1.1 CONFERENCE COMMITTEE REPORT ON H. F. No. 1362

1.2 A bill for an act

1.3 relating to state government; establishing the health and human services budget;
1.4 making changes to licensing; Minnesota family investment program, children,
1.5 and adult supports; child support; the Department of Health; health care
1.6 programs; making technical changes; chemical and mental health; continuing
1.7 care programs; establishing the State-County Results, Accountability, and
1.8 Service Delivery Redesign; public health; health-related fees; making forecast
1.9 adjustments; creating work groups and pilot projects; requiring reports;
1.10 decreasing provider reimbursements; increasing fees; appropriating money to
1.11 various state agencies for health and human services provisions; amending
1.12 Minnesota Statutes 2008, sections 62J.495; 62J.496; 62J.497, subdivisions
1.13 1, 2, by adding subdivisions; 62J.692, subdivision 7; 103I.208, subdivision 2;
1.14 125A.744, subdivision 3; 144.0724, subdivisions 2, 4, 8, by adding subdivisions;
1.15 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision 1a; 144.125,
1.16 subdivision 1; 144.226, subdivision 4; 144.72, subdivisions 1, 3; 144.9501,
1.17 subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions 1g, 4;
1.18 144.9508, subdivisions 2, 3, 4; 144.9512, subdivision 2; 144.966, by adding
1.19 a subdivision; 144.97, subdivisions 2, 4, 6, by adding subdivisions; 144.98,
1.20 subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision 1; 144A.073, by
1.21 adding a subdivision; 144A.44, subdivision 2; 144A.46, subdivision 1; 148.108;
1.22 148.6445, by adding a subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180,
1.23 subdivisions 1, 2, 3, 5; 153A.17; 156.015; 157.15, by adding a subdivision;
1.24 157.16; 157.22; 176.011, subdivision 9; 245.462, subdivision 18; 245.470,
1.25 subdivision 1; 245.4871, subdivision 27; 245.488, subdivision 1; 245.4885,
1.26 subdivision 1; 245A.03, by adding a subdivision; 245A.10, subdivisions 2, 3,
1.27 4, 5, by adding subdivisions; 245A.11, subdivision 2a, by adding a subdivision;
1.28 245A.16, subdivisions 1, 3; 245C.03, subdivision 2; 245C.04, subdivisions 1,
1.29 3; 245C.05, subdivision 4; 245C.08, subdivision 2; 245C.10, subdivision 3,
1.30 by adding subdivisions; 245C.17, by adding a subdivision; 245C.20; 245C.21,
1.31 subdivision 1a; 245C.23, subdivision 2; 246.50, subdivision 5, by adding
1.32 subdivisions; 246.51, by adding subdivisions; 246.511; 246.52; 246B.01, by
1.33 adding subdivisions; 252.46, by adding a subdivision; 252.50, subdivision
1.34 1; 254A.02, by adding a subdivision; 254A.16, by adding a subdivision;
1.35 254B.03, subdivisions 1, 3, by adding a subdivision; 254B.05, subdivision
1.36 1; 254B.09, subdivision 2; 256.01, subdivision 2b, by adding subdivisions;
1.37 256.045, subdivision 3; 256.476, subdivisions 5, 11; 256.962, subdivisions
1.38 2, 6; 256.963, by adding a subdivision; 256.969, subdivision 3a; 256.975,
1.39 subdivision 7; 256.983, subdivision 1; 256B.04, subdivision 16; 256B.055,
1.40 subdivisions 7, 12; 256B.056, subdivisions 3, 3b, 3c, by adding a subdivision;
1.41 256B.057, subdivisions 3, 9, by adding a subdivision; 256B.0575; 256B.0595,
1.42 subdivisions 1, 2; 256B.06, subdivisions 4, 5; 256B.0621, subdivision 2;

2.1 256B.0622, subdivision 2; 256B.0623, subdivision 5; 256B.0624, subdivisions
2.2 5, 8; 256B.0625, subdivisions 3c, 7, 8, 8a, 9, 13e, 17, 19a, 19c, 26, 41, 42, 47;
2.3 256B.0631, subdivision 1; 256B.0641, subdivision 3; 256B.0651; 256B.0652;
2.4 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657, subdivisions
2.5 2, 6, 8, by adding a subdivision; 256B.08, by adding a subdivision; 256B.0911,
2.6 subdivisions 1, 1a, 3, 3a, 4a, 5, 6, 7, by adding subdivisions; 256B.0913,
2.7 subdivision 4; 256B.0915, subdivisions 3e, 3h, 5, by adding a subdivision;
2.8 256B.0916, subdivision 2; 256B.0917, by adding a subdivision; 256B.092,
2.9 subdivision 8a, by adding subdivisions; 256B.0943, subdivision 1; 256B.0944,
2.10 by adding a subdivision; 256B.0945, subdivision 4; 256B.0947, subdivision
2.11 1; 256B.15, subdivisions 1, 1a, 1h, 2, by adding subdivisions; 256B.37,
2.12 subdivisions 1, 5; 256B.434, by adding a subdivision; 256B.437, subdivision 6;
2.13 256B.441, subdivisions 48, 55, by adding subdivisions; 256B.49, subdivisions
2.14 12, 13, 14, 17, by adding subdivisions; 256B.501, subdivision 4a; 256B.5011,
2.15 subdivision 2; 256B.5012, by adding a subdivision; 256B.5013, subdivision
2.16 1; 256B.69, subdivisions 5a, 5c, 5f; 256B.76, subdivisions 1, 4, by adding
2.17 a subdivision; 256B.761; 256D.024, by adding a subdivision; 256D.03,
2.18 subdivision 4; 256D.051, subdivision 2a; 256D.0515; 256D.06, subdivision
2.19 2; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.49, subdivision 3;
2.20 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivisions 1a, 7c;
2.21 256J.08, subdivision 73a; 256J.20, subdivision 3; 256J.24, subdivisions 5a,
2.22 10; 256J.26, by adding a subdivision; 256J.37, subdivision 3a, by adding a
2.23 subdivision; 256J.38, subdivision 1; 256J.45, subdivision 3; 256J.49, subdivision
2.24 13; 256J.575, subdivisions 3, 6, 7; 256J.621; 256J.626, subdivision 6; 256J.751,
2.25 by adding a subdivision; 256J.95, subdivision 12; 256L.04, subdivision 10a,
2.26 by adding a subdivision; 256L.05, subdivision 1, by adding subdivisions;
2.27 256L.11, subdivisions 1, 7; 256L.12, subdivision 9; 256L.17, subdivision 3;
2.28 259.67, by adding a subdivision; 270A.09, by adding a subdivision; 295.52,
2.29 by adding a subdivision; 327.14, by adding a subdivision; 327.15; 327.16;
2.30 327.20, subdivision 1, by adding a subdivision; 393.07, subdivision 10; 501B.89,
2.31 by adding a subdivision; 518A.53, subdivisions 1, 4, 10; 519.05; 604A.33,
2.32 subdivision 1; 609.232, subdivision 11; 626.556, subdivision 3c; 626.5572,
2.33 subdivisions 6, 13, 21; Laws 2003, First Special Session chapter 14, article
2.34 13C, section 2, subdivision 1, as amended; Laws 2007, chapter 147, article
2.35 19, section 3, subdivision 4, as amended; proposing coding for new law in
2.36 Minnesota Statutes, chapters 62A; 62Q; 156; 246B; 254B; 256; 256B; proposing
2.37 coding for new law as Minnesota Statutes, chapter 402A; repealing Minnesota
2.38 Statutes 2008, sections 62U.08; 103I.112; 144.9501, subdivision 17b; 148D.180,
2.39 subdivision 8; 246.51, subdivision 1; 246.53, subdivision 3; 256.962, subdivision
2.40 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10,
2.41 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092, subdivision 5a; 256B.19,
2.42 subdivision 1d; 256B.431, subdivision 23; 256D.46; 256I.06, subdivision 9;
2.43 256J.626, subdivision 7; 327.14, subdivisions 5, 6; Laws 1988, chapter 689,
2.44 section 251; Minnesota Rules, parts 4626.2015, subpart 9; 9100.0400, subparts
2.45 1, 3; 9100.0500; 9100.0600; 9500.1243, subpart 3; 9500.1261, subparts 3, 4, 5,
2.46 6; 9555.6125, subpart 4, item B.

2.47 May 10, 2009

2.48 The Honorable Margaret Anderson Kelliher
2.49 Speaker of the House of Representatives

2.50 The Honorable James P. Metzen
2.51 President of the Senate

2.52 We, the undersigned conferees for H. F. No. 1362 report that we have agreed upon
2.53 the items in dispute and recommend as follows:

That the Senate recede from its amendment and that H. F. No. 1362 be further amended as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1
LICENSING

Section 1. Minnesota Statutes 2008, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) A county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover ~~the actual cost of background studies. A county agency may also charge a fee to a corporate applicant or corporate license holder to recover~~ the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

4.1 (2) if the county has a shortage of providers in the county's area; or
4.2 (3) for new providers.

4.3 Sec. 2. Minnesota Statutes 2008, section 245A.10, subdivision 3, is amended to read:

4.4 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
4.5 under subdivision 1, an applicant for an initial license or certification issued by the
4.6 commissioner shall submit a $500 application fee with each new application required
4.7 under this subdivision. The application fee shall not be prorated, is nonrefundable, and
4.8 is in lieu of the annual license or certification fee that expires on December 31. The
4.9 commissioner shall not process an application until the application fee is paid.
4.10 (b) Except as provided in clauses (1) to (3), an applicant shall apply for a license
4.11 to provide services at a specific location.
4.12 (1) For a license to provide ~~waivered~~ residential-based habilitation services to
4.13 persons with developmental disabilities ~~or related conditions~~ under chapter 245B, an
4.14 applicant shall submit an application for each county in which the ~~waivered~~ services will
4.15 be provided. Upon licensure, the license holder may provide services to persons in that
4.16 county plus no more than three persons at any one time in each of up to ten additional
4.17 counties. A license holder in one county may not provide services under the home and
4.18 community-based waiver for persons with developmental disabilities to more than three
4.19 people in a second county without holding a separate license for that second county.
4.20 Applicants or licensees providing services under this clause to not more than three persons
4.21 remain subject to the inspection fees established in section 245A.10, subdivision 2, for
4.22 each location. The license issued by the commissioner must state the name of each
4.23 additional county where services are being provided to persons with developmental
4.24 disabilities. A license holder must notify the commissioner before making any changes
4.25 that would alter the license information listed under section 245A.04, subdivision 7,
4.26 paragraph (a), including any additional counties where persons with developmental
4.27 disabilities are being served.
4.28 (2) For a license to provide supported employment, crisis respite, or
4.29 semi-independent living services to persons with developmental disabilities ~~or related~~
4.30 ~~conditions~~ under chapter 245B, an applicant shall submit a single application to provide
4.31 services statewide.
4.32 (3) For a license to provide independent living assistance for youth under section
4.33 245A.22, an applicant shall submit a single application to provide services statewide.

4.34 Sec. 3. Minnesota Statutes 2008, section 245A.11, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

(i) individualized plan of care;

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

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

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

(4) the facility was licensed for adult foster care before March 1, ~~2003~~ 2009.

6.1 (e) The commissioner shall not issue a new adult foster care license under paragraph
6.2 (d) after June 30, ~~2005~~ 2011. The commissioner shall allow a facility with an adult foster
6.3 care license issued under paragraph (d) before June 30, ~~2005~~ 2011, to continue with a
6.4 capacity of five adults if the license holder continues to comply with the requirements in
6.5 paragraph (d).

6.6 **EFFECTIVE DATE.** This section is effective July 1, 2009.

6.7 Sec. 4. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
6.8 to read:

6.9 Subd. 7a. **Alternate overnight supervision technology; adult foster care license.**
6.10 (a) The commissioner may grant an applicant or license holder an adult foster care license
6.11 for a residence that does not have a caregiver in the residence during normal sleeping
6.12 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses
6.13 monitoring technology to alert the license holder when an incident occurs that may
6.14 jeopardize the health, safety, or rights of a foster care recipient. The applicant or license
6.15 holder must comply with all other requirements under Minnesota Rules, parts 9555.5105
6.16 to 9555.6265, and the requirements under this subdivision. The license printed by the
6.17 commissioner must state in bold and large font:

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

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

6.21 (b) Applications for a license under this section must be submitted directly to
6.22 the Department of Human Services licensing division. The licensing division must
6.23 immediately notify the host county and lead county contract agency and the host county
6.24 licensing agency. The licensing division must collaborate with the county licensing
6.25 agency in the review of the application and the licensing of the program.

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

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

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

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

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

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

7.8 (i) a description of the triggering incident;

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

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

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

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

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

7.14 When no physical presence response is completed for a three-month period, the
7.15 license holder's written policies and procedures must require a physical presence response
7.16 drill be to conducted for which the effectiveness of the response protocol under paragraph
7.17 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

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

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

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

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

7.33 (i) the license holder has a written description of the interactive technological
7.34 applications that will assist the licenser holder in communicating with and assessing the
7.35 needs related to care, health, and safety of the foster care recipients. This interactive
7.36 technology must permit the license holder to remotely assess the well being of the foster

8.1 care recipient without requiring the initiation of the foster care recipient. Requiring the
8.2 foster care recipient to initiate a telephone call does not meet this requirement;
8.3 (ii) the license holder documents how the remote license holder is qualified and
8.4 capable of meeting the needs of the foster care recipients and assessing foster care
8.5 recipients' needs under item (i) during the absence of the license holder on-site;
8.6 (iii) the license holder maintains written procedures to dispatch emergency response
8.7 personnel to the site in the event of an identified emergency; and
8.8 (iv) each foster care recipient's individualized plan of care, individual service plan
8.9 under section 256B.092, subdivision 1b, if required, or individual resident placement
8.10 agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the
8.11 maximum response time, which may be greater than ten minutes, for the license holder
8.12 to be on-site for that foster care recipient.
8.13 (f) All placement agreements, individual service agreements, and plans applicable
8.14 to the foster care recipient must clearly state that the adult foster care license category is
8.15 a program without the presence of a caregiver in the residence during normal sleeping
8.16 hours; the protocols in place for responding to situations that present a serious risk to
8.17 health, safety, or rights of foster care recipients under paragraph (e), clause (1) or (2); and a
8.18 signed informed consent from each foster care recipient or the person's legal representative
8.19 documenting the person's or legal representative's agreement with placement in the
8.20 program. If electronic monitoring technology is used in the home, the informed consent
8.21 form must also explain the following:
8.22 (1) how any electronic monitoring is incorporated into the alternative supervision
8.23 system;
8.24 (2) the backup system for any electronic monitoring in times of electrical outages or
8.25 other equipment malfunctions;
8.26 (3) how the license holder is trained on the use of the technology;
8.27 (4) the event types and license holder response times established under paragraph (e);
8.28 (5) how the license holder protects the foster care recipient's privacy related to
8.29 electronic monitoring and related to any electronically recorded data generated by the
8.30 monitoring system. A foster care recipient may not be removed from a program under
8.31 this subdivision for failure to consent to electronic monitoring. The consent form must
8.32 explain where and how the electronically recorded data is stored, with whom it will be
8.33 shared, and how long it is retained; and
8.34 (6) the risks and benefits of the alternative overnight supervision system.

9.1 The written explanations under clauses (1) to (6) may be accomplished through
9.2 cross-references to other policies and procedures as long as they are explained to the
9.3 person giving consent, and the person giving consent is offered a copy.
9.4 (g) Nothing in this section requires the applicant or license holder to develop or
9.5 maintain separate or duplicative polices, procedures, documentation, consent forms, or
9.6 individual plans that may be required for other licensing standards, if the requirements of
9.7 this section are incorporated into those documents.
9.8 (h) The commissioner may grant variances to the requirements of this section
9.9 according to section 245A.04, subdivision 9.
9.10 (i) For the purposes of paragraphs (d) through (h), license holder has the meaning
9.11 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
9.12 contractors affiliated with the license holder.
9.13 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
9.14 remotely determine what action the license holder needs to take to protect the well-being
9.15 of the foster care recipient.

9.16 Sec. 5. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
9.17 to read:

9.18 Subd. 8b. **Adult foster care data privacy and security.** (a) An adult foster
9.19 care license holder who creates, collects, records, maintains, stores, or discloses any
9.20 individually identifiable recipient data, whether in an electronic or any other format,
9.21 must comply with the privacy and security provisions of applicable privacy laws and
9.22 regulations, including:
9.23 (1) the federal Health Insurance Portability and Accountability Act of 1996
9.24 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
9.25 title 45, part 160, and subparts A and E of part 164; and
9.26 (2) the Minnesota Government Data Practices Act as codified in chapter 13.
9.27 (b) For purposes of licensure, the license holder shall be monitored for compliance
9.28 with the following data privacy and security provisions:
9.29 (1) the license holder must control access to data on foster care recipients according
9.30 to the definitions of public and private data on individuals under section 13.02;
9.31 classification of the data on individuals as private under section 13.46, subdivision 2;
9.32 and control over the collection, storage, use, access, protection, and contracting related
9.33 to data according to section 13.05, in which the license holder is assigned the duties
9.34 of a government entity;

10.1 (2) the license holder must provide each foster care recipient with a notice that
10.2 meets the requirements under section 13.04, in which the license holder is assigned the
10.3 duties of the government entity, and that meets the requirements of Code of Federal
10.4 Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of
10.5 the data, and to whom and why it may be disclosed pursuant to law. The notice must
10.6 inform the recipient that the license holder uses electronic monitoring and, if applicable,
10.7 that recording technology is used;
10.8 (3) the license holder must not install monitoring cameras in bathrooms;
10.9 (4) electronic monitoring cameras must not be concealed from the foster care
10.10 recipients; and
10.11 (5) electronic video and audio recordings of foster care recipients shall not be stored
10.12 by the license holder for more than five days.
10.13 (c) The commissioner shall develop, and make available to license holders and
10.14 county licensing workers, a checklist of the data privacy provisions to be monitored
10.15 for purposes of licensure.

10.16 Sec. 6. Minnesota Statutes 2008, section 245A.16, subdivision 1, is amended to read:

10.17 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
10.18 private agencies that have been designated or licensed by the commissioner to perform
10.19 licensing functions and activities under section 245A.04 and background studies for
10.20 ~~adult foster care, family adult day services, and~~ family child care~~,~~ under chapter 245C; to
10.21 recommend denial of applicants under section 245A.05; to issue correction orders, to issue
10.22 variances, and recommend a conditional license under section 245A.06, or to recommend
10.23 suspending or revoking a license or issuing a fine under section 245A.07, shall comply
10.24 with rules and directives of the commissioner governing those functions and with this
10.25 section. The following variances are excluded from the delegation of variance authority
10.26 and may be issued only by the commissioner:
10.27 (1) dual licensure of family child care and child foster care, dual licensure of child
10.28 and adult foster care, and adult foster care and family child care;
10.29 (2) adult foster care maximum capacity;
10.30 (3) adult foster care minimum age requirement;
10.31 (4) child foster care maximum age requirement;
10.32 (5) variances regarding disqualified individuals except that county agencies may
10.33 issue variances under section 245C.30 regarding disqualified individuals when the county
10.34 is responsible for conducting a consolidated reconsideration according to sections 245C.25

and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; and

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours.

(b) County agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

Sec. 7. Minnesota Statutes 2008, section 245A.16, subdivision 3, is amended to read:

Subd. 3. **Recommendations to commissioner.** The county or private agency shall not make recommendations to the commissioner regarding licensure without first conducting an inspection, and for ~~adult foster care, family adult day services, and~~ family child care, a background study of the applicant under chapter 245C. The county or private agency must forward its recommendation to the commissioner regarding the appropriate licensing action within 20 working days of receipt of a completed application.

Sec. 8. Minnesota Statutes 2008, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at reapplication for a license for ~~adult foster care, family adult day services, and~~ family child care.

(c) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services for an adult foster care license holder that is also:

(1) registered under chapter 144D; or

(2) licensed to provide home and community-based services to people with disabilities at the foster care location and the license holder does not reside in the foster care residence; and

12.1 (3) the following conditions are met:

12.2 (i) a study of the individual was conducted either at the time of initial licensure or
12.3 when the individual became affiliated with the license holder;

12.4 (ii) the individual has been continuously affiliated with the license holder since
12.5 the last study was conducted; and

12.6 (iii) the last study of the individual was conducted on or after October 1, 1995.

12.7 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall
12.8 conduct a study of an individual required to be studied under section 245C.03, at the
12.9 time of reapplication for a child foster care license. The county or private agency shall
12.10 collect and forward to the commissioner the information required under section 245C.05,
12.11 subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background
12.12 study conducted by the commissioner of human services under this paragraph must
12.13 include a review of the information required under section 245C.08, subdivisions 1,
12.14 paragraph (a), clauses (1) to (5), 3, and 4.

12.15 (e) The commissioner of human services shall conduct a background study of an
12.16 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
12.17 to (6), who is newly affiliated with a child foster care license holder. The county or
12.18 private agency shall collect and forward to the commissioner the information required
12.19 under section 245C.05, subdivisions 1 and 5. The background study conducted by the
12.20 commissioner of human services under this paragraph must include a review of the
12.21 information required under section 245C.08, subdivisions 1, 3, and 4.

12.22 (f) From January 1, 2010, to December 31, 2012, unless otherwise specified in
12.23 paragraph (c), the commissioner shall conduct a study of an individual required to be
12.24 studied under section 245C.03 at the time of reapplication for an adult foster care or family
12.25 adult day services license: (1) the county shall collect and forward to the commissioner
12.26 the information required under section 245C.05, subdivision 1, paragraphs (a) and (b),
12.27 and subdivision 5, paragraphs (a) and (b), for background studies conducted by the
12.28 commissioner for adult foster care and family adult day services when the license holder
12.29 resides in the adult foster care or family adult day services residence; (2) the license
12.30 holder shall collect and forward to the commissioner the information required under
12.31 section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b),
12.32 for background studies conducted by the commissioner for adult foster care when the
12.33 license holder does not reside in the adult foster care residence; and (3) the background
12.34 study conducted by the commissioner under this paragraph must include a review of the
12.35 information required under section 245C.08, subdivision 1, paragraph (a), clauses (1)
12.36 to (5), and subdivisions 3 and 4.

13.1 (g) The commissioner shall conduct a background study of an individual specified
13.2 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
13.3 affiliated with an adult foster care or family adult day services license holder: (1) the
13.4 county shall collect and forward to the commissioner the information required under
13.5 section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a)
13.6 and (b), for background studies conducted by the commissioner for adult foster care
13.7 and family adult day services when the license holder resides in the adult foster care or
13.8 family adult day services residence; (2) the license holder shall collect and forward to the
13.9 commissioner the information required under section 245C.05, subdivisions 1, paragraphs
13.10 (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the
13.11 commissioner for adult foster care when the license holder does not reside in the adult
13.12 foster care residence; and (3) the background study conducted by the commissioner under
13.13 this paragraph must include a review of the information required under section 245C.08,
13.14 subdivision 1, paragraph (a), and subdivisions 3 and 4.

13.15 (h) Applicants for licensure, license holders, and other entities as provided in this
13.16 chapter must submit completed background study forms to the commissioner before
13.17 individuals specified in section 245C.03, subdivision 1, begin positions allowing direct
13.18 contact in any licensed program.

13.19 ~~(g)~~ (i) For purposes of this section, a physician licensed under chapter 147 is
13.20 considered to be continuously affiliated upon the license holder's receipt from the
13.21 commissioner of health or human services of the physician's background study results.

13.22 Sec. 9. Minnesota Statutes 2008, section 245C.05, is amended by adding a subdivision
13.23 to read:

13.24 Subd. 2b. **County agency to collect and forward information to the**
13.25 **commissioner.** For background studies related to adult foster care and family adult
13.26 day services when the license holder resides in the adult foster care or family adult
13.27 day services residence, the county agency must collect the information required under
13.28 subdivision 1 and forward it to the commissioner.

13.29 Sec. 10. Minnesota Statutes 2008, section 245C.05, subdivision 4, is amended to read:

13.30 Subd. 4. **Electronic transmission.** For background studies conducted by the
13.31 Department of Human Services, the commissioner shall implement a system for the
13.32 electronic transmission of:

13.33 (1) background study information to the commissioner;

13.34 (2) background study results to the license holder; ~~and~~

14.1 (3) background study results to county and private agencies for background studies
14.2 conducted by the commissioner for child foster care; and
14.3 (4) background study results to county agencies for background studies conducted
14.4 by the commissioner for adult foster care and family adult day services.

14.5 Sec. 11. Minnesota Statutes 2008, section 245C.08, subdivision 2, is amended to read:

14.6 Subd. 2. **Background studies conducted by a county agency.** (a) For a background
14.7 study conducted by a county agency for ~~adult foster care, family adult day services, and~~
14.8 family child care services, the commissioner shall review:
14.9 (1) information from the county agency's record of substantiated maltreatment
14.10 of adults and the maltreatment of minors;
14.11 (2) information from juvenile courts as required in subdivision 4 for individuals
14.12 listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); and
14.13 (3) information from the Bureau of Criminal Apprehension.
14.14 (b) If the individual has resided in the county for less than five years, the study shall
14.15 include the records specified under paragraph (a) for the previous county or counties of
14.16 residence for the past five years.
14.17 (c) Notwithstanding expungement by a court, the county agency may consider
14.18 information obtained under paragraph (a), clause (3), unless the commissioner received
14.19 notice of the petition for expungement and the court order for expungement is directed
14.20 specifically to the commissioner.

14.21 Sec. 12. Minnesota Statutes 2008, section 245C.10, is amended by adding a
14.22 subdivision to read:

14.23 Subd. 5. **Adult foster care services.** The commissioner shall recover the cost of
14.24 background studies required under section 245C.03, subdivision 1, for the purposes of
14.25 adult foster care and family adult day services licensing, through a fee of no more than
14.26 $20 per study charged to the license holder. The fees collected under this subdivision are
14.27 appropriated to the commissioner for the purpose of conducting background studies.

14.28 Sec. 13. Minnesota Statutes 2008, section 245C.10, is amended by adding a
14.29 subdivision to read:

14.30 Subd. 8. **Private agencies.** The commissioner shall recover the cost of conducting
14.31 background studies under section 245C.33 for studies initiated by private agencies for the
14.32 purpose of adoption through a fee of no more than $70 per study charged to the private

15.1 agency. The fees collected under this subdivision are appropriated to the commissioner for
15.2 the purpose of conducting background studies.

15.3 Sec. 14. Minnesota Statutes 2008, section 245C.17, is amended by adding a
15.4 subdivision to read:

15.5 Subd. 6. **Notice to county agency.** For studies on individuals related to a license
15.6 to provide adult foster care and family adult day services, the commissioner shall also
15.7 provide a notice of the background study results to the county agency that initiated the
15.8 background study.

15.9 Sec. 15. Minnesota Statutes 2008, section 245C.20, is amended to read:

15.10 **245C.20 LICENSE HOLDER RECORD KEEPING.**

15.11 A licensed program shall document the date the program initiates a background
15.12 study under this chapter in the program's personnel files. When a background study is
15.13 completed under this chapter, a licensed program shall maintain a notice that the study
15.14 was undertaken and completed in the program's personnel files. Except when background
15.15 studies are initiated through the commissioner's online system, if a licensed program
15.16 has not received a response from the commissioner under section 245C.17 within 45
15.17 days of initiation of the background study request, the licensed program must contact the
15.18 ~~commissioner~~ human services licensing division to inquire about the status of the study. If
15.19 a license holder initiates a background study under the commissioner's online system, but
15.20 the background study subject's name does not appear in the list of active or recent studies
15.21 initiated by that license holder, the license holder must either contact the human services
15.22 licensing division or resubmit the background study information online for that individual.

15.23 Sec. 16. Minnesota Statutes 2008, section 245C.21, subdivision 1a, is amended to read:

15.24 Subd. 1a. **Submission of reconsideration request ~~to county or private agency~~.** (a)
15.25 For disqualifications related to studies conducted by county agencies for family child care,
15.26 and for disqualifications related to studies conducted by the commissioner for child foster
15.27 care, adult foster care, and family adult day services, the individual shall submit the request
15.28 for reconsideration to the county ~~or private~~ agency that initiated the background study.

15.29 (b) For disqualifications related to studies conducted by the commissioner for child
15.30 foster care, the individual shall submit the request for reconsideration to the private agency
15.31 that initiated the background study.

16.1 (c) A reconsideration request shall be submitted within 30 days of the individual's
16.2 receipt of the disqualification notice or the time frames specified in subdivision 2,
16.3 whichever time frame is shorter.

