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Marriage and Family Therapy</td>
<td>192,000</td>
<td>167,000</td>
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</tbody>
</table>

Subd. 6. Board of Medical Practice

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Medical Practice</td>
<td>3,866,000</td>
<td>3,866,000</td>
</tr>
</tbody>
</table>

Subd. 7. Board of Nursing

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Nursing</td>
<td>3,694,000</td>
<td>3,551,000</td>
</tr>
</tbody>
</table>

Subd. 8. Board of Nursing Home Administrators

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Nursing Home Administrators</td>
<td>2,153,000</td>
<td>2,145,000</td>
</tr>
</tbody>
</table>

Rulemaking. Of this appropriation, $25,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Subd. 9. Board of Medical Practice

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Medical Practice</td>
<td>3,866,000</td>
<td>3,866,000</td>
</tr>
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</table>

Subd. 10. Board of Nursing

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
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</thead>
<tbody>
<tr>
<td>Board of Nursing</td>
<td>3,694,000</td>
<td>3,551,000</td>
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</tbody>
</table>

Subd. 11. Board of Nursing Home Administrators

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Nursing Home Administrators</td>
<td>2,153,000</td>
<td>2,145,000</td>
</tr>
</tbody>
</table>

Rulemaking. Of this appropriation, $44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Electronic Licensing System Adaptors.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
</table>
| Electronic Licensing System Adaptors | Of this appropriation, $761,000 in fiscal year 2013 from the state government special revenue fund is to the administrative services unit to cover the costs to connect to the e-licensing system. Minnesota Statutes.
section 16E.22. Base level funding for this activity in fiscal year 2014 shall be $100,000.

298.3 Base level funding for this activity in fiscal year 2015 shall be $50,000.

298.5 Development and Implementation of a

298.6 Disciplinary, Regulatory, Licensing and

298.7 Information Management System. Of this

298.8 appropriation, $800,000 in fiscal year 2012

298.9 and $300,000 in fiscal year 2013 are for the
development of a shared system. Base level

298.10 funding for this activity in fiscal year 2014

298.11 shall be $50,000.

298.13 Administrative Services Unit - Operating

298.14 Costs. Of this appropriation, $526,000

298.15 in fiscal year 2012 and $526,000 in fiscal year 2013 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

298.21 Administrative Services Unit - Retirement

298.22 Costs. Of this appropriation in fiscal year 2012, $225,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

298.29 Administrative Services Unit - Volunteer

298.30 Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2012 and $150,000 in fiscal year 2013 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.
Administrative Services Unit - Contested

Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2012 and $200,000 in fiscal year 2013 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Base Adjustment. The State Government Special Revenue Fund base is decreased by $911,000 in fiscal year 2014 and $1,011,000 in fiscal year 2015.

Subd. 9. Board of Optometry 106,000 106,000
Subd. 10. Board of Pharmacy 2,341,000 2,344,000

Prescription Electronic Reporting. Of this appropriation, $356,000 in fiscal year 2012 and $356,000 in fiscal year 2013 from the state government special revenue fund are to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126. Base level funding
for this activity in fiscal year 2014 shall be $356,000.

300.3 Subd. 11. **Board of Physical Therapy**

389,000 345,000

300.4 **Rulemaking.** Of this appropriation, $44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

300.7 Subd. 12. **Board of Podiatry**

75,000 75,000

300.8 Subd. 13. **Board of Psychology**

846,000 846,000

300.9 Subd. 14. **Board of Social Work**

1,036,000 1,053,000

300.10 Subd. 15. **Board of Veterinary Medicine**

228,000 229,000

300.11 Subd. 16. **Board of Behavioral Health and Therapy**

414,000 414,000

300.13 Sec. 9. **EMERGENCY MEDICAL SERVICES**

300.14 **REGULATORY BOARD** $ 2,742,000 $ 2,742,000

300.15 **Regional Grants.** $585,000 in fiscal year 2012 and $585,000 in fiscal year 2013 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions.

300.20 **Notwithstanding Minnesota Statutes, section 144E.50, 100 percent of the appropriation shall be granted to the emergency medical service regions.**

300.24 **Cooper/Sams Volunteer Ambulance Program.** $700,000 in fiscal year 2012 and $700,000 in fiscal year 2013 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

300.29 (a) Of this amount, $611,000 in fiscal year 2012 and $611,000 in fiscal year 2013 are for the ambulance service personnel longevity award and incentive program.