16.4 ~~(c)~~ (d) The county or private agency shall forward the individual's request for
16.5 reconsideration and provide the commissioner with a recommendation whether to set aside
16.6 the individual's disqualification.

16.7 Sec. 17. Minnesota Statutes 2008, section 245C.23, subdivision 2, is amended to read:

16.8 Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The
16.9 commissioner shall notify the license holder of the disqualification and order the license
16.10 holder to immediately remove the individual from any position allowing direct contact
16.11 with persons receiving services from the license holder if:

16.12 (1) the individual studied does not submit a timely request for reconsideration
16.13 under section 245C.21;

16.14 (2) the individual submits a timely request for reconsideration, but the commissioner
16.15 does not set aside the disqualification for that license holder under section 245C.22;

16.16 (3) an individual who has a right to request a hearing under sections 245C.27 and
16.17 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
16.18 not request a hearing within the specified time; or

16.19 (4) an individual submitted a timely request for a hearing under sections 245C.27
16.20 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
16.21 disqualification under section 245A.08, subdivision 5, or 256.045.

16.22 (b) If the commissioner does not set aside the disqualification under section 245C.22,
16.23 and the license holder was previously ordered under section 245C.17 to immediately
16.24 remove the disqualified individual from direct contact with persons receiving services or
16.25 to ensure that the individual is under continuous, direct supervision when providing direct
16.26 contact services, the order remains in effect pending the outcome of a hearing under
16.27 sections 245C.27 and 256.045, or 245C.28 and chapter 14.

16.28 (c) For background studies related to child foster care, the commissioner shall
16.29 also notify the county or private agency that initiated the study of the results of the
16.30 reconsideration.

16.31 (d) For background studies related to adult foster care and family adult day services,
16.32 the commissioner shall also notify the county that initiated the study of the results of
16.33 the reconsideration.

17.1 Sec. 18. Minnesota Statutes 2008, section 256B.092, is amended by adding a
17.2 subdivision to read:

17.3 Subd. 5b. **Revised per diem based on legislated rate reduction.** Notwithstanding
17.4 section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction
17.5 that impacts payment to providers of adult foster care services, the commissioner may
17.6 issue adult foster care licenses that permit a capacity of five adults. The application for a
17.7 five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to
17.8 admission of the fifth recipient of adult foster care services, the county must negotiate a
17.9 revised per diem rate for room and board and waiver services that reflects the legislated
17.10 rate reduction and results in an overall average per diem reduction for all foster care
17.11 recipients in that home. The revised per diem must allow the provider to maintain, as
17.12 much as possible, the level of services or enhanced services provided in the residence,
17.13 while mitigating the losses of the legislated rate reduction.

17.14 **EFFECTIVE DATE.** This section is effective July 1, 2009.

17.15 Sec. 19. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

17.16 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
17.17 that the average per capita expenditures estimated in any fiscal year for home and
17.18 community-based waiver recipients does not exceed the average per capita expenditures
17.19 that would have been made to provide institutional services for recipients in the absence
17.20 of the waiver.

17.21 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
17.22 need-based methods for allocating to local agencies the home and community-based
17.23 waivered service resources available to support recipients with disabilities in need of
17.24 the level of care provided in a nursing facility or a hospital. The commissioner shall
17.25 allocate resources to single counties and county partnerships in a manner that reflects
17.26 consideration of:

17.27 (1) an incentive-based payment process for achieving outcomes;

17.28 (2) the need for a state-level risk pool;

17.29 (3) the need for retention of management responsibility at the state agency level; and

17.30 (4) a phase-in strategy as appropriate.

17.31 (c) Until the allocation methods described in paragraph (b) are implemented, the
17.32 annual allowable reimbursement level of home and community-based waiver services
17.33 shall be the greater of:

18.1 (1) the statewide average payment amount which the recipient is assigned under the
18.2 waiver reimbursement system in place on June 30, 2001, modified by the percentage of
18.3 any provider rate increase appropriated for home and community-based services; or
18.4 (2) an amount approved by the commissioner based on the recipient's extraordinary
18.5 needs that cannot be met within the current allowable reimbursement level. The
18.6 increased reimbursement level must be necessary to allow the recipient to be discharged
18.7 from an institution or to prevent imminent placement in an institution. The additional
18.8 reimbursement may be used to secure environmental modifications; assistive technology
18.9 and equipment; and increased costs for supervision, training, and support services
18.10 necessary to address the recipient's extraordinary needs. The commissioner may approve
18.11 an increased reimbursement level for up to one year of the recipient's relocation from an
18.12 institution or up to six months of a determination that a current waiver recipient is at
18.13 imminent risk of being placed in an institution.
18.14 (d) Beginning July 1, 2001, medically necessary private duty nursing services will be
18.15 authorized under this section as complex and regular care according to sections 256B.0651
18.16 and 256B.0653 to 256B.0656. The rate established by the commissioner for registered
18.17 nurse or licensed practical nurse services under any home and community-based waiver as
18.18 of January 1, 2001, shall not be reduced.
18.19 (e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
18.20 legislature adopts a rate reduction that impacts payment to providers of adult foster care
18.21 services, the commissioner may issue adult foster care licenses that permit a capacity of
18.22 five adults. The application for a five-bed license must meet the requirements of section
18.23 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care
18.24 services, the county must negotiate a revised per diem rate for room and board and waiver
18.25 services that reflects the legislated rate reduction and results in an overall average per
18.26 diem reduction for all foster care recipients in that home. The revised per diem must allow
18.27 the provider to maintain, as much as possible, the level of services or enhanced services
18.28 provided in the residence, while mitigating the losses of the legislated rate reduction.

18.29 **EFFECTIVE DATE.** This section is effective July 1, 2009.

18.30 Sec. 20. **WAIVER.**

18.31 By December 1, 2009, the commissioner shall request all federal approvals and
18.32 waiver amendments to the disability home and community-based waivers to allow properly
18.33 licensed adult foster care homes to provide residential services for up to five individuals.

18.34 **EFFECTIVE DATE.** This section is effective July 1, 2009.

19.1 Sec. 21. **REPEALER.**

19.2 (a) Minnesota Statutes 2008, section 245C.11, subdivisions 1 and 2, are repealed.

19.3 (b) Minnesota Statutes 2008, section 256B.092, subdivision 5a, is repealed effective
19.4 July 1, 2009.

19.5 (c) Minnesota Rules, part 9555.6125, subpart 4, item B, is repealed.

19.6 **ARTICLE 2**
19.7 **MFIP/CHILD CARE/ADULT SUPPORTS/FRAUD PREVENTION**

19.8 Section 1. Minnesota Statutes 2008, section 119B.09, subdivision 7, is amended to read:

19.9 Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child
19.10 care assistance under this chapter is the later of the date the application was signed; the
19.11 beginning date of employment, education, or training; the date the infant is born for
19.12 applicants to the at-home infant care program; or the date a determination has been made
19.13 that the applicant is a participant in employment and training services under Minnesota
19.14 Rules, part 3400.0080, or chapter 256J.

19.15 (b) Payment ceases for a family under the at-home infant child care program when a
19.16 family has used a total of 12 months of assistance as specified under section 119B.035.
19.17 Payment of child care assistance for employed persons on MFIP is effective the date of
19.18 employment or the date of MFIP eligibility, whichever is later. Payment of child care
19.19 assistance for MFIP or DWP participants in employment and training services is effective
19.20 the date of commencement of the services or the date of MFIP or DWP eligibility,
19.21 whichever is later. Payment of child care assistance for transition year child care must be
19.22 made retroactive to the date of eligibility for transition year child care.

19.23 (c) Notwithstanding paragraph (b), payment of child care assistance for participants
19.24 eligible under section 119B.05 may only be made retroactive for a maximum of six
19.25 months from the date of application for child care assistance.

19.26 **EFFECTIVE DATE.** This section is effective October 1, 2009.

19.27 Sec. 2. Minnesota Statutes 2008, section 119B.13, subdivision 6, is amended to read:

19.28 Subd. 6. **Provider payments.** (a) Counties or the state shall make vendor payments
19.29 to the child care provider or pay the parent directly for eligible child care expenses.

19.30 (b) If payments for child care assistance are made to providers, the provider shall
19.31 bill the county for services provided within ten days of the end of the service period. If
19.32 bills are submitted within ten days of the end of the service period, a county or the state
19.33 shall issue payment to the provider of child care under the child care fund within 30 days

20.1 of receiving a bill from the provider. Counties or the state may establish policies that
20.2 make payments on a more frequent basis.

20.3 (c) ~~All bills~~ If a provider has received an authorization of care and been issued a
20.4 billing form for an eligible family, the bill must be submitted within 60 days of the last
20.5 date of service on the bill. A county may pay a bill submitted more than 60 days after
20.6 the last date of service if the provider shows good cause why the bill was not submitted
20.7 within 60 days. Good cause must be defined in the county's child care fund plan under
20.8 section 119B.08, subdivision 3, and the definition of good cause must include county
20.9 error. A county may not pay any bill submitted more than a year after the last date of
20.10 service on the bill.

20.11 (d) If a provider provided care for a time period without receiving an authorization
20.12 of care and a billing form for an eligible family, payment of child care assistance may only
20.13 be made retroactively for a maximum of six months from the date the provider is issued
20.14 an authorization of care and billing form.

20.15 (e) A county may stop payment issued to a provider or may refuse to pay a bill
20.16 submitted by a provider if:

20.17 (1) the provider admits to intentionally giving the county materially false information
20.18 on the provider's billing forms; or

20.19 (2) a county finds by a preponderance of the evidence that the provider intentionally
20.20 gave the county materially false information on the provider's billing forms.

20.21 ~~(e)~~ (f) A county's payment policies must be included in the county's child care plan
20.22 under section 119B.08, subdivision 3. If payments are made by the state, in addition to
20.23 being in compliance with this subdivision, the payments must be made in compliance
20.24 with section 16A.124.

20.25 **EFFECTIVE DATE.** This section is effective October 1, 2009.

20.26 Sec. 3. Minnesota Statutes 2008, section 119B.21, subdivision 5, is amended to read:

20.27 Subd. 5. **Child care services grants.** (a) A child care resource and referral program
20.28 designated under section 119B.19, subdivision 1a, may award child care services grants
20.29 for:

20.30 (1) creating new licensed child care facilities and expanding existing facilities,
20.31 including, but not limited to, supplies, equipment, facility renovation, and remodeling;

20.32 (2) improving licensed child care facility programs;

20.33 (3) staff training and development services including, but not limited to, in-service
20.34 training, curriculum development, accreditation, certification, consulting, resource

21.1 centers, program and resource materials, supporting effective teacher-child interactions,
21.2 child-focused teaching, and content-driven classroom instruction;
21.3 (4) interim financing;
21.4 (5) capacity building through the purchase of appropriate technology to create,
21.5 enhance, and maintain business management systems;
21.6 (6) emergency assistance for child care programs;
21.7 (7) new programs or projects for the creation, expansion, or improvement of
21.8 programs that serve ethnic immigrant and refugee communities; and
21.9 (8) targeted recruitment initiatives to expand and build the capacity of the child
21.10 care system and to improve the quality of care provided by legal nonlicensed child care
21.11 providers.
21.12 (b) A child care resource and referral program designated under section 119B.19,
21.13 subdivision 1a, may award child care services grants to:
21.14 (1) licensed providers;
21.15 (2) providers in the process of being licensed;
21.16 (3) corporations or public agencies that develop or provide child care services;
21.17 (4) school-age care programs;
21.18 (5) legal nonlicensed or family, friend, and neighbor care providers; or
21.19 (6) any combination of clauses (1) to (5).
21.20 (c) A recipient of a child care services grant for facility improvements, interim
21.21 financing, or staff training and development must provide a 25 percent local match.
21.22 <u>(d) Beginning July 1, 2009, grants under this subdivision shall be increasingly</u>
21.23 <u>awarded for activities that improve provider quality, including activities under paragraph</u>
21.24 <u>(a), clauses (1) to (3) and (7).</u>

21.25 Sec. 4. Minnesota Statutes 2008, section 119B.21, subdivision 10, is amended to read:

21.26 Subd. 10. **Family child care technical assistance grants.** (a) A child care resource
21.27 and referral organization designated under section 119B.19, subdivision 1a, may award
21.28 technical assistance grants of up to $1,000. These grants may be used for:
21.29 (1) facility improvements, including, but not limited to, improvements to meet
21.30 licensing requirements;
21.31 (2) improvements to expand a child care facility or program;
21.32 (3) toys<u>, materials,</u> and equipment <u>to improve the learning environment</u>;
21.33 (4) technology and software to create, enhance, and maintain business management
21.34 systems;
21.35 (5) start-up costs;

(6) staff training and development; and

(7) other uses approved by the commissioner.

(b) A child care resource and referral program may award family child care technical assistance grants to:

(1) licensed family child care providers;

(2) child care providers in the process of becoming licensed; or

(3) legal nonlicensed or family, friend, and neighbor care providers.

(c) A local match is not required for a family child care technical assistance grant.

(d) Beginning July 1, 2009, grants under this subdivision shall be increasingly awarded for activities that improve provider quality, including activities under paragraph (a), clauses (1), (3), and (6).

Sec. 5. Minnesota Statutes 2008, section 119B.231, subdivision 2, is amended to read:

Subd. 2. **Provider eligibility.** (a) To be considered for an SRSA, a provider shall apply to the commissioner or have been chosen as an SRSA provider prior to June 30, 2009, and have complied with all requirements of the SRSA agreement. Priority for funds is given to providers who had agreements prior to June 30, 2009. If sufficient funds are available, the commissioner shall make applications available to additional providers. To be eligible to apply for an SRSA, a provider shall:

(1) be eligible for child care assistance payments under chapter 119B;

(2) have at least 25 percent of the children enrolled with the provider subsidized through the child care assistance program;

(3) provide full-time, full-year child care services; and

(4) ~~serve at least one child who is subsidized through the child care assistance program and who is expected to enter kindergarten within the following 30 months~~ have obtained a level 3 or 4 star rating under the voluntary Parent Aware quality rating system.

(b) The commissioner may waive the 25 percent requirement in paragraph (a), clause (2), if necessary to achieve geographic distribution of SRSA providers and diversity of types of care provided by SRSA providers.

(c) An eligible provider who would like to enter into an SRSA with the commissioner shall submit an SRSA application. To determine whether to enter into an SRSA with a provider, the commissioner shall evaluate the following factors:

(1) the ~~qualifications of the provider and the provider's staff~~ provider's Parent Aware rating score;

~~(2) the provider's staff-child ratios;~~

~~(3) the provider's curriculum;~~

23.1 ~~(4) the provider's current or planned parent education activities;~~

23.2 ~~(5)~~ (2) the provider's current or planned social service and employment linkages;

23.3 ~~(6) the provider's child development assessment plan;~~

23.4 ~~(7)~~ (3) the geographic distribution needed for SRSA providers;

23.5 ~~(8)~~ (4) the inclusion of a variety of child care delivery models; and

23.6 ~~(9)~~ (5) other related factors determined by the commissioner.

23.7 Sec. 6. Minnesota Statutes 2008, section 119B.231, subdivision 3, is amended to read:

23.8 Subd. 3. **Family and child eligibility.** (a) A family eligible to choose an SRSA
23.9 provider for their children shall:

23.10 (1) be eligible to receive child care assistance under any provision in chapter 119B
23.11 except section 119B.035;

23.12 (2) be in an authorized activity for an average of at least 35 hours per week when
23.13 initial eligibility is determined; and

23.14 (3) include a child who has not yet entered kindergarten.

23.15 (b) A family who is determined to be eligible to choose an SRSA provider remains
23.16 eligible to be paid at a higher rate through the SRSA provider when the following
23.17 conditions exist:

23.18 (1) the child attends child care with the SRSA provider a minimum of 25 hours per
23.19 week, on average;

23.20 (2) the family has a child who has not yet entered kindergarten; and

23.21 (3) the family maintains eligibility under chapter 119B except section 119B.035.

23.22 (c) ~~For the 12 months~~ After initial eligibility has been determined, a decrease in the
23.23 family's authorized activities to an average of less than 35 hours per week does not result
23.24 in ineligibility for the SRSA rate. A family must continue to maintain eligibility under this
23.25 chapter and be in an authorized activity.

23.26 (d) A family that moves between counties but continues to use the same SRSA
23.27 provider shall continue to receive SRSA funding for the increased payments.

23.28 Sec. 7. Minnesota Statutes 2008, section 119B.231, subdivision 4, is amended to read:

23.29 Subd. 4. **Requirements of providers.** An SRSA must include assessment,
23.30 evaluation, and reporting requirements that promote the goals of improved school
23.31 readiness and movement toward appropriate child development milestones. A provider
23.32 who enters into an SRSA shall comply with all SRSA requirements, including the
23.33 assessment, evaluation, and reporting requirements in the SRSA. Providers who have been
23.34 selected previously for SRSAs must begin the process to obtain a rating using Parent

24.1 Aware according to timelines established by the commissioner. If the initial Parent Aware
24.2 rating is less than three stars, the provider must submit a plan to improve the rating. If
24.3 a 3 or 4 star rating is not obtained within established timelines, the commissioner may
24.4 consider continuation of the agreement, depending upon the progress made and other
24.5 factors. Providers who apply and are selected for a new SRSA agreement on or after July
24.6 1, 2009, must have a level 3 or 4 star rating under the voluntary Parent Aware quality
24.7 rating system at the time the SRSA agreement is signed.

24.8 Sec. 8. Minnesota Statutes 2008, section 145A.17, is amended by adding a subdivision
24.9 to read:

24.10 Subd. 4a. **Home visitors as MFIP employment and training service providers.**
24.11 The county social service agency and the local public health department may mutually
24.12 agree to utilize home visitors under this section as MFIP employment and training service
24.13 providers under section 256J.49, subdivision 4, for MFIP participants who are: (1) ill or
24.14 incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section
24.15 256J.54. The county social service agency and the local public health department may
24.16 also mutually agree to utilize home visitors to provide outreach to MFIP families who are
24.17 being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

24.18 Sec. 9. Minnesota Statutes 2008, section 256.045, subdivision 3, is amended to read:

24.19 Subd. 3. **State agency hearings.** (a) State agency hearings are available for the
24.20 following:

24.21 (1) any person applying for, receiving or having received public assistance, medical
24.22 care, or a program of social services granted by the state agency or a county agency or
24.23 the federal Food Stamp Act whose application for assistance is denied, not acted upon
24.24 with reasonable promptness, or whose assistance is suspended, reduced, terminated, or
24.25 claimed to have been incorrectly paid;

24.26 (2) any patient or relative aggrieved by an order of the commissioner under section
24.27 252.27;

24.28 (3) a party aggrieved by a ruling of a prepaid health plan;

24.29 (4) except as provided under chapter 245C, any individual or facility determined by
24.30 a lead agency to have maltreated a vulnerable adult under section 626.557 after they have
24.31 exercised their right to administrative reconsideration under section 626.557;

24.32 (5) any person whose claim for foster care payment according to a placement of the
24.33 child resulting from a child protection assessment under section 626.556 is denied or not
24.34 acted upon with reasonable promptness, regardless of funding source;

25.1 (6) any person to whom a right of appeal according to this section is given by other
25.2 provision of law;
25.3 (7) an applicant aggrieved by an adverse decision to an application for a hardship
25.4 waiver under section 256B.15;
25.5 (8) an applicant aggrieved by an adverse decision to an application or redetermination
25.6 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;
25.7 (9) except as provided under chapter 245A, an individual or facility determined
25.8 to have maltreated a minor under section 626.556, after the individual or facility has
25.9 exercised the right to administrative reconsideration under section 626.556; ~~or~~
25.10 (10) except as provided under chapter 245C, an individual disqualified under sections
25.11 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance
25.12 of the evidence that the individual has committed an act or acts that meet the definition
25.13 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make
25.14 reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
25.15 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
25.16 this clause in which the basis for a disqualification is serious or recurring maltreatment,
25.17 which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated
25.18 into a single fair hearing. In such cases, the scope of review by the human services referee
25.19 shall include both the maltreatment determination and the disqualification. The failure to
25.20 exercise the right to an administrative reconsideration shall not be a bar to a hearing under
25.21 this section if federal law provides an individual the right to a hearing to dispute a finding
25.22 of maltreatment. Individuals and organizations specified in this section may contest the
25.23 specified action, decision, or final disposition before the state agency by submitting a
25.24 written request for a hearing to the state agency within 30 days after receiving written
25.25 notice of the action, decision, or final disposition, or within 90 days of such written notice
25.26 if the applicant, recipient, patient, or relative shows good cause why the request was not
25.27 submitted within the 30-day time limit~~.~~; or
25.28 (11) any person with an outstanding debt resulting from receipt of public assistance,
25.29 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
25.30 Department of Human Services or a county agency. The scope of the appeal is the validity
25.31 of the claimant agency's intention to request a setoff of a refund under chapter 270A
25.32 against the debt.
25.33 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
25.34 (10), is the only administrative appeal to the final agency determination specifically,
25.35 including a challenge to the accuracy and completeness of data under section 13.04.
25.36 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment

26.1 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
26.2 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
26.3 contested case proceeding under the provisions of chapter 14. Hearings requested under
26.4 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
26.5 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
26.6 only available when there is no juvenile court or adult criminal action pending. If such
26.7 action is filed in either court while an administrative review is pending, the administrative
26.8 review must be suspended until the judicial actions are completed. If the juvenile court
26.9 action or criminal charge is dismissed or the criminal action overturned, the matter may be
26.10 considered in an administrative hearing.

26.11 (c) For purposes of this section, bargaining unit grievance procedures are not an
26.12 administrative appeal.

26.13 (d) The scope of hearings involving claims to foster care payments under paragraph
26.14 (a), clause (5), shall be limited to the issue of whether the county is legally responsible
26.15 for a child's placement under court order or voluntary placement agreement and, if so,
26.16 the correct amount of foster care payment to be made on the child's behalf and shall not
26.17 include review of the propriety of the county's child protection determination or child
26.18 placement decision.

26.19 (e) A vendor of medical care as defined in section 256B.02, subdivision 7, or a
26.20 vendor under contract with a county agency to provide social services is not a party and
26.21 may not request a hearing under this section, except if assisting a recipient as provided in
26.22 subdivision 4.

26.23 (f) An applicant or recipient is not entitled to receive social services beyond the
26.24 services prescribed under chapter 256M or other social services the person is eligible
26.25 for under state law.

26.26 (g) The commissioner may summarily affirm the county or state agency's proposed
26.27 action without a hearing when the sole issue is an automatic change due to a change in
26.28 state or federal law.

26.29 Sec. 10. Minnesota Statutes 2008, section 256.983, subdivision 1, is amended to read:

26.30 Subdivision 1. **Programs established.** Within the limits of available appropriations,
26.31 the commissioner of human services shall require the maintenance of budget neutral
26.32 fraud prevention investigation programs in the counties participating in the fraud
26.33 prevention investigation project established under this section. If funds are sufficient,
26.34 the commissioner may also extend fraud prevention investigation programs to other
26.35 counties provided the expansion is budget neutral to the state. Under any expansion, the

27.1 commissioner has the final authority in decisions regarding the creation and realignment
27.2 of individual county or regional operations.

27.3 Sec. 11. Minnesota Statutes 2008, section 256I.03, subdivision 7, is amended to read:

27.4 Subd. 7. **Countable income.** "Countable income" means all income received by an
27.5 applicant or recipient less any applicable exclusions or disregards. For a recipient of any
27.6 cash benefit from the SSI program, countable income means the SSI benefit limit in effect
27.7 at the time the person is in a GRH ~~setting less $20~~, less the medical assistance personal
27.8 needs allowance. If the SSI limit has been reduced for a person due to events occurring
27.9 prior to the persons entering the GRH setting, countable income means actual income less
27.10 any applicable exclusions and disregards.

27.11 **EFFECTIVE DATE.** This section is effective April 1, 2010.

27.12 Sec. 12. Minnesota Statutes 2008, section 256I.05, subdivision 7c, is amended to read:

27.13 Subd. 7c. **Demonstration project.** The commissioner is authorized to pursue the
27.14 expansion of a demonstration project under federal food stamp regulation for the purpose
27.15 of gaining additional federal reimbursement of food and nutritional costs currently paid by
27.16 the state group residential housing program. The commissioner shall seek approval no
27.17 later than ~~January 1, 2004~~ October 1, 2009. Any reimbursement received is nondedicated
27.18 revenue to the general fund.

27.19 Sec. 13. Minnesota Statutes 2008, section 256J.24, subdivision 5, is amended to read:

27.20 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based
27.21 on the number of persons in the assistance unit eligible for both food and cash assistance
27.22 unless the restrictions in subdivision 6 on the birth of a child apply. The following table
27.23 represents the transitional standards effective ~~October 1, 2007~~ April 1, 2009.

	Number of Eligible People	Transitional Standard	Cash Portion	Food Portion
27.24				
27.25	1	~~$391~~ $428:	$250	~~$141~~ $178
27.26	2	~~$698~~ $764:	$437	~~$261~~ $327
27.27	3	~~$910~~ $1,005:	$532	~~$378~~ $473
27.28	4	~~$1,091~~ $1,217:	$621	~~$470~~ $596
27.29	5	~~$1,245~~ $1,393:	$697	~~$548~~ $696
27.30	6	~~$1,425~~ $1,602:	$773	~~$652~~ $829

7	~~$1,553~~ $1,748:	$850	~~$703~~ $898
8	~~$1,713~~ $1,934:	$916	~~$797~~ $1,018
9	~~$1,871~~ $2,119:	$980	~~$891~~ $1,139
10	~~$2,024~~ $2,298:	$1,035	~~$989~~ $1,263
over 10	add ~~$151~~ $178:	$53	~~$98~~ $125

per additional member.

The commissioner shall annually publish in the State Register the transitional standard for an assistance unit sizes 1 to 10 including a breakdown of the cash and food portions.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2009.

Sec. 14. Minnesota Statutes 2008, section 256J.425, subdivision 2, is amended to read:

Subd. 2. **Ill or incapacitated.** (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) participants who are suffering from an illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and ~~prevents the person from obtaining or retaining employment~~ severely limits the person's ability to obtain or maintain suitable employment. These participants must follow the treatment recommendations of the qualified professional certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required as a caregiver because of the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or retaining employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3).

Sec. 15. Minnesota Statutes 2008, section 256J.425, subdivision 3, is amended to read:

Subd. 3. **Hard-to-employ participants.** (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) a person 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 unsubsidized employment~~ the condition severely limits the person's ability to obtain or maintain suitable employment;

(2) a person who:

(i) has been assessed by a vocational specialist or the county agency to be unemployable for purposes of this subdivision; or

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but ~~not at a level that makes the participant eligible for an extension under subdivision 4~~ the condition severely limits the person's ability to obtain or maintain suitable employment. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person: (A) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

(3) a person who is determined by a qualified professional to be learning disabled, and the ~~disability~~ condition severely limits the person's ability to obtain~~, perform,~~ or maintain suitable employment. For purposes of the initial approval of a learning disability extension, the determination must have been made or confirmed within the previous 12 months. In the case of a non-English-speaking person: (i) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; and (ii) these reports must include a statement of confidence in the results. If a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.521; or

30.1 (4) a person who has been granted a family violence waiver, and who is complying
30.2 with an employment plan under section 256J.521, subdivision 3.
30.3 (b) For purposes of this section, "severely limits the person's ability to obtain or
30.4 maintain suitable employment" means that a qualified professional has determined that the
30.5 person's condition prevents the person from working 20 or more hours per week.

30.6 Sec. 16. Minnesota Statutes 2008, section 256J.49, subdivision 1, is amended to read:

30.7 Subdivision 1. **Scope.** The terms used in sections ~~256J.50~~ 256J.425 to 256J.72 have
30.8 the meanings given them in this section.

30.9 Sec. 17. Minnesota Statutes 2008, section 256J.49, subdivision 4, is amended to read:

30.10 Subd. 4. **Employment and training service provider.** "Employment and training
30.11 service provider" means:
30.12 (1) a public, private, or nonprofit agency with which a county has contracted to
30.13 provide employment and training services and which is included in the county's service
30.14 agreement submitted under section 256J.626, subdivision 4; ~~or~~
30.15 (2) a county agency, if the county has opted to provide employment and training
30.16 services and the county has indicated that fact in the service agreement submitted under
30.17 section 256J.626, subdivision 4; or
30.18 (3) a local public health department under section 145A.17, subdivision 3a, that a
30.19 county has designated to provide employment and training services and is included in the
30.20 county's service agreement submitted under section 256J.626, subdivision 4.
30.21 Notwithstanding section 116L.871, an employment and training services provider
30.22 meeting this definition may deliver employment and training services under this chapter.

30.23 Sec. 18. Minnesota Statutes 2008, section 256J.521, subdivision 2, is amended to read:

30.24 Subd. 2. **Employment plan; contents.** (a) Based on the assessment under
30.25 subdivision 1, the job counselor and the participant must develop an employment plan
30.26 that includes participation in activities and hours that meet the requirements of section
30.27 256J.55, subdivision 1. The purpose of the employment plan is to identify for each
30.28 participant the most direct path to unsubsidized employment and any subsequent steps that
30.29 support long-term economic stability. The employment plan should be developed using
30.30 the highest level of activity appropriate for the participant. Activities must be chosen from
30.31 clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of
30.32 preference for activities, priority must be given for activities related to a family violence
30.33 waiver when developing the employment plan. The employment plan must also list the

31.1 specific steps the participant will take to obtain employment, including steps necessary
31.2 for the participant to progress from one level of activity to another, and a timetable for
31.3 completion of each step. Levels of activity include:

31.4 (1) unsubsidized employment;

31.5 (2) job search;

31.6 (3) subsidized employment or unpaid work experience;

31.7 (4) unsubsidized employment and job readiness education or job skills training;

31.8 (5) unsubsidized employment or unpaid work experience and activities related to
31.9 a family violence waiver or preemployment needs; and

31.10 (6) activities related to a family violence waiver or preemployment needs.

31.11 (b) Participants who are determined to possess sufficient skills such that the
31.12 participant is likely to succeed in obtaining unsubsidized employment must job search at
31.13 least 30 hours per week for up to six weeks and accept any offer of suitable employment.
31.14 The remaining hours necessary to meet the requirements of section 256J.55, subdivision
31.15 1, may be met through participation in other work activities under section 256J.49,
31.16 subdivision 13. The participant's employment plan must specify, at a minimum: (1)
31.17 whether the job search is supervised or unsupervised; (2) support services that will
31.18 be provided; and (3) how frequently the participant must report to the job counselor.
31.19 Participants who are unable to find suitable employment after six weeks must meet
31.20 with the job counselor to determine whether other activities in paragraph (a) should be
31.21 incorporated into the employment plan. Job search activities which are continued after six
31.22 weeks must be structured and supervised.

31.23 (c) ~~Beginning July 1, 2004, activities and hourly requirements in the employment~~
31.24 ~~plan may be adjusted as necessary to accommodate the personal and family circumstances~~
31.25 ~~of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants~~
31.26 ~~who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d),~~
31.27 ~~must meet with the job counselor within ten days of the determination to revise the~~
31.28 ~~employment plan.~~

31.29 ~~(d)~~ Participants who are determined to have barriers to obtaining or retaining
31.30 employment that will not be overcome during six weeks of job search under paragraph (b)
31.31 must work with the job counselor to develop an employment plan that addresses those
31.32 barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6).
31.33 The employment plan must include enough hours to meet the participation requirements
31.34 in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours
31.35 is noted in the participant's file.

32.1 ~~(c)~~ (d) The job counselor and the participant must sign the employment plan to
32.2 indicate agreement on the contents.
32.3 ~~(f)~~ (e) Except as provided under paragraph ~~(g)~~ (f), failure to develop or comply with
32.4 activities in the plan, or voluntarily quitting suitable employment without good cause, will
32.5 result in the imposition of a sanction under section 256J.46.
32.6 ~~(g)~~ (f) When a participant fails to meet the agreed upon hours of participation in paid
32.7 employment because the participant is not eligible for holiday pay and the participant's
32.8 place of employment is closed for a holiday, the job counselor shall not impose a sanction
32.9 or increase the hours of participation in any other activity, including paid employment, to
32.10 offset the hours that were missed due to the holiday.
32.11 ~~(h)~~ (g) Employment plans must be reviewed at least every three months to determine
32.12 whether activities and hourly requirements should be revised. The job counselor is
32.13 encouraged to allow participants who are participating in at least 20 hours of work
32.14 activities to also participate in education and training activities in order to meet the federal
32.15 hourly participation rates.

32.16 Sec. 19. Minnesota Statutes 2008, section 256J.545, is amended to read:

32.17 **256J.545 FAMILY VIOLENCE WAIVER CRITERIA.**

32.18 (a) In order to qualify for a family violence waiver, an individual must provide
32.19 documentation of past or current family violence which may prevent the individual from
32.20 participating in certain employment activities.
32.21 (b) The following items may be considered acceptable documentation or verification
32.22 of family violence:
32.23 (1) police, government agency, or court records;
32.24 (2) a statement from a battered women's shelter staff with knowledge of the
32.25 circumstances ~~or credible evidence that supports the sworn statement~~;
32.26 (3) a statement from a sexual assault or domestic violence advocate with knowledge
32.27 of the circumstances ~~or credible evidence that supports the sworn statement~~; or
32.28 (4) a statement from professionals from whom the applicant or recipient has sought
32.29 assistance for the abuse.
32.30 (c) A claim of family violence may also be documented by a sworn statement from
32.31 the applicant or participant and a sworn statement from any other person with knowledge
32.32 of the circumstances or credible evidence that supports the client's statement.

32.33 Sec. 20. Minnesota Statutes 2008, section 256J.561, subdivision 2, is amended to read:

Subd. 2. **Participation requirements.** (a) All MFIP caregivers, except caregivers who meet the criteria in subdivision 3, must ~~participate in employment services~~ develop an individualized employment plan that identifies the activities the participant is required to participate in and the required hours of participation. ~~Except as specified in paragraphs (b) to (d), the employment plan must meet the requirements of section 256J.521, subdivision 2, contain allowable work activities, as defined in section 256J.49, subdivision 13, and, include at a minimum, the number of participation hours required under section 256J.55, subdivision 1.~~

~~(b) Minor caregivers and caregivers who are less than age 20 who have not completed high school or obtained a GED are required to comply with section 256J.54.~~

~~(c) A participant who has a family violence waiver shall develop and comply with an employment plan under section 256J.521, subdivision 3.~~

~~(d) As specified in section 256J.521, subdivision 2, paragraph (c), a participant who meets any one of the following criteria may work with the job counselor to develop an employment plan that contains less than the number of participation hours under section 256J.55, subdivision 1. Employment plans for participants covered under this paragraph must be tailored to recognize the special circumstances of caregivers and families including limitations due to illness or disability and caregiving needs:~~

~~(1) a participant who is age 60 or older;~~

~~(2) a participant who has been diagnosed by a qualified professional as suffering from an illness or incapacity that is expected to last for 30 days or more, including a pregnant participant who is determined to be unable to obtain or retain employment due to the pregnancy; or~~

~~(3) a participant who is determined by a qualified professional as being needed in the home to care for an ill or incapacitated family member, including caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c).~~

~~(e) For participants covered under paragraphs (c) and (d), the county shall review the participant's employment services status every three months to determine whether conditions have changed. When it is determined that the participant's status is no longer covered under paragraph (c) or (d), the county shall notify the participant that a new or revised employment plan is needed. The participant and job counselor shall meet within ten days of the determination to revise the employment plan.~~

34.1 (b) Participants who meet the eligibility requirements in section 256J.575,
34.2 subdivision 3, must develop a family stabilization services plan that meets the
34.3 requirements in section 256J.575, subdivision 5.
34.4 (c) Minor caregivers and caregivers who are less than age 20 who have not
34.5 completed high school or obtained a GED must develop an education plan that meets the
34.6 requirements in section 256J.54.
34.7 (d) Participants with a family violence waiver must develop an employment plan
34.8 that meets the requirements in section 256J.521, which cover the provisions in section
34.9 256J.575, subdivision 5.
34.10 (e) All other participants must develop an employment plan that meets the
34.11 requirements of section 256J.521, subdivision 2, and contains allowable work activities,
34.12 as defined in section 256J.49, subdivision 13. The employment plan must include, at a
34.13 minimum, the number of participation hours required under section 256J.55, subdivision 1.

34.14 Sec. 21. Minnesota Statutes 2008, section 256J.561, subdivision 3, is amended to read:

34.15 Subd. 3. **Child under 12 ~~weeks~~ months of age.** (a) A participant who has a
34.16 natural born child who is less than 12 ~~weeks~~ months of age who meets the criteria in this
34.17 subdivision is not required to participate in employment services until the child reaches
34.18 12 ~~weeks~~ months of age. To be eligible for this provision, the assistance unit must not
34.19 have already used this provision or the previously allowed child under age one exemption.
34.20 However, an assistance unit that has an approved child under age one exemption at the
34.21 time this provision becomes effective may continue to use that exemption until the child
34.22 reaches one year of age.
34.23 (b) The provision in paragraph (a) ends the first full month after the child reaches
34.24 12 ~~weeks~~ months of age. This provision is available only once in a caregiver's lifetime.
34.25 In a two-parent household, only one parent shall be allowed to use this provision. The
34.26 participant and job counselor must meet within ten days after the child reaches 12 ~~weeks~~
34.27 months of age to revise the participant's employment plan.

34.28 **EFFECTIVE DATE.** This section is effective March 1, 2010.

34.29 Sec. 22. Minnesota Statutes 2008, section 256J.57, subdivision 1, is amended to read:

34.30 Subdivision 1. **Good cause for failure to comply.** The county agency shall not
34.31 impose the sanction under section 256J.46 if it determines that the participant has good
34.32 cause for failing to comply with the requirements of sections 256J.515 to 256J.57. Good
34.33 cause exists when:
34.34 (1) appropriate child care is not available;

35.1 (2) the job does not meet the definition of suitable employment;
35.2 (3) the participant is ill or injured;
35.3 (4) a member of the assistance unit, a relative in the household, or a foster child in
35.4 the household is ill and needs care by the participant that prevents the participant from
35.5 complying with the employment plan;
35.6 (5) the participant is unable to secure necessary transportation;
35.7 (6) the participant is in an emergency situation that prevents compliance with the
35.8 employment plan;
35.9 (7) the schedule of compliance with the employment plan conflicts with judicial
35.10 proceedings;
35.11 (8) a mandatory MFIP meeting is scheduled during a time that conflicts with a
35.12 judicial proceeding or a meeting related to a juvenile court matter, or a participant's work
35.13 schedule;
35.14 (9) the participant is already participating in acceptable work activities;
35.15 (10) the employment plan requires an educational program for a caregiver under age
35.16 20, but the educational program is not available;
35.17 (11) activities identified in the employment plan are not available;
35.18 (12) the participant is willing to accept suitable employment, but suitable
35.19 employment is not available; ~~or~~
35.20 (13) the participant documents other verifiable impediments to compliance with the
35.21 employment plan beyond the participant's control; or
35.22 (14) the documentation needed to determine if a participant is eligible for family
35.23 stabilization services is not available, but there is information that the participant may
35.24 qualify and the participant is cooperating with the county or employment service provider's
35.25 efforts to obtain the documentation necessary to determine eligibility.
35.26 The job counselor shall work with the participant to reschedule mandatory meetings
35.27 for individuals who fall under clauses (1), (3), (4), (5), (6), (7), and (8).

35.28 Sec. 23. Minnesota Statutes 2008, section 256J.575, subdivision 3, is amended to read:
35.29 Subd. 3. **Eligibility.** (a) The following MFIP ~~or diversionary work program (DWP)~~
35.30 participants are eligible for the services under this section:
35.31 (1) a participant who meets the requirements for or has been granted a hardship
35.32 extension under section 256J.425, subdivision 2 or 3, except that it is not necessary for
35.33 the participant to have reached or be approaching 60 months of eligibility for this section
35.34 to apply;

36.1 (2) a participant who is applying for Supplemental Security Income or Social
36.2 Security disability insurance; ~~and~~
36.3 (3) a participant who is a noncitizen who has been in the United States for 12 or
36.4 fewer months; and
36.5 (4) a participant who is age 60 or older.
36.6 (b) Families must meet all other eligibility requirements for MFIP established in
36.7 this chapter. Families are eligible for financial assistance to the same extent as if they
36.8 were participating in MFIP.
36.9 (c) A participant under paragraph (a), clause (3), must be provided with English as a
36.10 second language opportunities and skills training for up to 12 months. After 12 months,
36.11 the case manager and participant must determine whether the participant should continue
36.12 with English as a second language classes or skills training, or both, and continue to
36.13 receive family stabilization services.
36.14 (d) If a county agency or employment services provider has information that
36.15 an MFIP participant may meet the eligibility criteria set forth in this subdivision, the
36.16 county agency or employment services provider must assist the participant in obtaining
36.17 the documentation necessary to determine eligibility. Until necessary documentation is
36.18 obtained, the participant must be treated as an eligible participant under subdivisions 5 to 7.

36.19 **EFFECTIVE DATE.** This section is effective July 1, 2009, except the amendment
36.20 to paragraph (a) striking "or diversionary work program (DWP)" is effective March 1,
36.21 2010.

36.22 Sec. 24. Minnesota Statutes 2008, section 256J.575, subdivision 4, is amended to read:

36.23 Subd. 4. **Universal participation.** All caregivers must participate in family
36.24 stabilization services as defined in subdivision 2, except for caregivers exempt under
36.25 section 256J.561, subdivision 3.

36.26 **EFFECTIVE DATE.** This section is effective March 1, 2010.

36.27 Sec. 25. Minnesota Statutes 2008, section 256J.575, subdivision 6, is amended to read:

36.28 Subd. 6. **Cooperation with services requirements.** (a) ~~To be eligible,~~ A participant
36.29 who is eligible for family stabilization services under this section shall comply with
36.30 paragraphs (b) to (d).
36.31 (b) Participants shall engage in family stabilization plan services for the appropriate
36.32 number of hours per week that the activities are scheduled and available, unless good
36.33 cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate
36.34 number of hours must be based on the participant's plan.

37.1 (c) The case manager shall review the participant's progress toward the goals in the
37.2 family stabilization plan every six months to determine whether conditions have changed,
37.3 including whether revisions to the plan are needed.
37.4 (d) A participant's requirement to comply with any or all family stabilization plan
37.5 requirements under this subdivision is excused when the case management services,
37.6 training and educational services, or family support services identified in the participant's
37.7 family stabilization plan are unavailable for reasons beyond the control of the participant,
37.8 including when money appropriated is not sufficient to provide the services.

37.9 Sec. 26. Minnesota Statutes 2008, section 256J.575, subdivision 7, is amended to read:

37.10 Subd. 7. **Sanctions.** (a) <u>The county agency or employment services provider must</u>
37.11 <u>follow the requirements of this subdivision at the time the county agency or employment</u>
37.12 <u>services provider has information that an MFIP recipient may meet the eligibility criteria</u>
37.13 <u>in subdivision 3.</u>
37.14 <u>(b)</u> The financial assistance grant of a participating family is reduced according to
37.15 section 256J.46, if a participating adult fails without good cause to comply or continue
37.16 to comply with the family stabilization plan requirements in this subdivision, unless
37.17 compliance has been excused under subdivision 6, paragraph (d).
37.18 ~~(b)~~ <u>(c)</u> Given the purpose of the family stabilization services in this section and the
37.19 nature of the underlying family circumstances that act as barriers to both employment and
37.20 full compliance with program requirements, there must be a review by the county agency
37.21 prior to imposing a sanction to determine whether the plan was appropriated to the needs
37.22 of the participant and family~~, and~~<u>. There must be a current assessment by a behavioral</u>
37.23 <u>health or medical professional confirming</u> that the participant in all ways had the ability to
37.24 comply with the plan~~, as confirmed by a behavioral health or medical professional~~.
37.25 ~~(c)~~ <u>(d)</u> Prior to the imposition of a sanction, the county agency or employment
37.26 services provider shall review the participant's case to determine if the family stabilization
37.27 plan is still appropriate and meet with the participant face-to-face. ~~The participant may~~
37.28 ~~bring an advocate~~ <u>The county agency or employment services provider must inform the</u>
37.29 <u>participant of the right to bring an advocate</u> to the face-to-face meeting.
37.30 During the face-to-face meeting, the county agency shall:
37.31 (1) determine whether the continued noncompliance can be explained and mitigated
37.32 by providing a needed family stabilization service, as defined in subdivision 2, paragraph
37.33 (d);
37.34 (2) determine whether the participant qualifies for a good cause exception under
37.35 section 256J.57, or if the sanction is for noncooperation with child support requirements,

determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(3) determine whether activities in the family stabilization plan are appropriate based on the family's circumstances;

(4) explain the consequences of continuing noncompliance;

(5) identify other resources that may be available to the participant to meet the needs of the family; and

(6) inform the participant of the right to appeal under section 256J.40.

If the lack of an identified activity or service can explain the noncompliance, the county shall work with the participant to provide the identified activity.

(d) If the participant fails to come to the face-to-face meeting, the case manager or a designee shall attempt at least one home visit. If a face-to-face meeting is not conducted, the county agency shall send the participant a written notice that includes the information under paragraph (c).

(e) After the requirements of paragraphs (c) and (d) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section 256J.31.

(f) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Sec. 27. Minnesota Statutes 2008, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION CASH BENEFITS.

(a) Effective October 1, 2009, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program with earnings, a participant who is employed may be eligible for work participation cash benefits of ~~$75~~ $50 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

(b) To be eligible for work participation cash benefits, the participant shall not receive MFIP or diversionary work program assistance during the month and the participant or participants must meet the following work requirements:

(1) if the participant is a single caregiver and has a child under six years of age, the participant must be employed at least 87 hours per month;

(2) if the participant is a single caregiver and does not have a child under six years of age, the participant must be employed at least 130 hours per month; or

39.1 (3) if the household is a two-parent family, at least one of the parents must be
39.2 employed an average of at least 130 hours per month.

39.3 Whenever a participant exits the diversionary work program or is terminated from
39.4 MFIP and meets the other criteria in this section, work participation cash benefits are
39.5 available for up to 24 consecutive months.

39.6 (c) Expenditures on the program are maintenance of effort state funds under
39.7 a separate state program for participants under paragraph (b), clauses (1) and (2).
39.8 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
39.9 funds. Months in which a participant receives work participation cash benefits under this
39.10 section do not count toward the participant's MFIP 60-month time limit.

39.11 Sec. 28. Minnesota Statutes 2008, section 256J.626, subdivision 7, is amended to read:

39.12 Subd. 7. **Performance base funds.** (a) For the purpose of this section, the following
39.13 terms have the meanings given.

39.14 (1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota
39.15 TANF and separate state program caseload has fallen relative to federal fiscal year 2005
39.16 based on caseload data from October 1 to September 30.

39.17 (2) "TANF participation rate target" means a 50 percent participation rate reduced by
39.18 the CRC for the previous year.

39.19 (b) For calendar year ~~2009~~ 2010 and yearly thereafter, each county and tribe will be
39.20 allocated 95 percent of their initial calendar year allocation. Counties and tribes will be
39.21 allocated additional funds based on performance as follows:

39.22 (1) a county or tribe that achieves ~~a 50 percent~~ the TANF participation rate target
39.23 or a five percentage point improvement over the previous year's TANF participation rate
39.24 under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive
39.25 months for the most recent year for which the measurements are available, will receive an
39.26 additional allocation equal to 2.5 percent of its initial allocation; ~~and~~

39.27 (2) a county or tribe that performs within or above its range of expected performance
39.28 on the annualized three-year self-support index under section 256J.751, subdivision 2,
39.29 clause (6), will receive an additional allocation equal to 2.5 percent of its initial allocation;
39.30 and

39.31 (3) a county or tribe that does not achieve ~~a 50 percent~~ the TANF participation rate
39.32 target or a five percentage point improvement over the previous year's TANF participation
39.33 rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive
39.34 months for the most recent year for which the measurements are available, will not

40.1 receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear
40.2 improvement plan with the commissioner; or

40.3 (4) a county or tribe that does not perform within or above its range of expected
40.4 performance on the annualized three-year self-support index under section 256J.751,
40.5 subdivision 2, clause (6), will not receive an additional allocation equal to 2.5 percent
40.6 of its initial allocation until after negotiating a multiyear improvement plan with the
40.7 commissioner.

40.8 ~~(b)~~ (c) For calendar year 2009 and yearly thereafter, performance-based funds for
40.9 a federally approved tribal TANF program in which the state and tribe have in place
40.10 a contract under section 256.01, addressing consolidated funding, will be allocated as
40.11 follows:

40.12 (1) a tribe that achieves the participation rate approved in its federal TANF plan
40.13 using the average of 12 consecutive months for the most recent year for which the
40.14 measurements are available, will receive an additional allocation equal to 2.5 percent of
40.15 its initial allocation; and

40.16 (2) a tribe that performs within or above its range of expected performance on the
40.17 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
40.18 will receive an additional allocation equal to 2.5 percent of its initial allocation; or

40.19 (3) a tribe that does not achieve the participation rate approved in its federal TANF
40.20 plan using the average of 12 consecutive months for the most recent year for which the
40.21 measurements are available, will not receive an additional allocation equal to 2.5 percent
40.22 of its initial allocation until after negotiating a multiyear improvement plan with the
40.23 commissioner; or

40.24 (4) a tribe that does not perform within or above its range of expected performance
40.25 on the annualized three-year self-support index under section 256J.751, subdivision
40.26 2, clause (6), will not receive an additional allocation equal to 2.5 percent until after
40.27 negotiating a multiyear improvement plan with the commissioner.

40.28 ~~(c)~~ (d) Funds remaining unallocated after the performance-based allocations
40.29 in paragraph ~~(a)~~ (b) are available to the commissioner for innovation projects under
40.30 subdivision 5.

40.31 ~~(d)~~ (1) If available funds are insufficient to meet county and tribal allocations under
40.32 paragraph ~~(a)~~ (b), the commissioner may make available for allocation funds that are
40.33 unobligated and available from the innovation projects through the end of the current
40.34 biennium.

40.35 (2) If after the application of clause (1) funds remain insufficient to meet county
40.36 and tribal allocations under paragraph ~~(a)~~ (b), the commissioner must proportionally

41.1 reduce the allocation of each county and tribe with respect to their maximum allocation
41.2 available under paragraph ~~(a)~~ (b).

41.3 Sec. 29. Minnesota Statutes 2008, section 256J.95, subdivision 3, is amended to read:

41.4 Subd. 3. **Eligibility for diversionary work program.** (a) Except for the categories
41.5 of family units listed below, all family units who apply for cash benefits and who
41.6 meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must
41.7 participate in the diversionary work program. Family units that are not eligible for the
41.8 diversionary work program include:

41.9 (1) child only cases;

41.10 (2) a single-parent family unit that includes a child under 12 ~~weeks~~ months of age.
41.11 A parent is eligible for this exception once in a parent's lifetime and is not eligible if
41.12 the parent has already used the previously allowed child under age one exemption from
41.13 MFIP employment services;

41.14 (3) a minor parent without a high school diploma or its equivalent;

41.15 (4) an 18- or 19-year-old caregiver without a high school diploma or its equivalent
41.16 who chooses to have an employment plan with an education option;

41.17 (5) a caregiver age 60 or over;

41.18 (6) family units with a caregiver who received DWP benefits in the 12 months prior
41.19 to the month the family applied for DWP, except as provided in paragraph (c);

41.20 (7) family units with a caregiver who received MFIP within the 12 months prior to
41.21 the month the family unit applied for DWP;

41.22 (8) a family unit with a caregiver who received 60 or more months of TANF
41.23 assistance;

41.24 (9) a family unit with a caregiver who is disqualified from DWP or MFIP due to
41.25 fraud; and

41.26 (10) refugees and asylees as defined in Code of Federal Regulations, title 45, part
41.27 400, subpart d, section 400.43, who arrived in the United States in the 12 months prior to
41.28 the date of application for family cash assistance.

41.29 (b) A two-parent family must participate in DWP unless both caregivers meet the
41.30 criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit
41.31 includes a parent who meets the criteria in paragraph (a), clause (6), (7), (8), (9), or (10).

41.32 (c) Once DWP eligibility is determined, the four months run consecutively. If a
41.33 participant leaves the program for any reason and reapplies during the four-month period,
41.34 the county must redetermine eligibility for DWP.

41.35 **EFFECTIVE DATE.** This section is effective March 1, 2010.

42.1 Sec. 30. Minnesota Statutes 2008, section 256J.95, subdivision 11, is amended to read:

42.2 Subd. 11. **Universal participation required.** (a) All DWP caregivers, except
42.3 caregivers who meet the criteria in paragraph (d), are required to participate in DWP
42.4 employment services. Except as specified in paragraphs (b) and (c), employment plans
42.5 under DWP must, at a minimum, meet the requirements in section 256J.55, subdivision 1.
42.6 (b) A caregiver who is a member of a two-parent family that is required to participate
42.7 in DWP who would otherwise be ineligible for DWP under subdivision 3 may be allowed
42.8 to develop an employment plan under section 256J.521, subdivision 2, ~~paragraph (c),~~ that
42.9 may contain alternate activities and reduced hours.
42.10 (c) A participant who is a victim of family violence shall be allowed to develop an
42.11 employment plan under section 256J.521, subdivision 3. A claim of family violence must
42.12 be documented by the applicant or participant by providing a sworn statement which is
42.13 supported by collateral documentation in section 256J.545, paragraph (b).
42.14 (d) One parent in a two-parent family unit that has a natural born child under 12
42.15 ~~weeks~~ <u>months</u> of age is not required to have an employment plan until the child reaches 12
42.16 ~~weeks~~ <u>months</u> of age unless the family unit has already used the exclusion under section
42.17 256J.561, subdivision 3, or the previously allowed child under age one exemption under
42.18 section 256J.56, paragraph (a), clause (5).
42.19 (e) The provision in paragraph (d) ends the first full month after the child reaches 12
42.20 ~~weeks~~ <u>months</u> of age. This provision is allowable only once in a caregiver's lifetime. In a
42.21 two-parent household, only one parent shall be allowed to use this category.
42.22 (f) The participant and job counselor must meet within ten working days after the
42.23 child reaches 12 ~~weeks~~ <u>months</u> of age to revise the participant's employment plan. The
42.24 employment plan for a family unit that has a child under 12 ~~weeks~~ <u>months</u> of age that has
42.25 already used the exclusion in section 256J.561 or the previously allowed child under
42.26 age one exemption under section 256J.56, paragraph (a), clause (5), must be tailored to
42.27 recognize the caregiving needs of the parent.

42.28 <u>**EFFECTIVE DATE.** This section is effective March 1, 2010.</u>

42.29 Sec. 31. Minnesota Statutes 2008, section 256J.95, subdivision 12, is amended to read:

42.30 Subd. 12. **Conversion or referral to MFIP.** (a) If at any time during the DWP
42.31 application process or during the four-month DWP eligibility period, it is determined that
42.32 a participant is unlikely to benefit from the diversionary work program, the county shall
42.33 convert or refer the participant to MFIP as specified in paragraph (d). Participants who are
42.34 determined to be unlikely to benefit from the diversionary work program must develop
42.35 and sign an employment plan. ~~Participants who meet any one of the criteria in paragraph~~

43.1 ~~(b) shall be considered to be unlikely to benefit from DWP, provided the necessary~~
43.2 ~~documentation is available to support the determination.~~
43.3 (b) A participant who~~:~~ meets the eligibility requirements under section 256J.575,
43.4 subdivision 3, must be considered to be unlikely to benefit from DWP, provided the
43.5 necessary documentation is available to support the determination.
43.6 ~~(1) has been determined by a qualified professional as being unable to obtain or retain~~
43.7 ~~employment due to an illness, injury, or incapacity that is expected to last at least 60 days;~~
43.8 ~~(2) is required in the home as a caregiver because of the illness, injury, or incapacity,~~
43.9 ~~of a family member, or a relative in the household, or a foster child, and the illness, injury,~~
43.10 ~~or incapacity and the need for a person to provide assistance in the home has been certified~~
43.11 ~~by a qualified professional and is expected to continue more than 60 days;~~
43.12 ~~(3) is determined by a qualified professional as being needed in the home to care for~~
43.13 ~~a child or adult meeting the special medical criteria in section 256J.561, subdivision 2,~~
43.14 ~~paragraph (d), clause (3);~~
43.15 ~~(4) is pregnant and is determined by a qualified professional as being unable to~~
43.16 ~~obtain or retain employment due to the pregnancy; or~~
43.17 ~~(5) has applied for SSI or SSDI.~~
43.18 (c) In a two-parent family unit, ~~both parents must be~~ if one parent is determined
43.19 to be unlikely to benefit from the diversionary work program ~~before~~, the family unit
43.20 ~~can~~ must be converted or referred to MFIP.
43.21 (d) A participant who is determined to be unlikely to benefit from the diversionary
43.22 work program shall be converted to MFIP and, if the determination was made within 30
43.23 days of the initial application for benefits, no additional application form is required.
43.24 A participant who is determined to be unlikely to benefit from the diversionary work
43.25 program shall be referred to MFIP and, if the determination is made more than 30
43.26 days after the initial application, the participant must submit a program change request
43.27 form. The county agency shall process the program change request form by the first of
43.28 the following month to ensure that no gap in benefits is due to delayed action by the
43.29 county agency. In processing the program change request form, the county must follow
43.30 section 256J.32, subdivision 1, except that the county agency shall not require additional
43.31 verification of the information in the case file from the DWP application unless the
43.32 information in the case file is inaccurate, questionable, or no longer current.
43.33 (e) The county shall not request a combined application form for a participant who
43.34 has exhausted the four months of the diversionary work program, has continued need for
43.35 cash and food assistance, and has completed, signed, and submitted a program change
43.36 request form within 30 days of the fourth month of the diversionary work program. The

44.1 county must process the program change request according to section 256J.32, subdivision
44.2 1, except that the county agency shall not require additional verification of information
44.3 in the case file unless the information is inaccurate, questionable, or no longer current.
44.4 When a participant does not request MFIP within 30 days of the diversionary work
44.5 program benefits being exhausted, a new combined application form must be completed
44.6 for any subsequent request for MFIP.