300.33 under Minnesota Statutes, section 144E.40.
(b) Of this amount, $89,000 in fiscal year 2012 and $89,000 in fiscal year 2013 are for the operations of the ambulance service personnel longevity award and incentive program, under Minnesota Statutes, section 256E.40.

**Ambulance Training Grant.** $361,000 in fiscal year 2012 and $361,000 in fiscal year 2013 are for training grants.

**EMSRB Board Operations.** $1,096,000 in fiscal year 2012 and $1,096,000 in fiscal year 2013 are for operations.

Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

**Subd. 33. Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

1. reimbursement for the Minnesota senior health options project; and
2. reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6, is amended to read:

**Subd. 6. Continuing Care Grants**

(a) **Aging and Adult Services Grants**

- (3,600,000)
- (3,600,000)

**Community Service/Service Development Grants Reduction.** Effective retroactively from July 1, 2009, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $5,807,000 $3,600,000 for each year of the biennium. Grants made during the biennium under Minnesota Statutes, section 256.9754,
shall not be used for new construction or building renovation.

**Aging Grants Delay.** Aging grants must be reduced by $917,000 in fiscal year 2011 and increased by $917,000 in fiscal year 2012. These adjustments are one-time and must not be applied to the base. This provision expires June 30, 2012.

**Medical Assistance Long-Term Care Facilities Grants**

- (b) Medical Assistance Long-Term Care Facilities Grants ($3,827,000) ($2,745,000)

**ICF/MR Variable Rates Suspension.** Effective retroactively from July 1, 2009, to June 30, 2010, no new variable rates shall be authorized for intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, section 256B.5013, subdivision 1.

**ICF/MR Occupancy Rate Adjustment Suspension.** Effective retroactively from July 1, 2009, to June 30, 2011, approval of new applications for occupancy rate adjustments for unoccupied short-term beds under Minnesota Statutes, section 256B.5013, subdivision 7, is suspended.

**Medical Assistance Long-Term Care Waivers and Home Care Grants**

- (c) Medical Assistance Long-Term Care Waivers and Home Care Grants ($2,318,000) ($5,807,000)

**Developmental Disability Waiver Acuity Factor.** Effective retroactively from January 1, 2010, the January 1, 2010, one percent growth factor in the developmental disability waiver allocations under Minnesota Statutes, section 256B.092, subdivisions 4 and 5, that is attributable to changes in acuity, is suspended to June 30, 2014, eliminated. Effective January 1, 2012, the one percent growth factor is eliminated.
growth factor in the developmental
disability waiver allocations is eliminated.
Notwithstanding any law to the contrary, this
provision does not expire.

(d) Adult Mental Health Grants (5,000,000) -0-
(e) Chemical Dependency Entitlement Grants (3,622,000) (3,622,000)
(f) Chemical Dependency Nonentitlement Grants (393,000) (393,000)

(g) Other Continuing Care Grants -0- (2,500,000)

Other Continuing Care Grants Delay.

Other continuing care grants must be reduced
by $1,414,000 in fiscal year 2011 and
increased by $1,414,000 in fiscal year 2012.
These adjustments are onetime and must not
be applied to the base. This provision expires
June 30, 2012.

(h) Deaf and Hard-of-Hearing Grants -0- (169,000)

Deaf and Hard-of-Hearing Grants Delay.
Effective retroactively from July 1, 2010,
deaf and hard-of-hearing grants must be
reduced by $169,000 in fiscal year 2011 and
increased by $169,000 in fiscal year 2012.
These adjustments are onetime and must not
be applied to the base. This provision expires
June 30, 2012.

Sec. 12. TRANSFERS.

Subdivision 1. Grants. The commissioner of human services, with the approval
of the commissioner of management and budget, and after notification of the chairs of
the senate health and human services budget and policy committee and the house of
representatives health and human services finance committee, may transfer unencumbered
appropriation balances for the biennium ending June 30, 2013, within fiscal years among
the MFIP; general assistance; general assistance medical care under Minnesota Statutes,
section 256D.03, subdivision 3; medical assistance; MFIP child care assistance under
Minnesota Statutes, section 119B.05; Minnesota supplemental aid; MinnesotaCare, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration. Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee quarterly about transfers made under this provision.

Sec. 13. INDIRECT COSTS NOT TO FUND PROGRAMS.
The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. EXPIRATION OF UNCODIFIED LANGUAGE.
All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 15. EFFECTIVE DATE.
The provisions in this article are effective July 1, 2011, unless a different effective date is specified.