44.7 **EFFECTIVE DATE.** This section is effective March 1, 2010.

44.8 Sec. 32. Minnesota Statutes 2008, section 256J.95, subdivision 13, is amended to read:

44.9 Subd. 13. **Immediate referral to employment services.** Within one working day of
44.10 determination that the applicant is eligible for the diversionary work program, but before
44.11 benefits are issued to or on behalf of the family unit, the county shall refer all caregivers to
44.12 employment services. The referral to the DWP employment services must be in writing
44.13 and must contain the following information:

44.14 (1) notification that, as part of the application process, applicants are required to
44.15 develop an employment plan or the DWP application will be denied;

44.16 (2) the employment services provider name and phone number;

44.17 (3) ~~the date, time, and location of the scheduled employment services interview;~~

44.18 ~~(4)~~ the immediate availability of supportive services, including, but not limited to,
44.19 child care, transportation, and other work-related aid; and

44.20 ~~(5)~~ (4) the rights, responsibilities, and obligations of participants in the program,
44.21 including, but not limited to, the grounds for good cause, the consequences of refusing or
44.22 failing to participate fully with program requirements, and the appeal process.

44.23 Sec. 33. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision
44.24 to read:

44.25 Subd. 3b. **Extension; adoption finalized after age 16.** A child who has attained the
44.26 age of 16 prior to finalization of their adoption is eligible for extension of the adoption
44.27 assistance agreement to the date the child attains age 21 if the child is:

44.28 (1) completing a secondary education program or a program leading to an equivalent
44.29 credential;

44.30 (2) enrolled in an institution which provides postsecondary or vocational education;

44.31 (3) participating in a program or activity designed to promote or remove barriers to
44.32 employment;

44.33 (4) employed for at least 80 hours per month; or

45.1 (5) incapable of doing any of the activities described in clauses (1) to (4) due to a
45.2 medical condition which incapability is supported by regularly updated information in
45.3 the case plan of the child.

45.4 **EFFECTIVE DATE.** This section is effective October 1, 2010.

45.5 Sec. 34. Minnesota Statutes 2008, section 270A.09, is amended by adding a
45.6 subdivision to read:

45.7 Subd. 1b. **Department of Human Services claims.** Notwithstanding subdivision 1,
45.8 any debtor contesting a setoff claim by the Department of Human Services or a county
45.9 agency whose claim relates to a debt resulting from receipt of public assistance, medical
45.10 care, or the federal Food Stamp Act shall have a hearing conducted in the same manner as
45.11 an appeal under sections 256.045 and 256.0451.

45.12 Sec. 35. **AMERICAN INDIAN CHILD WELFARE PROJECTS.**

45.13 Notwithstanding Minnesota Statutes, section 16A.28, the commissioner of human
45.14 services shall extend payment of state fiscal year 2009 funds in state fiscal year 2010
45.15 to tribes participating in the American Indian child welfare projects under Minnesota
45.16 Statutes, section 256.01, subdivision 14b. Future extensions of payment for a tribe
45.17 participating in the Indian child welfare projects under Minnesota Statutes, section 256.01,
45.18 subdivision 14b, must be granted according to the commissioner's authority under
45.19 Minnesota Statutes, section 16A.28.

45.20 Sec. 36. **REPEALER.**

45.21 Minnesota Statutes 2008, section 256I.06, subdivision 9, is repealed.

45.22 **ARTICLE 3**

45.23 **STATE-OPERATED SERVICES/MINNESOTA SEX OFFENDER PROGRAM**

45.24 Section 1. Minnesota Statutes 2008, section 246.50, subdivision 5, is amended to read:

45.25 Subd. 5. **Cost of care.** "Cost of care" means the commissioner's charge for services
45.26 provided to any person admitted to a state facility.

45.27 For purposes of this subdivision, "charge for services" means the ~~cost of services,~~
45.28 ~~treatment, maintenance, bonds issued for capital improvements, depreciation of buildings~~
45.29 ~~and equipment, and indirect costs related to the operation of state facilities. The~~
45.30 ~~commissioner may determine the charge for services on an anticipated average per diem~~
45.31 ~~basis as an all inclusive charge per facility, per disability group, or per treatment program.~~
45.32 ~~The commissioner may determine a charge per service, using a method that includes direct~~

46.1 ~~and indirect costs~~ usual and customary fee charged for services provided to clients. The
46.2 usual and customary fee shall be established in a manner required to appropriately bill
46.3 services to all payers and shall include the costs related to the operations of any program
46.4 offered by the state.

46.5 Sec. 2. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
46.6 to read:

46.7 Subd. 10. **State-operated community-based program.** "State-operated
46.8 community-based program" means any program operated in the community including
46.9 community behavioral health hospitals, crisis centers, residential facilities, outpatient
46.10 services, and other community-based services developed and operated by the state and
46.11 under the commissioner's control.

46.12 Sec. 3. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
46.13 to read:

46.14 Subd. 11. **Health plan company.** "Health plan company" has the meaning given it
46.15 in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in
46.16 section 256B.69, subdivision 2, paragraph (b), a county or group of counties participating
46.17 in county-based purchasing according to section 256B.692, and a children's mental health
46.18 collaborative under contract to provide medical assistance for individuals enrolled in
46.19 the prepaid medical assistance and MinnesotaCare programs under sections 245.493 to
46.20 245.495.

46.21 Sec. 4. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
46.22 to read:

46.23 Subd. 1a. **Clients in state-operated community-based programs; determination.**
46.24 The commissioner shall determine available health plan coverage from a health plan
46.25 company for services provided to clients admitted to a state-operated community-based
46.26 program. If the health plan coverage requires a co-pay or deductible, or if there is no
46.27 available health plan coverage, the commissioner shall determine or redetermine, what
46.28 part of the noncovered cost of care, if any, the client is able to pay. If the client is unable to
46.29 pay the uncovered cost of care, the commissioner shall determine the client's relatives'
46.30 ability to pay. The client and relatives shall provide to the commissioner documents and
46.31 proof necessary to determine the client and relatives' ability to pay. Failure to provide the
46.32 commissioner with sufficient information to determine ability to pay may make the client
46.33 or relatives liable for the full cost of care until the time when sufficient information is

47.1 provided. If it is determined that the responsible party does not have the ability to pay,
47.2 the commissioner shall waive payment of the portion that exceeds ability to pay under
47.3 the determination.

47.4 Sec. 5. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
47.5 to read:

47.6 Subd. 1b. **Clients served by regional treatment centers or nursing homes;**
47.7 **determination.** The commissioner shall determine or redetermine, if necessary, what part
47.8 of the cost of care, if any, a client served in regional treatment centers or nursing homes
47.9 operated by state-operated services, is able to pay. If the client is unable to pay the full cost
47.10 of care, the commissioner shall determine if the client's relatives have the ability to pay.
47.11 The client and relatives shall provide to the commissioner documents and proof necessary
47.12 to determine the client and relatives' ability to pay. Failure to provide the commissioner
47.13 with sufficient information to determine ability to pay may make the client or relatives
47.14 liable for the full cost of care until the time when sufficient information is provided. No
47.15 parent shall be liable for the cost of care given a client at a regional treatment center after
47.16 the client has reached the age of 18 years.

47.17 Sec. 6. Minnesota Statutes 2008, section 246.511, is amended to read:

47.18 **246.511 RELATIVE RESPONSIBILITY.**

47.19 Except for chemical dependency services paid for with funds provided under chapter
47.20 254B, a client's relatives shall not, pursuant to the commissioner's authority under section
47.21 246.51, be ordered to pay more than ~~ten percent of the cost of~~ the following: (1) for
47.22 services provided in a community-based service, the noncovered cost of care as determined
47.23 under the ability to pay determination; and (2) for services provided at a regional treatment
47.24 center operated by state-operated services, 20 percent of the cost of care, unless they
47.25 reside outside the state. Parents of children in state facilities shall have their responsibility
47.26 to pay determined according to section 252.27, subdivision 2, or in rules adopted under
47.27 chapter 254B if the cost of care is paid under chapter 254B. The commissioner may
47.28 accept voluntary payments in excess of ~~ten~~ 20 percent. The commissioner may require
47.29 full payment of the full per capita cost of care in state facilities for clients whose parent,
47.30 parents, spouse, guardian, or conservator do not reside in Minnesota.

47.31 Sec. 7. Minnesota Statutes 2008, section 246.52, is amended to read:

47.32 **246.52 PAYMENT FOR CARE; ORDER; ACTION.**

The commissioner shall issue an order to the client or the guardian of the estate, if there be one, and relatives determined able to pay requiring them to pay ~~monthly~~ to the state of Minnesota the amounts so determined the total of which shall not exceed the full cost of care. Such order shall specifically state the commissioner's determination and shall be conclusive unless appealed from as herein provided. When a client or relative fails to pay the amount due hereunder the attorney general, upon request of the commissioner, may institute, or direct the appropriate county attorney to institute, civil action to recover such amount.

Sec. 8. Minnesota Statutes 2008, section 246.54, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the Minnesota Security Hospital~~, the Minnesota sex offender program,~~ or the Minnesota extended treatment options program. For services at these facilities, a county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal ten percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. If payments received by the state under sections 246.50 to 246.53 exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

(b) Regardless of the facility to which the client is committed, subdivision 1 does not apply to the following individuals:

(1) clients who are committed as mentally ill and dangerous under section 253B.02, subdivision 17;

(2) clients who are committed as sexual psychopathic personalities under section 253B.02, subdivision 18b; and

(3) clients who are committed as sexually dangerous persons under section 253B.02, subdivision 18c.

For each of the individuals in clauses (1) to (3), the payment by the county to the state shall equal ten percent of the cost of care for each day as determined by the commissioner.

Sec. 9. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision to read:

Subd. 1a. **Client.** "Client" means a person who is admitted to the Minnesota sex offender program or subject to a court hold order under section 253B.185 for the purpose

49.1 of assessment, diagnosis, care, treatment, supervision, or other services provided by the
49.2 Minnesota sex offender program.

49.3 Sec. 10. Minnesota Statutes 2008, section 246B.01, is amended by adding a
49.4 subdivision to read:

49.5 Subd. 1b. **Client's county.** "Client's county" means the county of the client's
49.6 legal settlement for poor relief purposes at the time of commitment. If the client has no
49.7 legal settlement for poor relief in this state, it means the county of commitment, except
49.8 that when a client with no legal settlement for poor relief is committed while serving a
49.9 sentence at a penal institution, it means the county from which the client was sentenced.

49.10 Sec. 11. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
49.11 to read:

49.12 Subd. 2a. **Cost of care.** "Cost of care" means the commissioner's charge for housing
49.13 and treatment services provided to any person admitted to the Minnesota sex offender
49.14 program.

49.15 For purposes of this subdivision, "charge for housing and treatment services" means
49.16 the cost of services, treatment, maintenance, bonds issued for capital improvements,
49.17 depreciation of buildings and equipment, and indirect costs related to the operation of
49.18 state facilities. The commissioner may determine the charge for services on an anticipated
49.19 average per diem basis as an all-inclusive charge per facility.

49.20 Sec. 12. Minnesota Statutes 2008, section 246B.01, is amended by adding a
49.21 subdivision to read:

49.22 Subd. 2b. **Local social services agency.** "Local social services agency" means the
49.23 local social services agency of the client's county as defined in subdivision 1b and of the
49.24 county of commitment, and any other local social services agency possessing information
49.25 regarding, or requested by the commissioner to investigate, the financial circumstances
49.26 of a client.

49.27 Sec. 13. **[246B.07] PAYMENT FOR CARE AND TREATMENT:**
49.28 **DETERMINATION.**

49.29 Subdivision 1. **Procedures.** The commissioner shall determine or redetermine, if
49.30 necessary, what amount of the cost of care, if any, the client is able to pay. The client shall
49.31 provide to the commissioner documents and proof necessary to determine the ability to
49.32 pay. Failure to provide the commissioner with sufficient information to determine ability

50.1 to pay may make the client liable for the full cost of care until the time when sufficient
50.2 information is provided.

50.3 Subd. 2. **Rules.** The commissioner shall use the standards in section 246.51,
50.4 subdivision 2, to determine the client's liability for the care provided by the Minnesota sex
50.5 offender program.

50.6 Subd. 3. **Applicability.** The commissioner may recover, under sections 246B.07 to
50.7 246B.10, the cost of any care provided by the Minnesota sex offender program.

50.8 Sec. 14. **[246B.08] PAYMENT FOR CARE; ORDER; ACTION.**

50.9 The commissioner shall issue an order to the client or the guardian of the estate, if
50.10 there is one, requiring the client or guardian to pay to the state the amounts determined, the
50.11 total of which must not exceed the full cost of care. The order must specifically state the
50.12 commissioner's determination and must be conclusive, unless appealed. If a client fails to
50.13 pay the amount due, the attorney general, upon request of the commissioner, may institute,
50.14 or direct the appropriate county attorney to institute a civil action to recover the amount.

50.15 Sec. 15. **[246B.09] CLAIM AGAINST ESTATE OF DECEASED CLIENT.**

50.16 Subdivision 1. **Client's estate.** Upon the death of a client, or a former client, the
50.17 total cost of care provided to the client, less the amount actually paid toward the cost of
50.18 care by the client, must be filed by the commissioner as a claim against the estate of the
50.19 client with the court having jurisdiction to probate the estate, and all proceeds collected
50.20 by the state in the case must be divided between the state and county in proportion to
50.21 the cost of care each has borne.

50.22 Subd. 2. **Preferred status.** An estate claim in subdivision 1 must be considered an
50.23 expense of the last illness for purposes of section 524.3-805.

50.24 If the commissioner determines that the property or estate of a client is not more
50.25 than needed to care for and maintain the spouse and minor or dependent children of a
50.26 deceased client, the commissioner has the power to compromise the claim of the state in a
50.27 manner deemed just and proper.

50.28 Subd. 3. **Exception from statute of limitations.** Any statute of limitations that
50.29 limits the commissioner in recovering the cost of care obligation incurred by a client or
50.30 former client must not apply to any claim against an estate made under this section to
50.31 recover cost of care.

50.32 Sec. 16. **[246B.10] LIABILITY OF COUNTY; REIMBURSEMENT.**

51.1 The client's county shall pay to the state a portion of the cost of care provided in
51.2 the Minnesota sex offender program to a client who has legally settled in that county. A
51.3 county's payment must be made from the county's own sources of revenue and payments
51.4 must equal ten percent of the cost of care, as determined by the commissioner, for each
51.5 day or portion of a day, that the client spends at the facility. If payments received by the
51.6 state under this chapter exceed 90 percent of the cost of care, the county is responsible
51.7 for paying the state the remaining amount. The county is not entitled to reimbursement
51.8 from the client, the client's estate, or from the client's relatives, except as provided in
51.9 section 246B.07.

51.10 Sec. 17. Minnesota Statutes 2008, section 252.025, subdivision 7, is amended to read:

51.11 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
51.12 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have
51.13 developmental disabilities and exhibit severe behaviors which present a risk to public
51.14 safety. This program is statewide and must provide specialized residential services in
51.15 Cambridge and an array of ~~community support~~ community-based services ~~statewide~~ with
51.16 sufficient levels of care and a sufficient number of specialists to ensure that individuals
51.17 referred to the program receive the appropriate care. The individuals working in the
51.18 community-based services under this section are state employees supervised by the
51.19 commissioner of human services. No layoffs shall occur as a result of restructuring
51.20 under this section.

51.21 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
51.22 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
51.23 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

51.24 In consultation with community partners, the commissioner of human services
51.25 shall develop an array of community-based services to transform the current services
51.26 now provided to patients at the Anoka-Metro Regional Treatment Center. The
51.27 community-based services may be provided in facilities with 16 or fewer beds, and must
51.28 provide the appropriate level of care for the patients being admitted to the facilities. The
51.29 planning for this transition must be completed by October 1, 2009, with an initial report
51.30 to the committee chairs of health and human services by November 30, 2009, and a
51.31 semiannual report on progress until the transition is completed. The commissioner of
51.32 human services shall solicit interest from stakeholders and potential community partners.
51.33 The individuals working in the community-based services facilities under this section are

52.1 state employees supervised by the commissioner of human services. No layoffs shall
52.2 occur as a result of restructuring under this section.

52.3 Sec. 19. **REPEALER.**

52.4 Minnesota Statutes 2008, sections 246.51, subdivision 1; and 246.53, subdivision
52.5 3, are repealed.

52.6 **ARTICLE 4**
52.7 **DEPARTMENT OF HEALTH**

52.8 Section 1. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

52.9 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
52.10 paragraphs (b) to (e) have the meanings given.
52.11 (b) "Autism spectrum disorders" means one or more of the following conditions as
52.12 determined by criteria set forth in the most recent edition of the Diagnostic and Statistical
52.13 Manual of Mental Disorders of the American Psychiatric Association:
52.14 (1) autism or autistic disorder;
52.15 (2) Asperger's syndrome; or
52.16 (3) pervasive developmental disorder - not otherwise specified.
52.17 (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3.
52.18 (d) "Medically necessary care" means health care services appropriate, in terms of
52.19 type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic
52.20 testing and preventative services. Medically necessary care must be consistent with
52.21 generally accepted practice parameters as determined by physicians and licensed
52.22 psychologists who typically manage patients who have autism spectrum disorders.
52.23 (e) "Mental health professional" has the meaning given in section 245.4871,
52.24 subdivision 27.

52.25 Subd. 2. **Coverage required.** (a) A health plan must provide coverage for the
52.26 diagnosis, evaluation, assessment, and medically necessary care of autism spectrum
52.27 disorders, including but not limited to the following:
52.28 (1) intensive behavior therapy, such as applied behavior analysis, intensive early
52.29 intervention behavior therapy, intensive behavior intervention, and Lovaas therapy;
52.30 (2) behavior services, instruction, and management;
52.31 (3) speech therapy;
52.32 (4) occupational therapy;
52.33 (5) physical therapy; and
52.34 (6) medications.

53.1 (b) Coverage required under this section shall include treatment that is in accordance
53.2 with an individualized treatment plan prescribed by the insured's treating physician or
53.3 mental health professional.

53.4 (c) A health plan may not refuse to renew or reissue, or otherwise terminate or
53.5 restrict, coverage of an individual solely because the individual is diagnosed with an
53.6 autism spectrum disorder.

53.7 (d) A health plan may request an updated treatment plan only once every six months,
53.8 unless the health plan and the treating physician or mental health professional agree that a
53.9 more frequent review is necessary due to emerging circumstances.

53.10 Subd. 3. **No effect on other law.** Nothing in this section limits in any way the
53.11 coverage required under section 62Q.47.

53.12 Subd. 4. **State health care programs.** This section does not affect benefits
53.13 available under the medical assistance, MinnesotaCare, and general assistance medical
53.14 care programs, and the state employee group insurance plan (SEGIP). These programs and
53.15 SEGIP must maintain current levels of coverage.

53.16 **EFFECTIVE DATE.** This section is effective August 1, 2009, and applies to
53.17 coverage offered; issued; sold; renewed; or continued as defined in Minnesota Statutes,
53.18 section 60A.02, subdivision 2a; on or after that date.

53.19 Sec. 2. Minnesota Statutes 2008, section 62J.495, is amended to read:

53.20 **62J.495 HEALTH INFORMATION TECHNOLOGY AND**
53.21 **INFRASTRUCTURE.**

53.22 Subdivision 1. **Implementation.** By January 1, 2015, all hospitals and health care
53.23 providers must have in place an interoperable electronic health records system within their
53.24 hospital system or clinical practice setting. The commissioner of health, in consultation
53.25 with the e-Health ~~Information Technology and Infrastructure~~ Advisory Committee,
53.26 shall develop a statewide plan to meet this goal, including uniform standards to be used
53.27 for the interoperable system for sharing and synchronizing patient data across systems.
53.28 The standards must be compatible with federal efforts. The uniform standards must be
53.29 developed by January 1, 2009, ~~with a status report on the development of these standards~~
53.30 ~~submitted to the legislature by January 15, 2008~~ and updated on an ongoing basis. The
53.31 commissioner shall include an update on standards development as part of an annual
53.32 report to the legislature.

53.33 Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an
53.34 electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH

Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

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

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third party administrators, and pharmacy benefit manager in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

(2) support physician order entry;

(3) capture and query information relevant to health care quality; and

(4) exchange electronic health information with, and integrate such information from, other sources.

Subd. 2. **E-Health ~~Information Technology and Infrastructure~~ Advisory Committee.** (a) The commissioner shall establish ~~a~~ an e-Health ~~Information Technology and Infrastructure~~ Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for ~~administrative~~ clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health ~~Information Technology and Infrastructure~~ Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the ~~Health Information Technology and Infrastructure Advisory Committee~~ commissioner to fulfill the requirements of section 3013, paragraph (g) of the HITECH Act.

(c) The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending ~~future projects~~ action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.

(d) Notwithstanding section 15.059, this subdivision expires June 30, 2015.

Subd. 3. **Interoperable electronic health record requirements.** ~~(a)~~ To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be a qualified electronic health record.

(b) The electronic health record must be certified by the ~~Certification Commission for Healthcare Information Technology, or its successor~~ Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers ~~whose practice setting is a practice setting covered by the Certification Commission for Healthcare Information Technology certifications~~ only if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

56.1 (c) The electronic health record must meet the standards established according to
56.2 section 3004 of the HITECH Act as applicable.
56.3 (d) The electronic health record must have the ability to generate information on
56.4 clinical quality measures and other measures reported under sections 4101, 4102, and
56.5 4201 of the HITECH Act.
56.6 ~~(c)~~ (e) A health care provider who is a prescriber or dispenser of ~~controlled~~
56.7 ~~substances~~ legend drugs must have an electronic health record system that meets the
56.8 requirements of section 62J.497.

56.9 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner,
56.10 in consultation with the e-Health Advisory Committee, shall update the statewide
56.11 implementation plan required under subdivision 2 and released June 2008, to be consistent
56.12 with the updated Federal HIT Strategic Plan released by the Office of the National
56.13 Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan
56.14 shall meet the requirements for a plan required under section 3013 of the HITECH Act.
56.15 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall
56.16 work to ensure coordination between state, regional, and national efforts to support and
56.17 accelerate efforts to effectively use health information technology to improve the quality
56.18 and coordination of health care and continuity of patient care among health care providers,
56.19 to reduce medical errors, to improve population health, to reduce health disparities, and
56.20 to reduce chronic disease. The commissioner's coordination efforts shall include but not
56.21 be limited to:
56.22 (1) assisting in the development and support of health information technology
56.23 regional extension centers established under section 3012(c) of the HITECH Act to
56.24 provide technical assistance and disseminate best practices; and
56.25 (2) providing supplemental information to the best practices gathered by regional
56.26 centers to ensure that the information is relayed in a meaningful way to the Minnesota
56.27 health care community.
56.28 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
56.29 monitor national activity related to health information technology and shall coordinate
56.30 statewide input on policy development. The commissioner shall coordinate statewide
56.31 responses to proposed federal health information technology regulations in order to ensure
56.32 that the needs of the Minnesota health care community are adequately and efficiently
56.33 addressed in the proposed regulations. The commissioner's responses may include, but
56.34 are not limited to:
56.35 (1) reviewing and evaluating any standard, implementation specification, or
56.36 certification criteria proposed by the national HIT standards committee;

57.1 (2) reviewing and evaluating policy proposed by the national HIT policy
57.2 committee relating to the implementation of a nationwide health information technology
57.3 infrastructure;
57.4 (3) monitoring and responding to activity related to the development of quality
57.5 measures and other measures as required by section 4101 of the HITECH Act. Any
57.6 response related to quality measures shall consider and address the quality efforts required
57.7 under chapter 62U; and
57.8 (4) monitoring and responding to national activity related to privacy, security, and
57.9 data stewardship of electronic health information and individually identifiable health
57.10 information.
57.11 (d) To the extent that the state is either required or allowed to apply, or designate an
57.12 entity to apply for or carry out activities and programs under section 3013 of the HITECH
57.13 Act, the commissioner of health, in consultation with the e-Health Advisory Committee
57.14 and the commissioner of human services, shall be the lead applicant or sole designating
57.15 authority. The commissioner shall make such designations consistent with the goals and
57.16 objectives of sections 62J.495 to 62J.497, and sections 62J.50 to 62J.61.
57.17 (e) The commissioner of human services shall apply for funding necessary to
57.18 administer the incentive payments to providers authorized under title IV of the American
57.19 Recovery and Reinvestment Act.
57.20 (f) The commissioner shall include in the report to the legislature information on the
57.21 activities of this subdivision and provide recommendations on any relevant policy changes
57.22 that should be considered in Minnesota.

57.23 Subd. 5. **Collection of data for assessment and eligibility determination.** (a)
57.24 The commissioner of health, in consultation with the commissioner of human services,
57.25 may require providers, dispensers, group purchasers, and pharmaceutical electronic data
57.26 intermediaries to submit data in a form and manner specified by the commissioner to
57.27 assess the status of adoption, effective use, and interoperability of electronic health
57.28 records for the purpose of:
57.29 (1) demonstrating Minnesota's progress on goals established by the Office of the
57.30 National Coordinator to accelerate the adoption and effective use of health information
57.31 technology established under the HITECH Act;
57.32 (2) assisting the Center for Medicare and Medicaid Services and Department of
57.33 Human Services in determining eligibility of health care professionals and hospitals
57.34 to receive federal incentives for the adoption and effective use of health information
57.35 technology under the HITECH Act or other federal incentive programs;

58.1 (3) assisting the Office of the National Coordinator in completing required
58.2 assessments of the impact of the implementation and effective use of health information
58.3 technology in achieving goals identified in the national strategic plan, and completing
58.4 studies required by the HITECH Act;
58.5 (4) providing the data necessary to assist the Office of the National Coordinator in
58.6 conducting evaluations of regional extension centers as required by the HITECH Act; and
58.7 (5) other purposes as necessary to support the implementation of the HITECH Act.
58.8 (b) The commissioner shall coordinate with the commissioner of human services
58.9 and other state agencies in the collection of data required under this section to:
58.10 (1) avoid duplicative reporting requirements;
58.11 (2) maximize efficiencies in the development of reports on state activities as
58.12 required by HITECH; and
58.13 (3) determine health professional and hospital eligibility for incentives available
58.14 under the HITECH Act.
58.15 (c) The commissioner must not collect data or publish analyses that identify, or could
58.16 potentially identify, individual patients. The commissioner must not collect individual
58.17 data in identified or de-identified form.

58.18 Sec. 3. Minnesota Statutes 2008, section 62J.496, is amended to read:

58.19 **62J.496 ELECTRONIC HEALTH RECORD SYSTEM REVOLVING**
58.20 **ACCOUNT AND LOAN PROGRAM.**

58.21 Subdivision 1. **Account establishment.** (a) An account is established to: ~~provide~~
58.22 ~~loans to eligible borrowers to assist in financing the installation or support of an~~
58.23 ~~interoperable health record system. The system must provide for the interoperable~~
58.24 ~~exchange of health care information between the applicant and, at a minimum, a hospital~~
58.25 ~~system, pharmacy, and a health care clinic or other physician group.~~
58.26 (1) finance the purchase of certified electronic health records or qualified electronic
58.27 health records as defined in section 62J.495, subdivision 1a;
58.28 (2) enhance the utilization of electronic health record technology, which may include
58.29 costs associated with upgrading the technology to meet the criteria necessary to be a
58.30 certified electronic health record or a qualified electronic health record;
58.31 (3) train personnel in the use of electronic health record technology; and
58.32 (4) improve the secure electronic exchange of health information.
58.33 (b) Amounts deposited in the account, including any grant funds obtained through
58.34 federal or other sources, loan repayments, and interest earned on the amounts shall be

59.1 used only for awarding loans or loan guarantees, as a source of reserve and security for
59.2 leveraged loans, or for the administration of the account.

59.3 (c) The commissioner may accept contributions to the account from private sector
59.4 entities subject to the following provisions:

59.5 (1) the contributing entity may not specify the recipient or recipients of any loan
59.6 issued under this subdivision;

59.7 (2) the commissioner shall make public the identity of any private contributor to the
59.8 loan fund, as well as the amount of the contribution provided; and

59.9 (3) the commissioner may issue letters of commendation or make other awards that
59.10 have no financial value to any such entity.

59.11 A contributing entity may not specify that the recipient or recipients of any loan use
59.12 specific products or services, nor may the contributing entity imply that a contribution is
59.13 an endorsement of any specific product or service.

59.14 (d) The commissioner may use the loan funds to reimburse private sector entities
59.15 for any contribution made to the loan fund. Reimbursement to private entities may not
59.16 exceed the principle amount contributed to the loan fund.

59.17 (e) The commissioner may use funds deposited in the account to guarantee, or
59.18 purchase insurance for, a local obligation if the guarantee or purchase would improve
59.19 credit market access or reduce the interest rate applicable to the obligation involved.

59.20 (f) The commissioner may use funds deposited in the account as a source of revenue
59.21 or security for the payment of principal and interest on revenue or bonds issued by the
59.22 state if the proceeds of the sale of the bonds will be deposited into the loan fund.

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

59.24 (1) federally qualified health centers;

59.25 ~~(1)~~ (2) community clinics, as defined under section 145.9268;

59.26 ~~(2)~~ (3) nonprofit or local unit of government hospitals ~~eligible for rural hospital~~
59.27 ~~capital improvement grants, as defined in section 144.148~~ licensed under sections 144.50
59.28 to 144.56;

59.29 ~~(3) physician clinics located in a community with a population of less than 50,000~~
59.30 ~~according to United States Census Bureau statistics and outside the seven-county~~
59.31 ~~metropolitan area;~~

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

59.34 ~~(4)~~ (5) nursing facilities licensed under sections 144A.01 to 144A.27; ~~and~~

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

60.1 ~~(5)~~ (7) other providers of health or health care services approved by the
60.2 commissioner for which interoperable electronic health record capability would improve
60.3 quality of care, patient safety, or community health.
60.4 (b) The commissioner shall administer the loan fund to prioritize support and
60.5 assistance to:
60.6 (1) critical access hospitals;
60.7 (2) federally qualified health centers;
60.8 (3) entities that serve uninsured, underinsured, and medically underserved
60.9 individuals, regardless of whether such area is urban or rural; and
60.10 (4) individual or small group practices that are primarily focused on primary care.
60.11 ~~(b) To be eligible for a loan under this section, the~~ (c) An eligible applicant must
60.12 submit a loan application to the commissioner of health on forms prescribed by the
60.13 commissioner. The application must include, at a minimum:
60.14 (1) the amount of the loan requested and a description of the purpose or project
60.15 for which the loan proceeds will be used;
60.16 (2) a quote from a vendor;
60.17 (3) a description of the health care entities and other groups participating in the
60.18 project;
60.19 (4) evidence of financial stability and a demonstrated ability to repay the loan; and
60.20 (5) a description of how the system to be financed ~~interconnects~~ interoperates or
60.21 plans in the future to ~~interconnect~~ interoperate with other health care entities and provider
60.22 groups located in the same geographical area;
60.23 (6) a plan on how the certified electronic health record technology will be maintained
60.24 and supported over time; and
60.25 (7) any other requirements for applications included or developed pursuant to
60.26 section 3014 of the HITECH Act.

60.27 Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan or
60.28 low interest loan to a provider or provider group who is eligible under subdivision 2
60.29 ~~on a first-come, first-served basis provided that the applicant is able to comply with this~~
60.30 ~~section~~ consistent with the priorities established in subdivision 2. The total accumulative
60.31 loan principal must not exceed ~~$1,500,000~~ $3,000,000 per loan. The interest rate for each
60.32 loan, if imposed, shall not exceed the current market interest rate. The commissioner of
60.33 health has discretion over the size, interest rate, and number of loans made. Nothing in
60.34 this section shall require the commissioner to make a loan to an eligible borrower under
60.35 subdivision 2.

61.1 (b) The commissioner of health may prescribe forms and establish an application
61.2 process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable
61.3 application fee to cover the cost of administering the loan program. Any application
61.4 fees imposed and collected under the electronic health records system revolving account
61.5 and loan program in this section are appropriated to the commissioner of health for the
61.6 duration of the loan program. The commissioner may apply for and use all federal funds
61.7 available through the HITECH Act to administer the loan program.

61.8 (c) For loans approved prior to July 1, 2009, the borrower must begin repaying the
61.9 principal no later than two years from the date of the loan. Loans must be amortized no
61.10 later than six years from the date of the loan.

61.11 (d) For loans granted on January 1, 2010, or thereafter, the borrower must begin
61.12 repaying the principle no later than one year from the date of the loan. Loans must be
61.13 amortized no later than six years after the date of the loan.

61.14 ~~(d) Repayments~~ (e) All repayments and interest paid on each loan must be credited
61.15 to the account.

61.16 (f) The loan agreement shall include the assurances that borrower meets requirements
61.17 included or developed pursuant to section 3014 of the HITECH Act. The requirements
61.18 shall include, but are not limited to:

61.19 (1) submitting reports on quality measures in compliance with regulations adopted
61.20 by the federal government;

61.21 (2) demonstrating that any certified electronic health record technology purchased,
61.22 improved, or otherwise financially supported by this loan program is used to exchange
61.23 health information in a manner that, in accordance with law and standards applicable to
61.24 the exchange of information, improves the quality of health care;

61.25 (3) including a plan on how the borrower intends to maintain and support the
61.26 certified electronic health record technology over time and the resources expected to be
61.27 used to maintain and support the technology purchased with the loan; and

61.28 (4) complying with other requirements the secretary may require to use loans funds
61.29 under the HITECH Act.

61.30 Subd. 4. **Data classification.** Data collected by the commissioner of health on the
61.31 application to determine eligibility under subdivision 2 and to monitor borrowers' default
61.32 risk or collect payments owed under subdivision 3 are (1) private data on individuals as
61.33 defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section
61.34 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted
61.35 are public data.

62.1 Sec. 4. Minnesota Statutes 2008, section 62J.497, subdivision 1, is amended to read:

62.2 Subdivision 1. **Definitions.** For the purposes of this section, the following terms
62.3 have the meanings given.

62.4 (a) "Backward compatible" means that the newer version of a data transmission
62.5 standard would retain, at a minimum, the full functionality of the versions previously
62.6 adopted, and would permit the successful completion of the applicable transactions with
62.7 entities that continue to use the older versions.

62.8 ~~(a)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01,
62.9 subdivision 30. Dispensing does not include the direct administering of a controlled
62.10 substance to a patient by a licensed health care professional.

62.11 ~~(b)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled
62.12 substance, pursuant to a valid prescription.

62.13 ~~(c)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
62.14 title 45, part 160.103.

62.15 ~~(d)~~ (e) "E-prescribing" means the transmission using electronic media of prescription
62.16 or prescription-related information between a prescriber, dispenser, pharmacy benefit
62.17 manager, or group purchaser, either directly or through an intermediary, including
62.18 an e-prescribing network. E-prescribing includes, but is not limited to, two-way
62.19 transmissions between the point of care and the dispenser and two-way transmissions
62.20 related to eligibility, formulary, and medication history information.

62.21 ~~(e)~~ (f) "Electronic prescription drug program" means a program that provides for
62.22 e-prescribing.

62.23 ~~(f)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

62.24 ~~(g)~~ (h) "HL7 messages" means a standard approved by the standards development
62.25 organization known as Health Level Seven.

62.26 ~~(h)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under
62.27 Code of Federal Regulations, title 45, part 162.406.

62.28 ~~(i)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

62.29 ~~(j)~~ (k) "NCPDP Formulary and Benefits Standard" means the National Council for
62.30 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
62.31 Version 1, Release 0, October 2005.

62.32 ~~(k)~~ (l) "NCPDP SCRIPT Standard" means the National Council for Prescription
62.33 Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation
62.34 Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard
62.35 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
62.36 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and

63.1 regulations adopted under it. The standards shall be implemented according to the Centers
63.2 for Medicare and Medicaid Services schedule for compliance. Subsequently released
63.3 versions of the NCPDP SCRIPT Standard may be used, provided that the new version
63.4 of the standard is backward compatible to the current version adopted by the Centers for
63.5 Medicare and Medicaid Services.

63.6 ~~(l)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

63.7 ~~(m)~~ (n) "Prescriber" means a licensed health care ~~professional who is authorized to~~
63.8 ~~prescribe a controlled substance under section 152.12, subdivision 1.~~ practitioner, other
63.9 than a veterinarian, as defined in section 151.01, subdivision 23.

63.10 ~~(n)~~ (o) "Prescription-related information" means information regarding eligibility for
63.11 drug benefits, medication history, or related health or drug information.

63.12 ~~(o)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03,
63.13 subdivision 8.

63.14 Sec. 5. Minnesota Statutes 2008, section 62J.497, subdivision 2, is amended to read:

63.15 Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011,
63.16 all providers, group purchasers, prescribers, and dispensers must establish ~~and~~, maintain,
63.17 and use an electronic prescription drug program ~~that complies~~. This program must comply
63.18 with the applicable standards in this section for transmitting, directly or through an
63.19 intermediary, prescriptions and prescription-related information using electronic media.

63.20 (b) ~~Nothing in this section requires providers, group purchasers, prescribers, or~~
63.21 ~~dispensers to conduct the transactions described in this section.~~ If transactions described in
63.22 this section are conducted, they must be done electronically using the standards described
63.23 in this section. Nothing in this section requires providers, group purchasers, prescribers,
63.24 or dispensers to electronically conduct transactions that are expressly prohibited by other
63.25 sections or federal law.

63.26 (c) Providers, group purchasers, prescribers, and dispensers must use either HL7
63.27 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related
63.28 information internally when the sender and the recipient are part of the same legal entity. If
63.29 an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard
63.30 or other applicable standards required by this section. Any pharmacy within an entity
63.31 must be able to receive electronic prescription transmittals from outside the entity using
63.32 the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health
63.33 Insurance Portability and Accountability Act (HIPAA) requirement that may require the
63.34 use of a HIPAA transaction standard within an organization.

64.1 ~~(d) Entities transmitting prescriptions or prescription-related information where the~~
64.2 ~~prescriber is required by law to issue a prescription for a patient to a nonprescribing~~
64.3 ~~provider that in turn forwards the prescription to a dispenser are exempt from the~~
64.4 ~~requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or~~
64.5 ~~prescription-related information.~~

64.6 Sec. 6. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
64.7 to read:

64.8 Subd. 4. **Development and use of uniform formulary exception form.** (a) The
64.9 commissioner of health, in consultation with the Minnesota Administrative Uniformity
64.10 Committee, shall develop by July 1, 2009, or six weeks after enactment of this subdivision,
64.11 whichever is later, a uniform formulary exception form that allows health care providers
64.12 to request exceptions from group purchaser formularies using a uniform form. Upon
64.13 development of the form, all health care providers must submit requests for formulary
64.14 exceptions using the uniform form, and all group purchasers must accept this form from
64.15 health care providers.
64.16 (b) No later than January 1, 2011, the uniform formulary exception form must be
64.17 accessible and submitted by health care providers, and accepted and processed by group
64.18 purchasers, through secure electronic transmissions. Facsimile shall not be considered
64.19 secure electronic transmissions.

64.20 Sec. 7. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
64.21 to read:

64.22 Subd. 5. **Electronic drug prior authorization standardization and transmission.**
64.23 (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory
64.24 Committee and the Minnesota Administrative Uniformity Committee, shall, by February
64.25 15, 2010, identify an outline on how best to standardize drug prior authorization request
64.26 transactions between providers and group purchasers with the goal of maximizing
64.27 administrative simplification and efficiency in preparation for electronic transmissions.
64.28 (b) No later than January 1, 2011, drug prior authorization requests must be
64.29 accessible and submitted by health care providers, and accepted and processed by group
64.30 purchasers, electronically through secure electronic transmissions. Facsimile shall not be
64.31 considered electronic transmission.

64.32 Sec. 8. **[62Q.676] MEDICATION THERAPY MANAGEMENT.**

65.1 A pharmacy benefit manager that provides prescription drug services must make
65.2 available medication therapy management services for enrollees taking four or more
65.3 prescriptions to treat or prevent two or more chronic medical conditions. For purposes
65.4 of this section, "medication therapy management" means the provision of the following
65.5 pharmaceutical care services by, or under the supervision of, a licensed pharmacist to
65.6 optimize the therapeutic outcomes of the patient's medications:

65.7 (1) performing a comprehensive medication review to identify, resolve, and prevent
65.8 medication-related problems, including adverse drug events;

65.9 (2) communicating essential information to the patient's other primary care
65.10 providers; and

65.11 (3) providing verbal education and training designed to enhance patient
65.12 understanding and appropriate use of the patient's medications.

65.13 Nothing in this section shall be construed to expand or modify the scope of practice
65.14 of the pharmacist as defined in section 151.01, subdivision 27.

65.15 Sec. 9. Minnesota Statutes 2008, section 144.122, is amended to read:

65.16 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

65.17 (a) The state commissioner of health, by rule, may prescribe procedures and fees
65.18 for filing with the commissioner as prescribed by statute and for the issuance of original
65.19 and renewal permits, licenses, registrations, and certifications issued under authority of
65.20 the commissioner. The expiration dates of the various licenses, permits, registrations,
65.21 and certifications as prescribed by the rules shall be plainly marked thereon. Fees may
65.22 include application and examination fees and a penalty fee for renewal applications
65.23 submitted after the expiration date of the previously issued permit, license, registration,
65.24 and certification. The commissioner may also prescribe, by rule, reduced fees for permits,
65.25 licenses, registrations, and certifications when the application therefor is submitted
65.26 during the last three months of the permit, license, registration, or certification period.
65.27 Fees proposed to be prescribed in the rules shall be first approved by the Department of
65.28 Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
65.29 in an amount so that the total fees collected by the commissioner will, where practical,
65.30 approximate the cost to the commissioner in administering the program. All fees collected
65.31 shall be deposited in the state treasury and credited to the state government special revenue
65.32 fund unless otherwise specifically appropriated by law for specific purposes.

65.33 (b) The commissioner may charge a fee for voluntary certification of medical
65.34 laboratories and environmental laboratories, and for environmental and medical laboratory
65.35 services provided by the department, without complying with paragraph (a) or chapter 14.

66.1 Fees charged for environment and medical laboratory services provided by the department
66.2 must be approximately equal to the costs of providing the services.

66.3 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
66.4 conducted at clinics held by the services for children with disabilities program. All
66.5 receipts generated by the program are annually appropriated to the commissioner for use
66.6 in the maternal and child health program.

66.7 (d) The commissioner shall set license fees for hospitals and nursing homes that are
66.8 not boarding care homes at the following levels:

66.9 66.10 66.11 66.12	Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	~~$7,555~~ $7,655 plus ~~$13~~ $16 per bed
66.13	Non-JCAHO and non-AOA hospitals	~~$5,180~~ $5,280 plus ~~$247~~ $250 per bed
66.14	Nursing home	$183 plus $91 per bed

66.15 The commissioner shall set license fees for outpatient surgical centers, boarding care
66.16 homes, and supervised living facilities at the following levels:

66.17	Outpatient surgical centers	~~$3,349~~ $3,712
66.18	Boarding care homes	$183 plus $91 per bed
66.19	Supervised living facilities	$183 plus $91 per bed.

66.20 (e) Unless prohibited by federal law, the commissioner of health shall charge
66.21 applicants the following fees to cover the cost of any initial certification surveys required
66.22 to determine a provider's eligibility to participate in the Medicare or Medicaid program:

66.23	Prospective payment surveys for hospitals	$	900
66.24	Swing bed surveys for nursing homes	$	1,200
66.25	Psychiatric hospitals	$	1,400
66.26	Rural health facilities	$	1,100
66.27	Portable x-ray providers	$	500
66.28	Home health agencies	$	1,800
66.29	Outpatient therapy agencies	$	800
66.30	End stage renal dialysis providers	$	2,100
66.31	Independent therapists	$	800

Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 10. Minnesota Statutes 2008, section 144.226, subdivision 4, is amended to read:

Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $2 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).

(b) Effective August 1, 2005, ~~to June 30, 2009,~~ the surcharge in paragraph (a) ~~shall be~~ is $4.

Sec. 11. Minnesota Statutes 2008, section 148.6445, is amended by adding a subdivision to read:

Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is $25.

ARTICLE 5
HEALTH CARE

Section 1. Minnesota Statutes 2008, section 60A.092, subdivision 2, is amended to read:

Subd. 2. **Licensed assuming insurer.** Reinsurance is ceded to an assuming insurer if the assuming insurer is licensed to transact insurance or reinsurance in this state. For purposes of reinsuring any health risk, an insurer is defined under section 62A.63.

68.1 Sec. 2. Minnesota Statutes 2008, section 62D.03, subdivision 4, is amended to read:

68.2 Subd. 4. **Application requirements.** Each application for a certificate of authority
68.3 shall be verified by an officer or authorized representative of the applicant, and shall be
68.4 in a form prescribed by the commissioner of health. Each application shall include the
68.5 following:

68.6 (a) a copy of the basic organizational document, if any, of the applicant and of
68.7 each major participating entity; such as the articles of incorporation, or other applicable
68.8 documents, and all amendments thereto;

68.9 (b) a copy of the bylaws, rules and regulations, or similar document, if any, and all
68.10 amendments thereto which regulate the conduct of the affairs of the applicant and of
68.11 each major participating entity;

68.12 (c) a list of the names, addresses, and official positions of the following:

68.13 (1) all members of the board of directors, or governing body of the local government
68.14 unit, and the principal officers and shareholders of the applicant organization; and

68.15 (2) all members of the board of directors, or governing body of the local government
68.16 unit, and the principal officers of the major participating entity and each shareholder
68.17 beneficially owning more than ten percent of any voting stock of the major participating
68.18 entity;

68.19 The commissioner may by rule identify persons included in the term "principal
68.20 officers";

68.21 (d) a full disclosure of the extent and nature of any contract or financial arrangements
68.22 between the following:

68.23 (1) the health maintenance organization and the persons listed in clause (c)(1);

68.24 (2) the health maintenance organization and the persons listed in clause (c)(2);

68.25 (3) each major participating entity and the persons listed in clause (c)(1) concerning
68.26 any financial relationship with the health maintenance organization; and

68.27 (4) each major participating entity and the persons listed in clause (c)(2) concerning
68.28 any financial relationship with the health maintenance organization;

68.29 (e) the name and address of each participating entity and the agreed upon duration of
68.30 each contract or agreement;

68.31 (f) a copy of the form of each contract binding the participating entities and the
68.32 health maintenance organization. Contractual provisions shall be consistent with the
68.33 purposes of sections 62D.01 to 62D.30, in regard to the services to be performed under the
68.34 contract, the manner in which payment for services is determined, the nature and extent
68.35 of responsibilities to be retained by the health maintenance organization, the nature and
68.36 extent of risk sharing permissible, and contractual termination provisions;

69.1 (g) a copy of each contract binding major participating entities and the health
69.2 maintenance organization. Contract information filed with the commissioner shall be
69.3 confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon
69.4 the request of the health maintenance organization.

69.5 Upon initial filing of each contract, the health maintenance organization shall file
69.6 a separate document detailing the projected annual expenses to the major participating
69.7 entity in performing the contract and the projected annual revenues received by the entity
69.8 from the health maintenance organization for such performance. The commissioner
69.9 shall disapprove any contract with a major participating entity if the contract will result
69.10 in an unreasonable expense under section 62D.19. The commissioner shall approve or
69.11 disapprove a contract within 30 days of filing.

69.12 Within 120 days of the anniversary of the implementation of each contract, the
69.13 health maintenance organization shall file a document detailing the actual expenses
69.14 incurred and reported by the major participating entity in performing the contract in the
69.15 preceding year and the actual revenues received from the health maintenance organization
69.16 by the entity in payment for the performance;

69.17 (h) a statement generally describing the health maintenance organization, its health
69.18 maintenance contracts and separate health service contracts, facilities, and personnel,
69.19 including a statement describing the manner in which the applicant proposes to provide
69.20 enrollees with comprehensive health maintenance services and separate health services;

69.21 (i) a copy of the form of each evidence of coverage to be issued to the enrollees;

69.22 (j) a copy of the form of each individual or group health maintenance contract
69.23 and each separate health service contract which is to be issued to enrollees or their
69.24 representatives;

69.25 (k) financial statements showing the applicant's assets, liabilities, and sources of
69.26 financial support. If the applicant's financial affairs are audited by independent certified
69.27 public accountants, a copy of the applicant's most recent certified financial statement
69.28 may be deemed to satisfy this requirement;

69.29 (l) a description of the proposed method of marketing the plan, a schedule of
69.30 proposed charges, and a financial plan which includes a three-year projection of the
69.31 expenses and income and other sources of future capital;

69.32 (m) a statement reasonably describing the geographic area or areas to be served and
69.33 the type or types of enrollees to be served;

69.34 (n) a description of the complaint procedures to be utilized as required under section
69.35 62D.11;

70.1 (o) a description of the procedures and programs to be implemented to meet the
70.2 requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the
70.3 quality of health care provided to enrollees;

70.4 (p) a description of the mechanism by which enrollees will be afforded an
70.5 opportunity to participate in matters of policy and operation under section 62D.06;

70.6 (q) a copy of any agreement between the health maintenance organization and
70.7 an insurer ~~or~~, including any nonprofit health service corporation or another health
70.8 maintenance organization, regarding reinsurance, stop-loss coverage, insolvency
70.9 coverage, or any other type of coverage for potential costs of health services, as authorized
70.10 in sections 62D.04, subdivision 1, clause (f), 62D.05, subdivision 3, and 62D.13;

70.11 (r) a copy of the conflict of interest policy which applies to all members of the board
70.12 of directors and the principal officers of the health maintenance organization, as described
70.13 in section 62D.04, subdivision 1, paragraph (g). All currently licensed health maintenance
70.14 organizations shall also file a conflict of interest policy with the commissioner within 60
70.15 days after August 1, 1990, or at a later date if approved by the commissioner;

70.16 (s) a copy of the statement that describes the health maintenance organization's prior
70.17 authorization administrative procedures; and

70.18 (t) other information as the commissioner of health may reasonably require to be
70.19 provided.

70.20 Sec. 3. Minnesota Statutes 2008, section 62D.05, subdivision 3, is amended to read:

70.21 Subd. 3. **Contracts; health services.** A health maintenance organization may
70.22 contract with providers of health care services to render the services the health maintenance
70.23 organization has promised to provide under the terms of its health maintenance contracts,
70.24 may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts,
70.25 or other separate health service contracts, may, subject to the limitations of section
70.26 62D.04, subdivision 1, clause (f), contract with insurance companies ~~and~~, including
70.27 nonprofit health service plan corporations or other health maintenance organizations,
70.28 for insurance, indemnity or reimbursement of its cost of providing health care services
70.29 for enrollees or against the risks incurred by the health maintenance organization, may
70.30 contract with insurance companies and nonprofit health service plan corporations for
70.31 insolvency insurance coverage, and may contract with insurance companies and nonprofit
70.32 health service plan corporations to insure or cover the enrollees' costs and expenses in the
70.33 health maintenance organization, including the customary prepayment amount and any
70.34 co-payment obligations, and may contract to provide reinsurance or insolvency insurance
70.35 coverage to health insurers or nonprofit health service plan corporations.

Sec. 4. Minnesota Statutes 2008, section 62J.692, subdivision 7, is amended to read:

Subd. 7. **Transfers from the commissioner of human services.** ~~(a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), 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)~~ 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 medial 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).

~~(b) Fifty percent of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), 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. Of the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), 24 percent of the amount shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education. The remaining 26 percent of the amount transferred shall be distributed by the commissioner in accordance with subdivision 7a. If the federal approval is not obtained for the matching funds under section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount transferred under this paragraph 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.~~

~~(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (3) and (4), shall be distributed by the commissioner upon receipt to the University of Minnesota Board of Regents for the purposes of clinical graduate medical education.~~

Sec. 5. Minnesota Statutes 2008, section 256.01, subdivision 2b, is amended to read:

72.1 Subd. 2b. **Performance payments.** ~~(a)~~ The commissioner shall develop and
72.2 implement a pay-for-performance system to provide performance payments to eligible
72.3 medical groups and clinics that demonstrate optimum care in serving individuals
72.4 with chronic diseases who are enrolled in health care programs administered by the
72.5 commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any
72.6 federal matching money that is made available through the medical assistance program
72.7 for managed care oversight contracted through vendors, including consumer surveys,
72.8 studies, and external quality reviews as required by the federal Balanced Budget Act of
72.9 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external
72.10 quality review. Any federal money received for managed care oversight is appropriated
72.11 to the commissioner for this purpose. The commissioner may expend the federal money
72.12 received in either year of the biennium.

72.13 ~~(b) Effective July 1, 2008, or upon federal approval, whichever is later, the~~
72.14 ~~commissioner shall develop and implement a patient incentive health program to provide~~
72.15 ~~incentives and rewards to patients who are enrolled in health care programs administered~~
72.16 ~~by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and~~
72.17 ~~have met personal health goals established with the patients' primary care providers to~~
72.18 ~~manage a chronic disease or condition, including but not limited to diabetes, high blood~~
72.19 ~~pressure, and coronary artery disease.~~

72.20 Sec. 6. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
72.21 to read:

72.22 Subd. 18a. **Public Assistance Reporting Information System.** (a) Effective
72.23 October 1, 2009, the commissioner shall comply with the federal requirements in Public
72.24 Law 110-379 in implementing the Public Assistance Reporting Information System
72.25 (PARIS) to determine eligibility for all individuals applying for:

72.26 (1) health care benefits under chapters 256B, 256D, and 256L; and

72.27 (2) public benefits under chapters 119B, 256D, 256I, and the supplemental nutrition
72.28 assistance program.

72.29 (b) The commissioner shall determine eligibility under paragraph (a) by performing
72.30 data matches, including matching with medical assistance, cash, child care, and
72.31 supplemental assistance programs operated by other states.

72.32 **EFFECTIVE DATE.** This section is effective October 1, 2009.

72.33 Sec. 7. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
72.34 to read:

73.1 Subd. 18b. **Protections for American Indians.** Effective February 18, 2009, the
73.2 commissioner shall comply with the federal requirements in the American Recovery and
73.3 Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding American Indians.

73.4 Sec. 8. Minnesota Statutes 2008, section 256.962, subdivision 2, is amended to read:

73.5 Subd. 2. **Outreach grants.** (a) The commissioner shall award grants to public and
73.6 private organizations, regional collaboratives, and regional health care outreach centers
73.7 for outreach activities, including, but not limited to:

73.8 (1) providing information, applications, and assistance in obtaining coverage
73.9 through Minnesota public health care programs;

73.10 (2) collaborating with public and private entities such as hospitals, providers, health
73.11 plans, legal aid offices, pharmacies, insurance agencies, and faith-based organizations to
73.12 develop outreach activities and partnerships to ensure the distribution of information
73.13 and applications and provide assistance in obtaining coverage through Minnesota health
73.14 care programs; ~~and~~

73.15 (3) providing or collaborating with public and private entities to provide multilingual
73.16 and culturally specific information and assistance to applicants in areas of high
73.17 uninsurance in the state or populations with high rates of uninsurance; and

73.18 (4) targeting geographic areas with high rates of (i) eligible but unenrolled children,
73.19 including children who reside in rural areas, or (ii) racial and ethnic minorities and health
73.20 disparity populations.

73.21 (b) The commissioner shall ensure that all outreach materials are available in
73.22 languages other than English.

73.23 (c) The commissioner shall establish an outreach trainer program to provide
73.24 training to designated individuals from the community and public and private entities on
73.25 application assistance in order for these individuals to provide training to others in the
73.26 community on an as-needed basis.

73.27 Sec. 9. Minnesota Statutes 2008, section 256.962, subdivision 6, is amended to read:

73.28 Subd. 6. **School districts and charter schools.** (a) At the beginning of each school
73.29 year, a school district or charter school shall provide information to each student on the
73.30 availability of health care coverage through the Minnesota health care programs and how
73.31 to obtain an application for the Minnesota health care programs.

73.32 (b) ~~For each child who is determined to be eligible for the free and reduced-price~~
73.33 ~~school lunch program, the district shall provide the child's family with information on how~~
73.34 ~~to obtain an application for the Minnesota health care programs and application assistance.~~

74.1 ~~(c)~~ A school district or charter school shall also ensure that applications and
74.2 information on application assistance are available at early childhood education sites and
74.3 public schools located within the district's jurisdiction.

74.4 ~~(d)~~ (c) Each district shall designate an enrollment specialist to provide application
74.5 assistance and follow-up services with families who have indicated an interest in receiving
74.6 information or an application for the Minnesota health care program. A district is eligible
74.7 for the application assistance bonus described in subdivision 5.

74.8 ~~(e) Each~~ (d) If a school district or charter school maintains a district Web site, the
74.9 school district or charter school shall provide on ~~their~~ its Web site a link to information on
74.10 how to obtain an application and application assistance.

74.11 Sec. 10. **[256.964] DENTAL CARE PILOT PROJECTS.**

74.12 The commissioner shall authorize pilot projects to reduce the total cost to the state
74.13 for dental services provided to enrollees of the state public health care programs by
74.14 reducing hospital emergency room costs for preventable or nonemergency dental services.
74.15 As part of the project, a community dental clinic or dental provider, in collaboration with a
74.16 hospital emergency room, shall provide urgent care dental services as an alternative to the
74.17 hospital emergency room for nonemergency dental care. The project participants shall
74.18 establish a process to divert a patient presenting at the emergency room for nonemergency
74.19 dental care to the dental community clinic or to an appropriate dental provider. The
74.20 commissioner may establish special payment rates for urgent care services provided and
74.21 may change or waive existing payment policies in order to adequately reimburse providers
74.22 for providing cost-effective alternative services in an outpatient or urgent care setting.
74.23 The commissioner may establish a project in conjunction with the initiative authorized
74.24 under section 256.963.

74.25 Sec. 11. Minnesota Statutes 2008, section 256.969, subdivision 2b, is amended to read:

74.26 Subd. 2b. **Operating payment rates.** In determining operating payment rates for
74.27 admissions occurring on or after the rate year beginning January 1, 1991, and every two
74.28 years after, or more frequently as determined by the commissioner, the commissioner
74.29 shall obtain operating data from an updated base year and establish operating payment
74.30 rates per admission for each hospital based on the cost-finding methods and allowable
74.31 costs of the Medicare program in effect during the base year. Rates under the general
74.32 assistance medical care, medical assistance, and MinnesotaCare programs shall not be
74.33 rebased to more current data on January 1, 1997, January 1, 2005, ~~and~~ for the first 24
74.34 months of the rebased period beginning January 1, 2009, and for the first three months of

75.1 the rebased period beginning January 1, 2011. From April 1, 2011, to March 31, 2012,
75.2 rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change.
75.3 Effective April 1, 2012, rates shall be rebased at full value. The base year operating
75.4 payment rate per admission is standardized by the case mix index and adjusted by the
75.5 hospital cost index, relative values, and disproportionate population adjustment. The
75.6 cost and charge data used to establish operating rates shall only reflect inpatient services
75.7 covered by medical assistance and shall not include property cost information and costs
75.8 recognized in outlier payments.

75.9 Sec. 12. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

75.10 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
75.11 assistance program must not be submitted until the recipient is discharged. However,
75.12 the commissioner shall establish monthly interim payments for inpatient hospitals that
75.13 have individual patient lengths of stay over 30 days regardless of diagnostic category.
75.14 Except as provided in section 256.9693, medical assistance reimbursement for treatment
75.15 of mental illness shall be reimbursed based on diagnostic classifications. Individual
75.16 hospital payments established under this section and sections 256.9685, 256.9686, and
75.17 256.9695, in addition to third party and recipient liability, for discharges occurring during
75.18 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
75.19 inpatient services paid for the same period of time to the hospital. This payment limitation
75.20 shall be calculated separately for medical assistance and general assistance medical
75.21 care services. The limitation on general assistance medical care shall be effective for
75.22 admissions occurring on or after July 1, 1991. Services that have rates established under
75.23 subdivision 11 or 12, must be limited separately from other services. After consulting with
75.24 the affected hospitals, the commissioner may consider related hospitals one entity and
75.25 may merge the payment rates while maintaining separate provider numbers. The operating
75.26 and property base rates per admission or per day shall be derived from the best Medicare
75.27 and claims data available when rates are established. The commissioner shall determine
75.28 the best Medicare and claims data, taking into consideration variables of recency of the
75.29 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
75.30 The commissioner shall notify hospitals of payment rates by December 1 of the year
75.31 preceding the rate year. The rate setting data must reflect the admissions data used to
75.32 establish relative values. Base year changes from 1981 to the base year established for the
75.33 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
75.34 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
75.35 1. The commissioner may adjust base year cost, relative value, and case mix index data

76.1 to exclude the costs of services that have been discontinued by the October 1 of the year
76.2 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
76.3 that encompass portions of two or more rate years shall have payments established based
76.4 on payment rates in effect at the time of admission unless the date of admission preceded
76.5 the rate year in effect by six months or more. In this case, operating payment rates for
76.6 services rendered during the rate year in effect and established based on the date of
76.7 admission shall be adjusted to the rate year in effect by the hospital cost index.

76.8 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
76.9 payment, before third-party liability and spenddown, made to hospitals for inpatient
76.10 services is reduced by .5 percent from the current statutory rates.

76.11 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
76.12 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
76.13 before third-party liability and spenddown, is reduced five percent from the current
76.14 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
76.15 facilities defined under subdivision 16 are excluded from this paragraph.

76.16 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
76.17 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
76.18 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
76.19 from the current statutory rates. Mental health services within diagnosis related groups
76.20 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
76.21 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
76.22 assistance does not include general assistance medical care. Payments made to managed
76.23 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
76.24 this reduction.

76.25 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
76.26 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
76.27 to hospitals for inpatient services before third-party liability and spenddown, is reduced
76.28 3.46 percent from the current statutory rates. Mental health services with diagnosis related
76.29 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
76.30 paragraph. Payments made to managed care plans shall be reduced for services provided
76.31 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

76.32 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
76.33 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
76.34 to hospitals for inpatient services before third-party liability and spenddown, is reduced
76.35 1.9 percent from the current statutory rates. Mental health services with diagnosis related
76.36 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this

77.1 paragraph. Payments made to managed care plans shall be reduced for services provided
77.2 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

77.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
77.4 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
77.5 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
77.6 from the current statutory rates. Mental health services with diagnosis related groups
77.7 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
77.8 Payments made to managed care plans shall be reduced for services provided on or after
77.9 July 1, 2010, to reflect this reduction.

77.10 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
77.11 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
77.12 hospitals for inpatient services before third-party liability and spenddown, is reduced
77.13 one percent from the current statutory rates. Facilities defined under subdivision 16 are
77.14 excluded from this paragraph. Payments made to managed care plans shall be reduced for
77.15 services provided on or after October 1, 2009, to reflect this reduction.

77.16 Sec. 13. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
77.17 to read:

77.18 Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain**
77.19 **treatments.** (a) The commissioner must not make medical assistance payments to a
77.20 hospital for any costs of care that result from a condition listed in paragraph (c), if the
77.21 condition was hospital acquired.

77.22 (b) For purposes of this subdivision, a condition is hospital acquired if it is not
77.23 identified by the hospital as present on admission. For purposes of this subdivision,
77.24 medical assistance includes general assistance medical care and MinnesotaCare.

77.25 (c) The prohibition in paragraph (a) applies to payment for each hospital-acquired
77.26 condition listed in this paragraph that is represented by an ICD-9-CM diagnosis code and
77.27 is designated as a complicating condition or a major complicating condition:

77.28 (1) foreign object retained after surgery (ICD-9-CM codes 998.4 or 998.7);

77.29 (2) air embolism (ICD-9-CM code 999.1);

77.30 (3) blood incompatibility (ICD-9-CM code 999.6);

77.31 (4) pressure ulcers stage III or IV (ICD-9-CM codes 707.23 or 707.24);

77.32 (5) falls and trauma, including fracture, dislocation, intracranial injury, crushing
77.33 injury, burn, and electric shock (ICD-9-CM codes with these ranges on the complicating
77.34 condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929;
77.35 940-949; and 991-994);

78.1 (6) catheter-associated urinary tract infection (ICD-9-CM code 996.64);

78.2 (7) vascular catheter-associated infection (ICD-9-CM code 999.31);

78.3 (8) manifestations of poor glycemic control (ICD-9-CM codes 249.10; 249.11;
78.4 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and
78.5 251.0);

78.6 (9) surgical site infection (ICD-9-CM codes 996.67 or 998.59) following certain
78.7 orthopedic procedures (procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07;
78.8 81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and
78.9 81.85);

78.10 (10) surgical site infection (ICD-9-CM code 998.59) following bariatric surgery
78.11 (procedure codes 44.38; 44.39; or 44.95) for a principal diagnosis of morbid obesity
78.12 (ICD-9-CM code 278.01);

78.13 (11) surgical site infection, mediastinitis (ICD-9-CM code 519.2) following coronary
78.14 artery bypass graft (procedure codes 36.10 to 36.19); and

78.15 (12) deep vein thrombosis (ICD-9-CM codes 453.40 to 453.42) or pulmonary
78.16 embolism (ICD-9-CM codes 415.11 or 415.91) following total knee replacement
78.17 (procedure code 81.54) or hip replacement (procedure codes 00.85 to 00.87 or 81.51
78.18 to 81.52).

78.19 (d) The prohibition in paragraph (a) applies to any additional payments that result
78.20 from a hospital-acquired condition listed in paragraph (c), including, but not limited to,
78.21 additional treatment or procedures, readmission to the facility after discharge, increased
78.22 length of stay, change to a higher diagnostic category, or transfer to another hospital. In
78.23 the event of a transfer to another hospital, the hospital where the condition listed under
78.24 paragraph (c) was acquired is responsible for any costs incurred at the hospital to which
78.25 the patient is transferred.

78.26 (e) A hospital shall not bill a recipient of services for any payment disallowed under
78.27 this subdivision.

78.28 Sec. 14. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
78.29 to read:

78.30 Subd. 28. **Temporary rate increase for qualifying hospitals.** For the period
78.31 from April 1, 2009, to September 30, 2010, for each hospital with a medical assistance
78.32 utilization rate equal to or greater than 25 percent during the base year, the commissioner
78.33 shall provide an equal percentage rate increase for each medical assistance admission. The
78.34 commissioner shall estimate the percentage rate increase using as the state share of the
78.35 increase the amount available under section 256B.199, paragraph (d). The commissioner

79.1 shall settle up payments to qualifying hospitals based on actual payments under that
79.2 section and actual hospital admissions.

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

79.4 Sec. 15. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
79.5 to read:

79.6 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
79.7 **and intervention program.** For services provided on or after July 1, 2010, in addition to
79.8 any other payment under this section, the commissioner shall reimburse hospitals for the
79.9 increase in the fee for the early hearing detection and intervention program described in
79.10 section 144.125, subdivision 1, paid by the hospital for public program recipients.

79.11 Sec. 16. **[256B.032] ELIGIBLE VENDORS OF MEDICAL CARE.**

79.12 (a) Effective January 1, 2011, the commissioner shall establish performance
79.13 thresholds for health care providers included in the provider peer grouping system
79.14 developed by the commissioner of health under section 62U.04. The thresholds shall be
79.15 set at the 10th percentile of the combined cost and quality measure used for provider peer
79.16 grouping, and separate thresholds shall be set for hospital and physician services.

79.17 (b) Beginning January 1, 2012, any health care provider with a combined cost and
79.18 quality score below the threshold set in paragraph (a) shall be prohibited from enrolling
79.19 as a vendor of medical care in the medical assistance, general assistance medical care,
79.20 or MinnesotaCare programs, and shall not be eligible for direct payments under those
79.21 programs or for payments made by managed care plans under their contracts with the
79.22 commissioner under section 256B.69 or 256L.12. A health care provider that is prohibited
79.23 from enrolling as a vendor or receiving payments under this paragraph may reenroll
79.24 effective January 1 of any subsequent year if the provider's most recent combined cost and
79.25 quality score exceeds the threshold established in paragraph (a).

79.26 (c) Notwithstanding paragraph (b), a provider may continue to participate as a vendor
79.27 or as part of a managed care plan provider network if the commissioner determines that a
79.28 contract with the provider is necessary to ensure adequate access to health care services.

79.29 (d) By January 15, 2013, the commissioner shall report to the legislature on the
79.30 impact of this section. The commissioner's report shall include information on:

79.31 (1) the providers falling below the thresholds as of January 1, 2012;

79.32 (2) the volume of services and cost of care provided to enrollees in the medical
79.33 assistance, general assistance medical care, or MinnesotaCare programs in the 12 months
79.34 prior to January 1, 2012, by providers falling below the thresholds;

80.1 (3) providers who fell below the thresholds but continued to be eligible vendors
80.2 under paragraph (c);

80.3 (4) the estimated cost savings achieved by not contracting with providers who do
80.4 not meet the performance thresholds; and

80.5 (5) recommendations for increasing the threshold levels of performance over time.

80.6 Sec. 17. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to
80.7 read:

80.8 Subd. 3c. **Asset limitations for families and children.** A household of two or more
80.9 persons must not own more than $20,000 in total net assets, and a household of one
80.10 person must not own more than $10,000 in total net assets. In addition to these maximum
80.11 amounts, an eligible individual or family may accrue interest on these amounts, but they
80.12 must be reduced to the maximum at the time of an eligibility redetermination. The value of
80.13 assets that are not considered in determining eligibility for medical assistance for families
80.14 and children is the value of those assets excluded under the AFDC state plan as of July 16,
80.15 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
80.16 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

80.17 (1) household goods and personal effects are not considered;

80.18 (2) capital and operating assets of a trade or business up to $200,000 are not
80.19 considered, except that a bank account that contains personal income or assets, or is used to
80.20 pay personal expenses, is not considered a capital or operating asset of a trade or business;

80.21 (3) one motor vehicle is excluded for each person of legal driving age who is
80.22 employed or seeking employment;

80.23 (4) one burial plot and all other burial expenses equal to the supplemental security
80.24 income program asset limit are not considered for each individual;

80.25 (5) court-ordered settlements up to $10,000 are not considered;

80.26 (6) individual retirement accounts and funds are not considered; and

80.27 (7) assets owned by children are not considered.

80.28 The assets specified in clause (2) must be disclosed to the local agency at the time of
80.29 application and at the time of an eligibility redetermination, and must be verified upon
80.30 request of the local agency.

80.31 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
80.32 approval, whichever is later.

80.33 Sec. 18. Minnesota Statutes 2008, section 256B.056, subdivision 3d, is amended to
80.34 read:

81.1 Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions
81.2 3 to 3c may be reduced to allowable limits as follows:
81.3 (a) Assets may be reduced in any of the three calendar months before the month
81.4 of application in which the applicant seeks coverage by~~:~~
81.5 ~~(1) designating burial funds up to $1,500 for each applicant, spouse, and MA-eligible~~
81.6 ~~dependent child; and~~
81.7 ~~(2)~~ paying ~~health service~~ bills for health services that are incurred in the retroactive
81.8 period for which the applicant seeks eligibility, starting with the oldest bill. After assets
81.9 are reduced to allowable limits, eligibility begins with the next dollar of MA-covered
81.10 health services incurred in the retroactive period. Applicants reducing assets under this
81.11 subdivision who also have excess income shall first spend excess assets to pay health
81.12 service bills and may meet the income spenddown on remaining bills.
81.13 (b) Assets may be reduced beginning the month of application by~~:~~
81.14 ~~(1)~~ paying bills for health services that are incurred during the period specified in
81.15 Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical
81.16 assistance~~; and~~. After assets are reduced to allowable limits, eligibility begins with the
81.17 next dollar of medical assistance covered health services incurred in the period. Applicants
81.18 reducing assets under this subdivision who also have excess income shall first spend excess
81.19 assets to pay health service bills and may meet the income spenddown on remaining bills.
81.20 ~~(2) using any means other than a transfer of assets for less than fair market value as~~
81.21 ~~defined in section 256B.0595, subdivision 1, paragraph (b).~~

81.22 **EFFECTIVE DATE.** This section is effective January 1, 2011.

81.23 Sec. 19. Minnesota Statutes 2008, section 256B.057, is amended by adding a
81.24 subdivision to read:

81.25 Subd. 11. **Treatment for colorectal cancer.** (a) Medical assistance shall be paid for
81.26 an individual who:
81.27 (1) has been screened for colorectal cancer by the colorectal cancer prevention
81.28 demonstration project;
81.29 (2) according to the individual's treating health professional, needs treatment for
81.30 colorectal cancer;
81.31 (3) meets income eligibility guidelines for the colorectal cancer prevention
81.32 demonstration project;
81.33 (4) is under the age of 65; and
81.34 (5) is not otherwise eligible for medical assistance or covered under creditable
81.35 coverage as defined under United States Code, title 42, section 300gg(a).

82.1 (b) Medical assistance provided under this subdivision shall be limited to services
82.2 provided during the period that the individual receives treatment for colorectal cancer.
82.3 (c) An individual meeting the criteria in paragraph (a) is eligible for medical
82.4 assistance without meeting the eligibility criteria relating to income and assets in section
82.5 256B.056, subdivisions 1a to 5b.
82.6 (d) This subdivision expires December 31, 2010.

82.7 Sec. 20. Minnesota Statutes 2008, section 256B.0575, is amended to read:

82.8 **256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED**
82.9 **PERSONS.**

82.10 Subdivision 1. **Income deductions.** When an institutionalized person is determined
82.11 eligible for medical assistance, the income that exceeds the deductions in paragraphs (a)
82.12 and (b) must be applied to the cost of institutional care.
82.13 (a) The following amounts must be deducted from the institutionalized person's
82.14 income in the following order:
82.15 (1) the personal needs allowance under section 256B.35 or, for a veteran who
82.16 does not have a spouse or child, or a surviving spouse of a veteran having no child, the
82.17 amount of an improved pension received from the veteran's administration not exceeding
82.18 $90 per month;
82.19 (2) the personal allowance for disabled individuals under section 256B.36;
82.20 (3) if the institutionalized person has a legally appointed guardian or conservator,
82.21 five percent of the recipient's gross monthly income up to $100 as reimbursement for
82.22 guardianship or conservatorship services;
82.23 (4) a monthly income allowance determined under section 256B.058, subdivision
82.24 2, but only to the extent income of the institutionalized spouse is made available to the
82.25 community spouse;
82.26 (5) a monthly allowance for children under age 18 which, together with the net
82.27 income of the children, would provide income equal to the medical assistance standard
82.28 for families and children according to section 256B.056, subdivision 4, for a family size
82.29 that includes only the minor children. This deduction applies only if the children do not
82.30 live with the community spouse and only to the extent that the deduction is not included
82.31 in the personal needs allowance under section 256B.35, subdivision 1, as child support
82.32 garnished under a court order;
82.33 (6) a monthly family allowance for other family members, equal to one-third of the
82.34 difference between 122 percent of the federal poverty guidelines and the monthly income
82.35 for that family member;

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses, as specified in subdivision 2, incurred for necessary medical or remedial care for the institutionalized person that are recognized under state law, not medical assistance covered expenses, and ~~that are~~ not subject to payment by a third party.

~~Reasonable expenses are limited to expenses that have not been previously used as a deduction from income and are incurred during the enrollee's current period of eligibility, including retroactive months associated with the current period of eligibility, for medical assistance payment of long-term care services.~~

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Subd. 2. **Reasonable expenses.** For the purposes of subdivision 1, paragraph (a), clause (9), reasonable expenses are limited to expenses that have not been previously used as a deduction from income and were not:

(1) for long-term care expenses incurred during a period of ineligibility as defined in section 256B.0595, subdivision 2;

84.1 (2) incurred more than three months before the month of application associated with
84.2 the current period of eligibility;

84.3 (3) for expenses incurred by a recipient that are duplicative of services that are
84.4 covered under chapter 256B; or

84.5 (4) nursing facility expenses incurred without a timely assessment as required under
84.6 section 256B.0911.

84.7 Sec. 21. Minnesota Statutes 2008, section 256B.0595, subdivision 1, is amended to
84.8 read:

84.9 Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before
84.10 August 10, 1993, if an institutionalized person or the institutionalized person's spouse has
84.11 given away, sold, or disposed of, for less than fair market value, any asset or interest
84.12 therein, except assets other than the homestead that are excluded under the supplemental
84.13 security program, within 30 months before or any time after the date of institutionalization
84.14 if the person has been determined eligible for medical assistance, or within 30 months
84.15 before or any time after the date of the first approved application for medical assistance
84.16 if the person has not yet been determined eligible for medical assistance, the person is
84.17 ineligible for long-term care services for the period of time determined under subdivision
84.18 2.

84.19 (b) Effective for transfers made after August 10, 1993, an institutionalized person, an
84.20 institutionalized person's spouse, or any person, court, or administrative body with legal
84.21 authority to act in place of, on behalf of, at the direction of, or upon the request of the
84.22 institutionalized person or institutionalized person's spouse, may not give away, sell, or
84.23 dispose of, for less than fair market value, any asset or interest therein, except assets other
84.24 than the homestead that are excluded under the Supplemental Security Income program,
84.25 for the purpose of establishing or maintaining medical assistance eligibility. This applies
84.26 to all transfers, including those made by a community spouse after the month in which
84.27 the institutionalized spouse is determined eligible for medical assistance. For purposes of
84.28 determining eligibility for long-term care services, any transfer of such assets within 36
84.29 months before or any time after an institutionalized person requests medical assistance
84.30 payment of long-term care services, or 36 months before or any time after a medical
84.31 assistance recipient becomes an institutionalized person, for less than fair market value
84.32 may be considered. Any such transfer is presumed to have been made for the purpose
84.33 of establishing or maintaining medical assistance eligibility and the institutionalized
84.34 person is ineligible for long-term care services for the period of time determined under
84.35 subdivision 2, unless the institutionalized person furnishes convincing evidence to

85.1 establish that the transaction was exclusively for another purpose, or unless the transfer is
85.2 permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a
85.3 trust that are considered transfers of assets under federal law, or in the case of any other
85.4 disposal of assets made on or after February 8, 2006, any transfers made within 60 months
85.5 before or any time after an institutionalized person requests medical assistance payment of
85.6 long-term care services and within 60 months before or any time after a medical assistance
85.7 recipient becomes an institutionalized person, may be considered.

85.8 (c) This section applies to transfers, for less than fair market value, of income
85.9 or assets, including assets that are considered income in the month received, such as
85.10 inheritances, court settlements, and retroactive benefit payments or income to which the
85.11 institutionalized person or the institutionalized person's spouse is entitled but does not
85.12 receive due to action by the institutionalized person, the institutionalized person's spouse,
85.13 or any person, court, or administrative body with legal authority to act in place of, on
85.14 behalf of, at the direction of, or upon the request of the institutionalized person or the
85.15 institutionalized person's spouse.

85.16 (d) This section applies to payments for care or personal services provided by a
85.17 relative, unless the compensation was stipulated in a notarized, written agreement which
85.18 was in existence when the service was performed, the care or services directly benefited
85.19 the person, and the payments made represented reasonable compensation for the care
85.20 or services provided. A notarized written agreement is not required if payment for the
85.21 services was made within 60 days after the service was provided.

85.22 (e) This section applies to the portion of any asset or interest that an institutionalized
85.23 person, an institutionalized person's spouse, or any person, court, or administrative body
85.24 with legal authority to act in place of, on behalf of, at the direction of, or upon the request
85.25 of the institutionalized person or the institutionalized person's spouse, transfers to any
85.26 annuity that exceeds the value of the benefit likely to be returned to the institutionalized
85.27 person or institutionalized person's spouse while alive, based on estimated life expectancy
85.28 as determined according to the current actuarial tables published by the Office of the
85.29 Chief Actuary of the Social Security Administration. The commissioner may adopt rules
85.30 reducing life expectancies based on the need for long-term care. This section applies to an
85.31 annuity purchased on or after March 1, 2002, that:

85.32 (1) is not purchased from an insurance company or financial institution that is
85.33 subject to licensing or regulation by the Minnesota Department of Commerce or a similar
85.34 regulatory agency of another state;

85.35 (2) does not pay out principal and interest in equal monthly installments; or

85.36 (3) does not begin payment at the earliest possible date after annuitization.

86.1 (f) Effective for transactions, including the purchase of an annuity, occurring on or
86.2 after February 8, 2006, by or on behalf of an institutionalized person who has applied for
86.3 or is receiving long-term care services or the institutionalized person's spouse shall be
86.4 treated as the disposal of an asset for less than fair market value unless the department is
86.5 named a preferred remainder beneficiary as described in section 256B.056, subdivision
86.6 11. Any subsequent change to the designation of the department as a preferred remainder
86.7 beneficiary shall result in the annuity being treated as a disposal of assets for less than
86.8 fair market value. The amount of such transfer shall be the maximum amount the
86.9 institutionalized person or the institutionalized person's spouse could receive from the
86.10 annuity or similar financial instrument. Any change in the amount of the income or
86.11 principal being withdrawn from the annuity or other similar financial instrument at the
86.12 time of the most recent disclosure shall be deemed to be a transfer of assets for less than
86.13 fair market value unless the institutionalized person or the institutionalized person's spouse
86.14 demonstrates that the transaction was for fair market value. In the event a distribution
86.15 of income or principal has been improperly distributed or disbursed from an annuity or
86.16 other retirement planning instrument of an institutionalized person or the institutionalized
86.17 person's spouse, a cause of action exists against the individual receiving the improper
86.18 distribution for the cost of medical assistance services provided or the amount of the
86.19 improper distribution, whichever is less.

86.20 (g) Effective for transactions, including the purchase of an annuity, occurring on
86.21 or after February 8, 2006, by or on behalf of an institutionalized person applying for or
86.22 receiving long-term care services shall be treated as a disposal of assets for less than fair
86.23 market value unless it is:

86.24 (i) an annuity described in subsection (b) or (q) of section 408 of the Internal
86.25 Revenue Code of 1986; or

86.26 (ii) purchased with proceeds from:

86.27 (A) an account or trust described in subsection (a), (c), or (p) of section 408 of the
86.28 Internal Revenue Code;

86.29 (B) a simplified employee pension within the meaning of section 408(k) of the
86.30 Internal Revenue Code; or

86.31 (C) a Roth IRA described in section 408A of the Internal Revenue Code; or

86.32 (iii) an annuity that is irrevocable and nonassignable; is actuarially sound as
86.33 determined in accordance with actuarial publications of the Office of the Chief Actuary of
86.34 the Social Security Administration; and provides for payments in equal amounts during
86.35 the term of the annuity, with no deferral and no balloon payments made.

87.1 (h) For purposes of this section, long-term care services include services in a nursing
87.2 facility, services that are eligible for payment according to section 256B.0625, subdivision
87.3 2, because they are provided in a swing bed, intermediate care facility for persons with
87.4 developmental disabilities, and home and community-based services provided pursuant
87.5 to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and
87.6 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient
87.7 in a nursing facility or in a swing bed, or intermediate care facility for persons with
87.8 developmental disabilities or who is receiving home and community-based services under
87.9 sections 256B.0915, 256B.092, and 256B.49.

87.10 (i) This section applies to funds used to purchase a promissory note, loan, or
87.11 mortgage unless the note, loan, or mortgage:

87.12 (1) has a repayment term that is actuarially sound;

87.13 (2) provides for payments to be made in equal amounts during the term of the loan,
87.14 with no deferral and no balloon payments made; and

87.15 (3) prohibits the cancellation of the balance upon the death of the lender.

87.16 In the case of a promissory note, loan, or mortgage that does not meet an exception
87.17 in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding
87.18 balance due as of the date of the institutionalized person's request for medical assistance
87.19 payment of long-term care services.

87.20 (j) This section applies to the purchase of a life estate interest in another person's
87.21 home unless the purchaser resides in the home for a period of at least one year after the
87.22 date of purchase.

87.23 (k) This section applies to transfers into a pooled trust that qualifies under United
87.24 States Code, title 42, section 1396p(d)(4)(C), by:

87.25 (1) a person age 65 or older or the person's spouse; or

87.26 (2) any person, court, or administrative body with legal authority to act in place
87.27 of, on behalf of, at the direction of, or upon the request of a person age 65 or older or
87.28 the person's spouse.

87.29 Sec. 22. Minnesota Statutes 2008, section 256B.0595, subdivision 2, is amended to
87.30 read:

87.31 Subd. 2. **Period of ineligibility for long-term care services.** (a) For any
87.32 uncompensated transfer occurring on or before August 10, 1993, the number of months
87.33 of ineligibility for long-term care services shall be the lesser of 30 months, or the
87.34 uncompensated transfer amount divided by the average medical assistance rate for nursing
87.35 facility services in the state in effect on the date of application. The amount used to

88.1 calculate the average medical assistance payment rate shall be adjusted each July 1 to
88.2 reflect payment rates for the previous calendar year. The period of ineligibility begins
88.3 with the month in which the assets were transferred. If the transfer was not reported to
88.4 the local agency at the time of application, and the applicant received long-term care
88.5 services during what would have been the period of ineligibility if the transfer had been
88.6 reported, a cause of action exists against the transferee for the cost of long-term care
88.7 services provided during the period of ineligibility, or for the uncompensated amount of
88.8 the transfer, whichever is less. The uncompensated transfer amount is the fair market
88.9 value of the asset at the time it was given away, sold, or disposed of, less the amount of
88.10 compensation received.

88.11 (b) For uncompensated transfers made after August 10, 1993, the number of months
88.12 of ineligibility for long-term care services shall be the total uncompensated value of the
88.13 resources transferred divided by the average medical assistance rate for nursing facility
88.14 services in the state in effect on the date of application. The amount used to calculate
88.15 the average medical assistance payment rate shall be adjusted each July 1 to reflect
88.16 payment rates for the previous calendar year. The period of ineligibility begins with the
88.17 first day of the month after the month in which the assets were transferred except that
88.18 if one or more uncompensated transfers are made during a period of ineligibility, the
88.19 total assets transferred during the ineligibility period shall be combined and a penalty
88.20 period calculated to begin on the first day of the month after the month in which the first
88.21 uncompensated transfer was made. If the transfer was reported to the local agency after
88.22 the date that advance notice of a period of ineligibility that affects the next month could
88.23 be provided to the recipient and the recipient received medical assistance services or the
88.24 transfer was not reported to the local agency, and the applicant or recipient received
88.25 medical assistance services during what would have been the period of ineligibility if
88.26 the transfer had been reported, a cause of action exists against the transferee for that
88.27 portion of long-term care services provided during the period of ineligibility, or for the
88.28 uncompensated amount of the transfer, whichever is less. The uncompensated transfer
88.29 amount is the fair market value of the asset at the time it was given away, sold, or disposed
88.30 of, less the amount of compensation received. Effective for transfers made on or after
88.31 March 1, 1996, involving persons who apply for medical assistance on or after April 13,
88.32 1996, no cause of action exists for a transfer unless:

88.33 (1) the transferee knew or should have known that the transfer was being made by a
88.34 person who was a resident of a long-term care facility or was receiving that level of care in
88.35 the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins the first day of the month following advance notice of the ~~penalty~~ period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the ~~application of the penalty~~ period of ineligibility resulting from the uncompensated transfer; and

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a ~~penalty~~ period of ineligibility results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

(f) A period of ineligibility established under paragraph (c) may be eliminated if all of the assets transferred for less than fair market value used to calculate the period of ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned within 12 months after the date the period of ineligibility began. A period of ineligibility must not be adjusted if less than the full amount of the transferred assets or the full cash value of the transferred assets are returned.

EFFECTIVE DATE. This section is effective for periods of ineligibility established on or after January 1, 2011.

Sec. 23. Minnesota Statutes 2008, 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

90.1 other persons residing lawfully in the United States. Citizens or nationals of the United
90.2 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
90.3 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
90.4 Public Law 109-171.

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

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

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

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

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

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

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

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

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

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

90.26 (c) All qualified noncitizens who were residing in the United States before August
90.27 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
90.28 medical assistance with federal financial participation.

90.29 (d) All qualified noncitizens who entered the United States on or after August 22,
90.30 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
90.31 medical assistance with federal financial participation through November 30, 1996.

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

91.1 (i) refugees admitted to the United States according to United States Code, title 8,
91.2 section 1157;
91.3 (ii) persons granted asylum according to United States Code, title 8, section 1158;
91.4 (iii) persons granted withholding of deportation according to United States Code,
91.5 title 8, section 1253(h);
91.6 (iv) veterans of the United States armed forces with an honorable discharge for
91.7 a reason other than noncitizen status, their spouses and unmarried minor dependent
91.8 children; or
91.9 (v) persons on active duty in the United States armed forces, other than for training,
91.10 their spouses and unmarried minor dependent children.
91.11 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
91.12 criteria in items (i) to (v) are eligible for medical assistance without federal financial
91.13 participation as described in paragraph (j).
91.14 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
91.15 women who are qualified noncitizens, as described in paragraph (b), are eligible for
91.16 medical assistance with federal financial participation as provided by the federal Children's
91.17 Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.
91.18 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
91.19 are lawfully present in the United States, as defined in Code of Federal Regulations, title
91.20 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
91.21 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
91.22 with the United States Citizenship and Immigration Services to pursue any applicable
91.23 immigration status, including citizenship, that would qualify them for medical assistance
91.24 with federal financial participation.
91.25 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
91.26 for medical assistance with federal financial participation through December 31, 1996.
91.27 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
91.28 medical assistance without federal financial participation as described in paragraph (j).
91.29 (3) Beginning December 1, 1996, persons residing in the United States prior to
91.30 August 22, 1996, who were not receiving medical assistance and persons who arrived on
91.31 or after August 22, 1996, are eligible for medical assistance without federal financial
91.32 participation as described in paragraph (j).
91.33 (f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
91.34 are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this
91.35 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
91.36 Code, title 8, section 1101(a)(15).

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

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

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or ~~eligible for medical assistance as described in paragraph (j),~~ lawfully present as designated in paragraph (e) and who 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~~, followed by 60 days postpartum without federal financial participation~~.

(j) 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.

(k) 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.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 24. Minnesota Statutes 2008, section 256B.06, subdivision 5, is amended to read:

Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility for any federal or state funded medical assistance under this section, the income and resources of all noncitizens shall be deemed to include their sponsors' income

93.1 and resources as required under the Personal Responsibility and Work Opportunity
93.2 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
93.3 subsequently set out in federal rules. This section is effective May 1, 1997. Beginning
93.4 July 1, 2010, sponsor deeming does not apply to pregnant women and children who are
93.5 qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

93.6 **EFFECTIVE DATE.** This section is effective July 1, 2010.

93.7 Sec. 25. Minnesota Statutes 2008, section 256B.0625, subdivision 3, is amended to
93.8 read:

93.9 Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.
93.10 (b) Rates paid for anesthesiology services provided by physicians shall be according
93.11 to the formula utilized in the Medicare program and shall use a conversion factor "at
93.12 percentile of calendar year set by legislature.," except that rates paid to physicians for the
93.13 medical direction of a certified registered nurse anesthetist shall be the same as the rate
93.14 paid to the certified registered nurse anesthetist under medical direction.

93.15 Sec. 26. Minnesota Statutes 2008, section 256B.0625, subdivision 3c, is amended to
93.16 read:

93.17 Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after
93.18 receiving recommendations from professional physician associations, professional
93.19 associations representing licensed nonphysician health care professionals, and consumer
93.20 groups, shall establish a 13-member Health Services Policy Committee, which consists of
93.21 12 voting members and one nonvoting member. The Health Services Policy Committee
93.22 shall advise the commissioner regarding health services pertaining to the administration
93.23 of health care benefits covered under the medical assistance, general assistance medical
93.24 care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at
93.25 least quarterly. The Health Services Policy Committee shall annually elect a physician
93.26 chair from among its members, who shall work directly with the commissioner's medical
93.27 director, to establish the agenda for each meeting. The Health Services Policy Committee
93.28 shall also recommend criteria for verifying centers of excellence for specific aspects of
93.29 medical care where a specific set of combined services, a volume of patients necessary to
93.30 maintain a high level of competency, or a specific level of technical capacity is associated
93.31 with improved health outcomes.
93.32 (b) The commissioner shall establish a dental subcommittee to operate under the
93.33 Health Services Policy Committee. The dental subcommittee consists of general dentists,
93.34 dental specialists, safety net providers, dental hygienists, health plan company and

94.1 county and public health representatives, health researchers, consumers, and a designee
94.2 of the commissioner of health. The dental subcommittee shall advise the commissioner
94.3 regarding:

94.4 (1) the critical access dental program under section 256B.76, subdivision 4, including
94.5 but not limited to criteria for designating and terminating critical access dental providers;

94.6 (2) any changes to the critical access dental provider program necessary to comply
94.7 with program expenditure limits;

94.8 (3) dental coverage policy based on evidence, quality, continuity of care, and best
94.9 practices;

94.10 (4) the development of dental delivery models; and

94.11 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).

94.12 (c) The Health Services Policy Committee shall study approaches to making
94.13 provider reimbursement under the medical assistance, MinnesotaCare, and general
94.14 assistance medical care programs contingent on patient participation in a patient-centered
94.15 decision-making process, and shall evaluate the impact of these approaches on health
94.16 care quality, patient satisfaction, and health care costs. The committee shall present
94.17 findings and recommendations to the commissioner and the legislative committees with
94.18 jurisdiction over health care by January 15, 2010.

94.19 (d) The Health Services Policy Committee shall monitor and track the practice
94.20 patterns of physicians providing services to medical assistance, MinnesotaCare, and
94.21 general assistance medical care enrollees under fee-for-service, managed care, and
94.22 county-based purchasing. The committee shall focus on services or specialties for which
94.23 there is a high variation in utilization across physicians, or which are associated with
94.24 high medical costs. The commissioner, based upon the findings of the committee, shall
94.25 regularly notify physicians whose practice patterns indicate higher than average utilization
94.26 or costs. Managed care and county-based purchasing plans shall provide the committee
94.27 with utilization and cost data necessary to implement this paragraph.

94.28 (e) The Health Services Policy Committee shall review caesarean section rates
94.29 for the fee-for-service medical assistance population. The committee may develop best
94.30 practices policies related to the minimization of caesarean sections, including but not
94.31 limited to standards and guidelines for health care providers and health care facilities.

94.32 Sec. 27. Minnesota Statutes 2008, section 256B.0625, subdivision 9, is amended to
94.33 read:

95.1 Subd. 9. **Dental services.** (a) Medical assistance covers dental services. ~~Dental~~
95.2 ~~services include, with prior authorization, fixed bridges that are cost-effective for persons~~
95.3 ~~who cannot use removable dentures because of their medical condition.~~
95.4 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
95.5 following services:
95.6 (1) comprehensive exams, limited to once every five years;
95.7 (2) periodic exams, limited to one per year;
95.8 (3) limited exams;
95.9 (4) bitewing x-rays, limited to one per year;
95.10 (5) periapical x-rays;
95.11 (6) panoramic x-rays, limited to one every five years, and only if provided in
95.12 conjunction with a posterior extraction or scheduled outpatient facility procedure, or as
95.13 medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology
95.14 and trauma. Panoramic x-rays may be taken once every two years for patients who cannot
95.15 cooperate for intraoral film due to a developmental disability or medical condition that
95.16 does not allow for intraoral film placement;
95.17 (7) prophylaxis, limited to one per year;
95.18 (8) application of fluoride varnish, limited to one per year;
95.19 (9) posterior fillings, all at the amalgam rate;
95.20 (10) anterior fillings;
95.21 (11) endodontics, limited to root canals on the anterior and premolars only;
95.22 (12) removable prostheses, each dental arch limited to one every six years;
95.23 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
95.24 abscesses;
95.25 (14) palliative treatment and sedative fillings for relief of pain; and
95.26 (15) full-mouth debridement, limited to one every five years.
95.27 (c) In addition to the services specified in paragraph (b), medical assistance
95.28 covers the following services for adults, if provided in an outpatient hospital setting or
95.29 freestanding ambulatory surgical center as part of outpatient dental surgery:
95.30 (1) periodontics, limited to periodontal scaling and root planing once every two
95.31 years;
95.32 (2) general anesthesia; and
95.33 (3) full-mouth survey once every five years.
95.34 (d) Medical assistance covers dental services for children that are medically
95.35 necessary. The following guidelines apply:
95.36 (1) posterior fillings are paid at the amalgam rate;

96.1 (2) application of sealants once every five years per permanent molar; and

96.2 (3) application of fluoride varnish once every six months.

96.3 **EFFECTIVE DATE.** This section is effective January 1, 2010.

96.4 Sec. 28. Minnesota Statutes 2008, section 256B.0625, subdivision 11, is amended to
96.5 read:

96.6 Subd. 11. **Nurse anesthetist services.** Medical assistance covers nurse anesthetist
96.7 services. Rates paid for anesthesiology services provided by a certified registered nurse
96.8 ~~anesthetists~~ anesthetist under the direction of a physician shall be according to the formula
96.9 utilized in the Medicare program and shall use the conversion factor that is used by
96.10 the Medicare program. Rates paid for anesthesiology services provided by a certified
96.11 registered nurse anesthetist who is not directed by a physician shall be the same rate as
96.12 paid under subdivision 3, paragraph (b).

96.13 Sec. 29. Minnesota Statutes 2008, section 256B.0625, subdivision 13, is amended to
96.14 read:

96.15 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
96.16 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
96.17 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
96.18 program as a dispensing physician, or by a physician, physician assistant, or a nurse
96.19 practitioner employed by or under contract with a community health board as defined in
96.20 section 145A.02, subdivision 5, for the purposes of communicable disease control.

96.21 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
96.22 unless authorized by the commissioner.

96.23 (c) Medical assistance covers the following over-the-counter drugs when prescribed
96.24 by a licensed practitioner or by a licensed pharmacist who meets standards established by
96.25 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,
96.26 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for
96.27 adults with documented vitamin deficiencies, vitamins for children under the age of seven
96.28 and pregnant or nursing women, and any other over-the-counter drug identified by the
96.29 commissioner, in consultation with the formulary committee, as necessary, appropriate,
96.30 and cost-effective for the treatment of certain specified chronic diseases, conditions,
96.31 or disorders, and this determination shall not be subject to the requirements of chapter
96.32 14. A pharmacist may prescribe over-the-counter medications as provided under this
96.33 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing
96.34 over-the-counter drugs under this paragraph, licensed pharmacists must consult with the

97.1 recipient to determine necessity, provide drug counseling, review drug therapy for potential
97.2 adverse interactions, and make referrals as needed to other health care professionals.
97.3 (d) Effective January 1, 2006, medical assistance shall not cover drugs that
97.4 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
97.5 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
97.6 for individuals eligible for drug coverage as defined in the Medicare Prescription
97.7 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
97.8 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
97.9 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this
97.10 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
97.11 title 42, section 1396r-8(d)(2)(E), shall not be covered.

97.12 Sec. 30. Minnesota Statutes 2008, section 256B.0625, subdivision 13e, is amended to
97.13 read:

97.14 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
97.15 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
97.16 the maximum allowable cost set by the federal government or by the commissioner plus
97.17 the fixed dispensing fee; or the usual and customary price charged to the public. The
97.18 amount of payment basis must be reduced to reflect all discount amounts applied to the
97.19 charge by any provider/insurer agreement or contract for submitted charges to medical
97.20 assistance programs. The net submitted charge may not be greater than the patient liability
97.21 for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee
97.22 for intravenous solutions which must be compounded by the pharmacist shall be $8 per
97.23 bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral
97.24 nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral
97.25 nutritional products dispensed in quantities greater than one liter. Actual acquisition
97.26 cost includes quantity and other special discounts except time and cash discounts.
97.27 Effective July 1, ~~2008~~ 2009, the actual acquisition cost of a drug shall be estimated by the
97.28 commissioner, at average wholesale price minus ~~14~~ 15 percent. The actual acquisition
97.29 cost of antihemophilic factor drugs shall be estimated at the average wholesale price
97.30 minus 30 percent. The maximum allowable cost of a multisource drug may be set by the
97.31 commissioner and it shall be comparable to, but no higher than, the maximum amount
97.32 paid by other third-party payors in this state who have maximum allowable cost programs.
97.33 Establishment of the amount of payment for drugs shall not be subject to the requirements
97.34 of the Administrative Procedure Act.

98.1 (b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
98.2 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
98.3 facilities when a unit dose blister card system, approved by the department, is used. Under
98.4 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
98.5 The National Drug Code (NDC) from the drug container used to fill the blister card must
98.6 be identified on the claim to the department. The unit dose blister card containing the
98.7 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
98.8 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
98.9 will be required to credit the department for the actual acquisition cost of all unused
98.10 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
98.11 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
98.12 dispensed in a quantity that is less than a 30-day supply.

98.13 (c) Whenever a generically equivalent product is available, payment shall be on the
98.14 basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost
98.15 established by the commissioner.

98.16 (d) The basis for determining the amount of payment for drugs administered in an
98.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
98.18 provider or the amount established for Medicare by the United States Department of
98.19 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
98.20 Security Act.

98.21 (e) The commissioner may negotiate lower reimbursement rates for specialty
98.22 pharmacy products than the rates specified in paragraph (a). The commissioner may
98.23 require individuals enrolled in the health care programs administered by the department
98.24 to obtain specialty pharmacy products from providers with whom the commissioner has
98.25 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
98.26 used by a small number of recipients or recipients with complex and chronic diseases
98.27 that require expensive and challenging drug regimens. Examples of these conditions
98.28 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
98.29 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
98.30 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
98.31 biotechnology drugs, high-cost therapies, and therapies that require complex care. The
98.32 commissioner shall consult with the formulary committee to develop a list of specialty
98.33 pharmacy products subject to this paragraph. In consulting with the formulary committee
98.34 in developing this list, the commissioner shall take into consideration the population
98.35 served by specialty pharmacy products, the current delivery system and standard of care in

99.1 the state, and access to care issues. The commissioner shall have the discretion to adjust
99.2 the reimbursement rate to prevent access to care issues.

99.3 Sec. 31. Minnesota Statutes 2008, section 256B.0625, subdivision 13h, is amended to
99.4 read:

99.5 Subd. 13h. **Medication therapy management services.** (a) Medical assistance
99.6 and general assistance medical care cover medication therapy management services for
99.7 a recipient taking four or more prescriptions to treat or prevent two or more chronic
99.8 medical conditions, or a recipient with a drug therapy problem that is identified or prior
99.9 authorized by the commissioner that has resulted or is likely to result in significant
99.10 nondrug program costs. The commissioner may cover medical therapy management
99.11 services under MinnesotaCare if the commissioner determines this is cost-effective. For
99.12 purposes of this subdivision, "medication therapy management" means the provision
99.13 of the following pharmaceutical care services by a licensed pharmacist to optimize the
99.14 therapeutic outcomes of the patient's medications:

99.15 (1) performing or obtaining necessary assessments of the patient's health status;

99.16 (2) formulating a medication treatment plan;

99.17 (3) monitoring and evaluating the patient's response to therapy, including safety
99.18 and effectiveness;

99.19 (4) performing a comprehensive medication review to identify, resolve, and prevent
99.20 medication-related problems, including adverse drug events;

99.21 (5) documenting the care delivered and communicating essential information to
99.22 the patient's other primary care providers;

99.23 (6) providing verbal education and training designed to enhance patient
99.24 understanding and appropriate use of the patient's medications;

99.25 (7) providing information, support services, and resources designed to enhance
99.26 patient adherence with the patient's therapeutic regimens; and

99.27 (8) coordinating and integrating medication therapy management services within the
99.28 broader health care management services being provided to the patient.

99.29 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
99.30 the pharmacist as defined in section 151.01, subdivision 27.

99.31 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
99.32 must meet the following requirements:

99.33 (1) have a valid license issued under chapter 151;

99.34 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
99.35 completed a structured and comprehensive education program approved by the Board of

100.1 Pharmacy and the American Council of Pharmaceutical Education for the provision and
100.2 documentation of pharmaceutical care management services that has both clinical and
100.3 didactic elements;

100.4 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
100.5 have developed a structured patient care process that is offered in a private or semiprivate
100.6 patient care area that is separate from the commercial business that also occurs in the
100.7 setting, or in home settings, excluding long-term care and group homes, if the service is
100.8 ordered by the provider-directed care coordination team; and

100.9 (4) make use of an electronic patient record system that meets state standards.

100.10 (c) For purposes of reimbursement for medication therapy management services,
100.11 the commissioner may enroll individual pharmacists as medical assistance and general
100.12 assistance medical care providers. The commissioner may also establish contact
100.13 requirements between the pharmacist and recipient, including limiting the number of
100.14 reimbursable consultations per recipient.

100.15 ~~(d) The commissioner, after receiving recommendations from professional medical~~
100.16 ~~associations, professional pharmacy associations, and consumer groups, shall convene~~
100.17 ~~an 11-member Medication Therapy Management Advisory Committee to advise~~
100.18 ~~the commissioner on the implementation and administration of medication therapy~~
100.19 ~~management services. The committee shall be comprised of: two licensed physicians;~~
100.20 ~~two licensed pharmacists; two consumer representatives; two health plan company~~
100.21 ~~representatives; and three members with expertise in the area of medication therapy~~
100.22 ~~management, who may be licensed physicians or licensed pharmacists. The committee is~~
100.23 ~~governed by section 15.059, except that committee members do not receive compensation~~
100.24 ~~or reimbursement for expenses. The advisory committee expires on June 30, 2007.~~

100.25 ~~(e) The commissioner shall evaluate the effect of medication therapy management~~
100.26 ~~on quality of care, patient outcomes, and program costs, and shall include a description~~
100.27 ~~of any savings generated in the medical assistance and general assistance medical care~~
100.28 ~~programs that can be attributable to this coverage. The evaluation shall be submitted to~~
100.29 ~~the legislature by December 15, 2007. The commissioner may contract with a vendor~~
100.30 ~~or an academic institution that has expertise in evaluating health care outcomes for the~~
100.31 ~~purpose of completing the evaluation.~~

100.32 (d) The commissioner shall establish a pilot project for an intensive medication
100.33 therapy management program for patients identified by the commissioner with multiple
100.34 chronic conditions and a high number of medications who are at high risk of preventable
100.35 hospitalizations, emergency room use, medication complications, and suboptimal
100.36 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.

Sec. 32. Minnesota Statutes 2008, 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 ~~includes~~ providers shall perform driver-assisted ~~service to~~ 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 ~~available~~. The ~~maximum~~ 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;

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

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

102.6 (2) the base rates for special transportation services in areas defined under RUCA
102.7 to be super rural shall be equal to the reimbursement rate established in clause (1) plus
102.8 11.3 percent; and

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

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

102.13 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
102.14 112.5 percent of the respective mileage rate in clause (1).

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

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

102.21 Sec. 33. Minnesota Statutes 2008, section 256B.0625, subdivision 17a, is amended to
102.22 read:

102.23 Subd. 17a. **Payment for ambulance services.** Medical assistance covers
102.24 ambulance services. Providers shall bill ambulance services according to Medicare
102.25 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
102.26 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
102.27 services shall be paid at the Medicare reimbursement rate or at the medical assistance
102.28 payment rate in effect on July 1, 2000, whichever is greater.

102.29 Sec. 34. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
102.30 subdivision to read:

102.31 Subd. 18b. **Broker dispatching prohibition.** The commissioner shall not use a
102.32 broker or coordinator for any purpose related to transportation services under subdivision
102.33 18.

103.1 Sec. 35. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
103.2 subdivision to read:

103.3 Subd. 25a. **Prior authorization of diagnostic imaging services.** (a) Effective
103.4 January 1, 2010, the commissioner shall require prior authorization or decision support
103.5 for the ordering providers at the time the service is ordered for the following outpatient
103.6 diagnostic imaging services: computerized tomography (CT), magnetic resonance
103.7 imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography
103.8 (PET), cardiac imaging and ultrasound diagnostic imaging.

103.9 (b) Prior authorization under this subdivision is not required for diagnostic imaging
103.10 services performed as part of a hospital emergency room visit, inpatient hospitalization, or
103.11 if concurrent with or on the same day as an urgent care facility visit.

103.12 (c) This subdivision does not apply to services provided to recipients who are
103.13 enrolled in Medicare, the prepaid medical assistance program, the prepaid general
103.14 assistance medical care program, or the MinnesotaCare program.

103.15 (d) The commissioner may contract with a private entity to provide the prior
103.16 authorization or decision support required under this subdivision. The contracting entity
103.17 must incorporate clinical guidelines that are based on evidence-based medical literature, if
103.18 available. By January 1, 2012, the contracting entity shall report to the commissioner the
103.19 results of prior authorization or decision support.

103.20 Sec. 36. Minnesota Statutes 2008, section 256B.0625, subdivision 26, is amended to
103.21 read:

103.22 Subd. 26. **Special education services.** (a) Medical assistance covers medical
103.23 services identified in a recipient's individualized education plan and covered under the
103.24 medical assistance state plan. Covered services include occupational therapy, physical
103.25 therapy, speech-language therapy, clinical psychological services, nursing services,
103.26 school psychological services, school social work services, personal care assistants
103.27 serving as management aides, assistive technology devices, transportation services,
103.28 health assessments, and other services covered under the medical assistance state plan.
103.29 Mental health services eligible for medical assistance reimbursement must be provided or
103.30 coordinated through a children's mental health collaborative where a collaborative exists if
103.31 the child is included in the collaborative operational target population. The provision or
103.32 coordination of services does not require that the individual education plan be developed
103.33 by the collaborative.

103.34 The services may be provided by a Minnesota school district that is enrolled as a
103.35 medical assistance provider or its subcontractor, and only if the services meet all the

104.1 requirements otherwise applicable if the service had been provided by a provider other
104.2 than a school district, in the following areas: medical necessity, physician's orders,
104.3 documentation, personnel qualifications, and prior authorization requirements. The
104.4 nonfederal share of costs for services provided under this subdivision is the responsibility
104.5 of the local school district as provided in section 125A.74. Services listed in a child's
104.6 individual education plan are eligible for medical assistance reimbursement only if those
104.7 services meet criteria for federal financial participation under the Medicaid program.

104.8 (b) Approval of health-related services for inclusion in the individual education plan
104.9 does not require prior authorization for purposes of reimbursement under this chapter.
104.10 The commissioner may require physician review and approval of the plan not more than
104.11 once annually or upon any modification of the individual education plan that reflects a
104.12 change in health-related services.

104.13 (c) Services of a speech-language pathologist provided under this section are covered
104.14 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

104.15 (1) holds a masters degree in speech-language pathology;

104.16 (2) is licensed by the Minnesota Board of Teaching as an educational
104.17 speech-language pathologist; and

104.18 (3) either has a certificate of clinical competence from the American Speech and
104.19 Hearing Association, has completed the equivalent educational requirements and work
104.20 experience necessary for the certificate or has completed the academic program and is
104.21 acquiring supervised work experience to qualify for the certificate.

104.22 (d) Medical assistance coverage for medically necessary services provided under
104.23 other subdivisions in this section may not be denied solely on the basis that the same or
104.24 similar services are covered under this subdivision.

104.25 (e) The commissioner shall develop and implement package rates, bundled rates, or
104.26 per diem rates for special education services under which separately covered services are
104.27 grouped together and billed as a unit in order to reduce administrative complexity.

104.28 (f) The commissioner shall develop a cost-based payment structure for payment
104.29 of these services. The commissioner shall reimburse claims submitted based on an
104.30 interim rate, and shall settle at a final rate once the department has determined it. The
104.31 commissioner shall notify the school district of the final rate. The school district has 60
104.32 days to appeal the final rate. To appeal the final rate, the school district shall file a written
104.33 appeal request to the commissioner within 60 days of the date the final rate determination
104.34 was mailed. The appeal request shall specify (1) the disputed items and (2) the name and
104.35 address of the person to contact regarding the appeal.

105.1 (g) Effective July 1, 2000, medical assistance services provided under an individual
105.2 education plan or an individual family service plan by local school districts shall not count
105.3 against medical assistance authorization thresholds for that child.
105.4 (h) Nursing services as defined in section 148.171, subdivision 15, and provided
105.5 as an individual education plan health-related service, are eligible for medical assistance
105.6 payment if they are otherwise a covered service under the medical assistance program.
105.7 Medical assistance covers the administration of prescription medications by a licensed
105.8 nurse who is employed by or under contract with a school district when the administration
105.9 of medications is identified in the child's individualized education plan. The simple
105.10 administration of medications alone is not covered under medical assistance when
105.11 administered by a provider other than a school district or when it is not identified in the
105.12 child's individualized education plan.

105.13 Sec. 37. Minnesota Statutes 2008, section 256B.08, is amended by adding a
105.14 subdivision to read:

105.15 Subd. 4. **Data from Social Security.** The commissioner shall accept data from the
105.16 Social Security Administration in accordance with United States Code, title 42, section
105.17 1396U-5(a).

105.18 **EFFECTIVE DATE.** This section is effective January 1, 2010.

105.19 Sec. 38. Minnesota Statutes 2008, section 256B.15, subdivision 1, is amended to read:

105.20 Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that
105.21 individuals or couples, either or both of whom participate in the medical assistance
105.22 program, use their own assets to pay their share of the total cost of their care during or
105.23 after their enrollment in the program according to applicable federal law and the laws of
105.24 this state. The following provisions apply:
105.25 (1) subdivisions 1c to 1k shall not apply to claims arising under this section which
105.26 are presented under section 525.313;
105.27 (2) the provisions of subdivisions 1c to 1k expanding the interests included in an
105.28 estate for purposes of recovery under this section give effect to the provisions of United
105.29 States Code, title 42, section 1396p, governing recoveries, but do not give rise to any
105.30 express or implied liens in favor of any other parties not named in these provisions;
105.31 (3) the continuation of a recipient's life estate or joint tenancy interest in real
105.32 property after the recipient's death for the purpose of recovering medical assistance under
105.33 this section modifies common law principles holding that these interests terminate on
105.34 the death of the holder;

106.1 (4) all laws, rules, and regulations governing or involved with a recovery of medical
106.2 assistance shall be liberally construed to accomplish their intended purposes;
106.3 (5) a deceased recipient's life estate and joint tenancy interests continued under this
106.4 section shall be owned by the remaindermen or surviving joint tenants as their interests
106.5 may appear on the date of the recipient's death. They shall not be merged into the
106.6 remainder interest or the interests of the surviving joint tenants by reason of ownership.
106.7 They shall be subject to the provisions of this section. Any conveyance, transfer, sale,
106.8 assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs,
106.9 successors, and assigns shall be deemed to include all of their interest in the deceased
106.10 recipient's life estate or joint tenancy interest continued under this section; and
106.11 (6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy
106.12 interests in real property after the recipient's death do not apply to a homestead owned
106.13 of record, on the date the recipient dies, by the recipient and the recipient's spouse as
106.14 joint tenants with a right of survivorship. Homestead means the real property occupied
106.15 by the surviving joint tenant spouse as their sole residence on the date the recipient dies
106.16 and classified and taxed to the recipient and surviving joint tenant spouse as homestead
106.17 property for property tax purposes in the calendar year in which the recipient dies. For
106.18 purposes of this exemption, real property the recipient and their surviving joint tenant
106.19 spouse purchase solely with the proceeds from the sale of their prior homestead, own
106.20 of record as joint tenants, and qualify as homestead property under section 273.124 in
106.21 the calendar year in which the recipient dies and prior to the recipient's death shall be
106.22 deemed to be real property classified and taxed to the recipient and their surviving joint
106.23 tenant spouse as homestead property in the calendar year in which the recipient dies.
106.24 The surviving spouse, or any person with personal knowledge of the facts, may provide
106.25 an affidavit describing the homestead property affected by this clause and stating facts
106.26 showing compliance with this clause. The affidavit shall be prima facie evidence of the
106.27 facts it states.
106.28 (b) For purposes of this section, "medical assistance" includes the medical assistance
106.29 program under this chapter and the general assistance medical care program under chapter
106.30 256D and alternative care for nonmedical assistance recipients under section 256B.0913.
106.31 (c) For purposes of this section, beginning January 1, 2010, "medical assistance"
106.32 does not include Medicare cost-sharing benefits in accordance with United States Code,
106.33 title 42, section 1396p.
106.34 (d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j,
106.35 related to the continuation of a recipient's life estate or joint tenancy interests in real
106.36 property after the recipient's death for the purpose of recovering medical assistance, are

107.1 effective only for life estates and joint tenancy interests established on or after August 1,
107.2 2003. For purposes of this paragraph, medical assistance does not include alternative care.

107.3 Sec. 39. Minnesota Statutes 2008, section 256B.15, subdivision 1a, is amended to read:

107.4 Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance
107.5 hereunder, on the person's death, if single, or on the death of the survivor of a married
107.6 couple, either or both of whom received medical assistance, or as otherwise provided
107.7 for in this section, the total amount paid for medical assistance rendered for the person
107.8 and spouse shall be filed as a claim against the estate of the person or the estate of the
107.9 surviving spouse in the court having jurisdiction to probate the estate or to issue a decree
107.10 of descent according to sections 525.31 to 525.313.

107.11 (b) For the purposes of this section, the person's estate must consist of:

107.12 (1) the person's probate estate;

107.13 (2) all of the person's interests or proceeds of those interests in real property the
107.14 person owned as a life tenant or as a joint tenant with a right of survivorship at the time of
107.15 the person's death;

107.16 (3) all of the person's interests or proceeds of those interests in securities the person
107.17 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time
107.18 of the person's death, to the extent the interests or proceeds of those interests become part
107.19 of the probate estate under section 524.6-307;

107.20 (4) all of the person's interests in joint accounts, multiple-party accounts, and
107.21 pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of
107.22 those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the
107.23 person's death to the extent the interests become part of the probate estate under section
107.24 524.6-207; and

107.25 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,
107.26 living trust, or other arrangements.

107.27 (c) For the purpose of this section and recovery in a surviving spouse's estate for
107.28 medical assistance paid for a predeceased spouse, the estate must consist of all of the legal
107.29 title and interests the deceased individual's predeceased spouse had in jointly owned or
107.30 marital property at the time of the spouse's death, as defined in subdivision 2b, and the
107.31 proceeds of those interests, that passed to the deceased individual or another individual, a
107.32 survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy
107.33 in common, survivorship, life estate, living trust, or other arrangement. A deceased
107.34 recipient who, at death, owned the property jointly with the surviving spouse shall have
107.35 an interest in the entire property.

108.1 (d) For the purpose of recovery in a single person's estate or the estate of a survivor
108.2 of a married couple, "other arrangement" includes any other means by which title to all or
108.3 any part of the jointly owned or marital property or interest passed from the predeceased
108.4 spouse to another including, but not limited to, transfers between spouses which are
108.5 permitted, prohibited, or penalized for purposes of medical assistance.

108.6 (e) A claim shall be filed if medical assistance was rendered for either or both
108.7 persons under one of the following circumstances:

108.8 (a) (1) the person was over 55 years of age, and received services under this chapter;

108.9 (b) (2) the person resided in a medical institution for six months or longer, received
108.10 services under this chapter, and, at the time of institutionalization or application for
108.11 medical assistance, whichever is later, the person could not have reasonably been expected
108.12 to be discharged and returned home, as certified in writing by the person's treating
108.13 physician. For purposes of this section only, a "medical institution" means a skilled
108.14 nursing facility, intermediate care facility, intermediate care facility for persons with
108.15 developmental disabilities, nursing facility, or inpatient hospital; or

108.16 (c) (3) the person received general assistance medical care services under chapter
108.17 256D.

108.18 (f) The claim shall be considered an expense of the last illness of the decedent for the
108.19 purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or
108.20 county agency with a claim under this section must be a creditor under section 524.6-307.
108.21 Any statute of limitations that purports to limit any county agency or the state agency,
108.22 or both, to recover for medical assistance granted hereunder shall not apply to any claim
108.23 made hereunder for reimbursement for any medical assistance granted hereunder. Notice
108.24 of the claim shall be given to all heirs and devisees of the decedent whose identity can be
108.25 ascertained with reasonable diligence. The notice must include procedures and instructions
108.26 for making an application for a hardship waiver under subdivision 5; time frames for
108.27 submitting an application and determination; and information regarding appeal rights and
108.28 procedures. Counties are entitled to one-half of the nonfederal share of medical assistance
108.29 collections from estates that are directly attributable to county effort. Counties are entitled
108.30 to ten percent of the collections for alternative care directly attributable to county effort.

108.31 Sec. 40. Minnesota Statutes 2008, section 256B.15, subdivision 1h, is amended to read:

108.32 Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For
108.33 purposes of this section, paragraphs (b) to (k) (j) apply if a person received medical
108.34 assistance for which a claim may be filed under this section and died single, or the

109.1 surviving spouse of the couple and was not survived by any of the persons described
109.2 in subdivisions 3 and 4.

109.3 ~~(b) For purposes of this section, the person's estate consists of: (1) the person's~~
109.4 ~~probate estate; (2) all of the person's interests or proceeds of those interests in real property~~
109.5 ~~the person owned as a life tenant or as a joint tenant with a right of survivorship at the~~
109.6 ~~time of the person's death; (3) all of the person's interests or proceeds of those interests in~~
109.7 ~~securities the person owned in beneficiary form as provided under sections 524.6-301 to~~
109.8 ~~524.6-311 at the time of the person's death, to the extent they become part of the probate~~
109.9 ~~estate under section 524.6-307; (4) all of the person's interests in joint accounts, multiple~~
109.10 ~~party accounts, and pay on death accounts, or the proceeds of those accounts, as provided~~
109.11 ~~under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent~~
109.12 ~~they become part of the probate estate under section 524.6-207; and (5) the person's~~
109.13 ~~legal title or interest at the time of the person's death in real property transferred under~~
109.14 ~~a transfer on death deed under section 507.071, or in the proceeds from the subsequent~~
109.15 ~~sale of the person's interest in the real property. Notwithstanding any law or rule to the~~
109.16 ~~contrary, a state or county agency with a claim under this section shall be a creditor under~~
109.17 ~~section 524.6-307.~~

109.18 ~~(c)~~ (b) Notwithstanding any law or rule to the contrary, the person's life estate or joint
109.19 tenancy interest in real property not subject to a medical assistance lien under sections
109.20 514.980 to 514.985 on the date of the person's death shall not end upon the person's death
109.21 and shall continue as provided in this subdivision. The life estate in the person's estate
109.22 shall be that portion of the interest in the real property subject to the life estate that is equal
109.23 to the life estate percentage factor for the life estate as listed in the Life Estate Mortality
109.24 Table of the health care program's manual for a person who was the age of the medical
109.25 assistance recipient on the date of the person's death. The joint tenancy interest in real
109.26 property in the estate shall be equal to the fractional interest the person would have owned
109.27 in the jointly held interest in the property had they and the other owners held title to the
109.28 property as tenants in common on the date the person died.

109.29 ~~(d)~~ (c) The court upon its own motion, or upon motion by the personal representative
109.30 or any interested party, may enter an order directing the remaindermen or surviving joint
109.31 tenants and their spouses, if any, to sign all documents, take all actions, and otherwise
109.32 fully cooperate with the personal representative and the court to liquidate the decedent's
109.33 life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of
109.34 those interests to the personal representative and provide for any legal and equitable
109.35 sanctions as the court deems appropriate to enforce and carry out the order, including an
109.36 award of reasonable attorney fees.

110.1 ~~(c)~~ (d) The personal representative may make, execute, and deliver any conveyances
110.2 or other documents necessary to convey the decedent's life estate or joint tenancy interest
110.3 in the estate that are necessary to liquidate and reduce to cash the decedent's interest or
110.4 for any other purposes.

110.5 ~~(f)~~ (e) Subject to administration, all costs, including reasonable attorney fees,
110.6 directly and immediately related to liquidating the decedent's life estate or joint tenancy
110.7 interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation
110.8 allocable to the decedent's interest and the net proceeds shall be turned over to the personal
110.9 representative and applied to payment of the claim presented under this section.

110.10 ~~(g)~~ (f) The personal representative shall bring a motion in the district court in which
110.11 the estate is being probated to compel the remaindermen or surviving joint tenants to
110.12 account for and deliver to the personal representative all or any part of the proceeds of any
110.13 sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the
110.14 decedent's life estate or joint tenancy interest in the decedent's estate, and do everything
110.15 necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of
110.16 the sale or other disposition over to the personal representative. The court may grant any
110.17 legal or equitable relief including, but not limited to, ordering a partition of real estate
110.18 under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy
110.19 interest available to the estate for payment of a claim under this section.

110.20 ~~(h)~~ (g) Subject to administration, the personal representative shall use all of the cash
110.21 or proceeds of interests to pay an allowable claim under this section. The remaindermen
110.22 or surviving joint tenants and their spouses, if any, may enter into a written agreement
110.23 with the personal representative or the claimant to settle and satisfy obligations imposed at
110.24 any time before or after a claim is filed.

110.25 ~~(i)~~ (h) The personal representative may, at their discretion, provide any or all of the
110.26 other owners, remaindermen, or surviving joint tenants with an affidavit terminating the
110.27 decedent's estate's interest in real property the decedent owned as a life tenant or as a joint
110.28 tenant with others, if the personal representative determines in good faith that neither the
110.29 decedent nor any of the decedent's predeceased spouses received any medical assistance
110.30 for which a claim could be filed under this section, or if the personal representative has
110.31 filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as
110.32 presented, or if there is a written agreement under paragraph ~~(h)~~ (g), or if the claim, as
110.33 allowed, has been paid in full or to the full extent of the assets the estate has available
110.34 to pay it. The affidavit may be recorded in the office of the county recorder or filed in
110.35 the Office of the Registrar of Titles for the county in which the real property is located.
110.36 Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit

111.1 shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a
111.2 joint tenant with others. The affidavit shall:
111.3 (1) be signed by the personal representative;
111.4 (2) identify the decedent and the interest being terminated;
111.5 (3) give recording information sufficient to identify the instrument that created the
111.6 interest in real property being terminated;
111.7 (4) legally describe the affected real property;
111.8 (5) state that the personal representative has determined that neither the decedent
111.9 nor any of the decedent's predeceased spouses received any medical assistance for which
111.10 a claim could be filed under this section;
111.11 (6) state that the decedent's estate has other assets sufficient to pay the claim, as
111.12 presented, or that there is a written agreement between the personal representative and
111.13 the claimant and the other owners or remaindermen or other joint tenants to satisfy the
111.14 obligations imposed under this subdivision; and
111.15 (7) state that the affidavit is being given to terminate the estate's interest under this
111.16 subdivision, and any other contents as may be appropriate.
111.17 The recorder or registrar of titles shall accept the affidavit for recording or filing. The
111.18 affidavit shall be effective as provided in this section and shall constitute notice even if it
111.19 does not include recording information sufficient to identify the instrument creating the
111.20 interest it terminates. The affidavit shall be conclusive evidence of the stated facts.
111.21 ~~(j)~~ (i) The holder of a lien arising under subdivision 1c shall release the lien at
111.22 the holder's expense against an interest terminated under paragraph ~~(h)~~ (g) to the extent
111.23 of the termination.
111.24 ~~(k)~~ (j) If a lien arising under subdivision 1c is not released under paragraph ~~(j)~~ (i),
111.25 prior to closing the estate, the personal representative shall deed the interest subject to the
111.26 lien to the remaindermen or surviving joint tenants as their interests may appear. Upon
111.27 recording or filing, the deed shall work a merger of the recipient's life estate or joint
111.28 tenancy interest, subject to the lien, into the remainder interest or interest the decedent and
111.29 others owned jointly. The lien shall attach to and run with the property to the extent of
111.30 the decedent's interest at the time of the decedent's death.

111.31 Sec. 41. Minnesota Statutes 2008, section 256B.15, subdivision 2, is amended to read:

111.32 Subd. 2. **Limitations on claims.** The claim shall include only the total amount
111.33 of medical assistance rendered after age 55 or during a period of institutionalization
111.34 described in subdivision 1a, ~~clause (b)~~ paragraph (e), and the total amount of general
111.35 assistance medical care rendered, and shall not include interest. Claims that have been

112.1 allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A
112.2 claim against the estate of a surviving spouse who did not receive medical assistance, for
112.3 medical assistance rendered for the predeceased spouse, shall be payable from the full
112.4 value of all of the predeceased spouse's assets and interests which are part of the surviving
112.5 spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in
112.6 the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate
112.7 that were marital property or jointly owned property at any time during the marriage. The
112.8 claim is not payable from the value of assets or proceeds of assets in the estate attributable
112.9 to a predeceased spouse whom the individual married after the death of the predeceased
112.10 recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the
112.11 estate which the nonrecipient decedent spouse acquired with assets which were not marital
112.12 property or jointly owned property after the death of the predeceased recipient spouse.
112.13 Claims for alternative care shall be net of all premiums paid under section 256B.0913,
112.14 subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or
112.15 after July 1, 2003. Claims against marital property shall be limited to claims against
112.16 recipients who died on or after July 1, 2009.

112.17 Sec. 42. Minnesota Statutes 2008, section 256B.15, is amended by adding a
112.18 subdivision to read:

112.19 Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and
112.20 subdivisions 1a and 2, paragraphs (b) to (d) apply.

112.21 (b) At the time of death of a recipient spouse and solely for purpose of recovery of
112.22 medical assistance benefits received, a predeceased recipient spouse shall have a legal
112.23 title or interest in the undivided whole of all of the property which the recipient and the
112.24 recipient's surviving spouse owned jointly or which was marital property at any time
112.25 during their marriage regardless of the form of ownership and regardless of whether
112.26 it was owned or titled in the names of one or both the recipient and the recipient's
112.27 spouse. Title and interest in the property of a predeceased recipient spouse shall not end
112.28 or extinguish upon the person's death and shall continue for the purpose of allowing
112.29 recovery of medical assistance in the estate of the surviving spouse. Upon the death of
112.30 the predeceased recipient spouse, title and interest in the predeceased spouse's property
112.31 shall vest in the surviving spouse by operation of law and without the necessity for any
112.32 probate or decree of descent proceedings and shall continue to exist after the death of the
112.33 predeceased spouse and the surviving spouse to permit recovery of medical assistance.
112.34 The recipient spouse and the surviving spouse of a deceased recipient spouse shall not

113.1 encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of
113.2 these interests before or upon death.
113.3 (c) For purposes of this section, "marital property" includes any and all real or
113.4 personal property of any kind or interests in such property the predeceased recipient
113.5 spouse and their spouse, or either of them, owned at the time of their marriage to each
113.6 other or acquired during their marriage regardless of whether it was owned or titled in
113.7 the names of one or both of them. If either or both spouses of a married couple received
113.8 medical assistance, all property owned during the marriage or which either or both spouses
113.9 acquired during their marriage shall be presumed to be marital property for purposes of
113.10 recovering medical assistance unless there is clear and convincing evidence to the contrary.
113.11 (d) The agency responsible for the claim for medical assistance for a recipient spouse
113.12 may, at its discretion, release specific real and personal property from the provisions of
113.13 this section. The release shall extinguish the interest created under paragraph (b) in the
113.14 land it describes upon filing or recording. The release need not be attested, certified, or
113.15 acknowledged as a condition of filing or recording and shall be filed or recorded in the
113.16 office of the county recorder or registrar of titles, as appropriate, in the county where the
113.17 real property is located. The party to whom the release is given shall be responsible for
113.18 paying all fees and costs necessary to record and file the release. If the property described
113.19 in the release is registered property, the registrar of titles shall accept it for recording and
113.20 shall record it on the certificate of title for each parcel of property described in the release.
113.21 If the property described in the release is abstract property, the recorder shall accept it
113.22 for filing and file it in the county's grantor-grantee indexes and any tract index the county
113.23 maintains for each parcel of property described in the release.

113.24 Sec. 43. Minnesota Statutes 2008, section 256B.15, is amended by adding a
113.25 subdivision to read:

113.26 Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to
113.27 intervene as a party in any proceeding involving recovery of medical assistance upon
113.28 filing a notice of intervention and serving such notice on the other parties.

113.29 Sec. 44. **[256B.196] INTERGOVERNMENTAL TRANSFERS; HOSPITAL**
113.30 **PAYMENTS.**

113.31 Subdivision 1. **Federal approval required.** This section is contingent on federal
113.32 approval of the intergovernmental transfers and payments authorized under this section.
113.33 This section is also contingent on current payment by the government entities of the
113.34 intergovernmental transfers under this section.

114.1 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and
114.2 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
114.3 services upper payment limit for nonstate government hospitals. The commissioner shall
114.4 then determine the amount of a supplemental payment to Hennepin County Medical
114.5 Center and Regions Hospital for these services that would increase medical assistance
114.6 spending in this category to the aggregate upper payment limit for all nonstate government
114.7 hospitals in Minnesota. In making this determination, the commissioner shall allot the
114.8 available increases between Hennepin County Medical Center and Regions Hospital
114.9 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
114.10 the two facilities. The commissioner shall adjust this allotment as necessary based on
114.11 federal approvals, the amount of intergovernmental transfers received from Hennepin and
114.12 Ramsey Counties, and other factors, in order to maximize the additional total payments.
114.13 The commissioner shall inform Hennepin County and Ramsey County of the periodic
114.14 intergovernmental transfers necessary to match federal Medicaid payments available
114.15 under this subdivision in order to make supplementary medical assistance payments to
114.16 Hennepin County Medical Center and Regions Hospital equal to an amount that when
114.17 combined with existing medical assistance payments to nonstate governmental hospitals
114.18 would increase total payments to hospitals in this category for outpatient services to
114.19 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
114.20 receipt of these periodic transfers, the commissioner shall make supplementary payments
114.21 to Hennepin County Medical Center and Regions Hospital.

114.22 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
114.23 determine an upper payment limit for physicians affiliated with Hennepin County Medical
114.24 Center and with Regions Hospital. The upper payment limit shall be based on the average
114.25 commercial rate or be determined using another method acceptable to the Centers for
114.26 Medicare and Medicaid Services. The commissioner shall inform Hennepin County and
114.27 Ramsey County of the periodic intergovernmental transfers necessary to match the federal
114.28 Medicaid payments available under this subdivision in order to make supplementary
114.29 payments to physicians affiliated with Hennepin County Medical Center and Regions
114.30 Hospital equal to the difference between the established medical assistance payment for
114.31 physician services and the upper payment limit. Upon receipt of these periodic transfers,
114.32 the commissioner shall make supplementary payments to physicians of Hennepin Faculty
114.33 Associates and HealthPartners.

114.34 (c) Beginning January 1, 2010, Hennepin County and Ramsey County shall make
114.35 monthly intergovernmental transfers to the commissioner in the following amounts:
114.36 $133,333 by Hennepin County and $100,000 by Ramsey County. The commissioner shall

115.1 increase the medical assistance capitation payments to Metropolitan Health Plan and
115.2 HealthPartners by an amount equal to the annual value of the monthly transfers plus
115.3 federal financial participation.

115.4 (d) The commissioner shall inform Hennepin County and Ramsey County on an
115.5 ongoing basis of the need for any changes needed in the intergovernmental transfers
115.6 in order to continue the payments under paragraphs (a) to (c), at their maximum level,
115.7 including increases in upper payment limits, changes in the federal Medicaid match, and
115.8 other factors.

115.9 (e) The payments in paragraphs (a) to (c) shall be implemented independently of
115.10 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

115.11 Subd. 3. **Intergovernmental transfers.** Based on the determination by the
115.12 commissioner under subdivision 2, Hennepin County and Ramsey County shall make
115.13 periodic intergovernmental transfers to the commissioner for the purposes of subdivision
115.14 2, paragraphs (a) to (c). All of the intergovernmental transfers made by Hennepin County
115.15 shall be used to match federal payments to Hennepin County Medical Center under
115.16 subdivision 2, paragraph (a); to physicians affiliated with Hennepin Faculty Associates
115.17 under subdivision 2, paragraph (b); and to Metropolitan Health Plan under subdivision
115.18 2, paragraph (c). All of the intergovernmental transfers made by Ramsey County shall
115.19 be used to match federal payments to Regions Hospital under subdivision 2, paragraph
115.20 (a); to physicians affiliated with HealthPartners under subdivision 2, paragraph (b); and to
115.21 HealthPartners under subdivision 2, paragraph (c).

115.22 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the
115.23 intergovernmental transfers under subdivision 3 and the payments under subdivision
115.24 2, based on the commissioner's determination of Medicare upper payment limits,
115.25 hospital-specific charge limits, hospital-specific limitations on disproportionate share
115.26 payments, medical inflation, actuarial certification, and cost-effectiveness for purposes
115.27 of federal waivers. Any adjustments must be made on a proportional basis. The
115.28 commissioner may make adjustments under this subdivision only after consultation
115.29 with the affected counties and hospitals. All payments under subdivision 2 and all
115.30 intergovernmental transfers under subdivision 3 are limited to amounts available after all
115.31 other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

115.32 (b) The ratio of medical assistance payments specified in subdivision 2 to the
115.33 voluntary intergovernmental transfers specified in subdivision 3 shall not be reduced
115.34 except as provided under paragraph (a).

116.1 Subd. 5. **Recession period.** Each type of intergovernmental transfer in subdivision
116.2 2, paragraphs (a) to (d), for payment periods from October 1, 2008, through December
116.3 31, 2010, is voluntary on the part of Hennepin and Ramsey Counties, meaning that the
116.4 transfer must be agreed to, in writing, by the counties prior to any payments being issued.
116.5 One agreement on each type of transfer shall cover the entire recession period.

116.6 Sec. 45. Minnesota Statutes 2008, section 256B.199, is amended to read:

116.7 **256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

116.8 (a) Effective July 1, 2007, the commissioner shall apply for federal matching funds
116.9 for the expenditures in paragraphs (b) and (c).

116.10 (b) The commissioner shall apply for federal matching funds for certified public
116.11 expenditures as follows:

116.12 (1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions
116.13 Hospital, the University of Minnesota, and Fairview-University Medical Center shall
116.14 report quarterly to the commissioner beginning June 1, 2007, payments made during the
116.15 second previous quarter that may qualify for reimbursement under federal law;

116.16 (2) based on these reports, the commissioner shall apply for federal matching
116.17 funds. These funds are appropriated to the commissioner for the payments under section
116.18 256.969, subdivision 27; and

116.19 (3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform
116.20 the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share
116.21 hospital payment money expected to be available in the current federal fiscal year.

116.22 (c) The commissioner shall apply for federal matching funds for general assistance
116.23 medical care expenditures as follows:

116.24 (1) for hospital services occurring on or after July 1, 2007, general assistance medical
116.25 care expenditures for fee-for-service inpatient and outpatient hospital payments made by
116.26 the department shall be used to apply for federal matching funds, except as limited below:

116.27 (i) only those general assistance medical care expenditures made to an individual
116.28 hospital that would not cause the hospital to exceed its individual hospital limits under
116.29 section 1923 of the Social Security Act may be considered; and

116.30 (ii) general assistance medical care expenditures may be considered only to the extent
116.31 of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

116.32 (2) all hospitals must provide any necessary expenditure, cost, and revenue
116.33 information required by the commissioner as necessary for purposes of obtaining federal
116.34 Medicaid matching funds for general assistance medical care expenditures.

117.1 (d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall
117.2 apply for additional federal matching funds available as disproportionate share hospital
117.3 payments under the American Recovery and Reinvestment Act of 2009. These funds shall
117.4 be made available as the state share of payments under section 256.969, subdivision 28.
117.5 The entities required to report certified public expenditures under paragraph (b), clause
117.6 (1), shall report additional certified public expenditures as necessary under this paragraph.

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

117.8 Sec. 46. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

117.9 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
117.10 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
117.11 basis beginning January 1, 1996. Managed care contracts which were in effect on June
117.12 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
117.13 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
117.14 commissioner may issue separate contracts with requirements specific to services to
117.15 medical assistance recipients age 65 and older.
117.16 (b) A prepaid health plan providing covered health services for eligible persons
117.17 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
117.18 of its contract with the commissioner. Requirements applicable to managed care programs
117.19 under chapters 256B, 256D, and 256L, established after the effective date of a contract
117.20 with the commissioner take effect when the contract is next issued or renewed.
117.21 (c) Effective for services rendered on or after January 1, 2003, the commissioner shall
117.22 withhold five percent of managed care plan payments under this section and county-based
117.23 purchasing plan's payment rate under section 256B.692 for the prepaid medical assistance
117.24 and general assistance medical care programs pending completion of performance targets.
117.25 Each performance target must be quantifiable, objective, measurable, and reasonably
117.26 attainable, except in the case of a performance target based on a federal or state law or rule.
117.27 Criteria for assessment of each performance target must be outlined in writing prior to the
117.28 contract effective date. The managed care plan must demonstrate, to the commissioner's
117.29 satisfaction, that the data submitted regarding attainment of the performance target is
117.30 accurate. The commissioner shall periodically change the administrative measures used
117.31 as performance targets in order to improve plan performance across a broader range of
117.32 administrative services. The performance targets must include measurement of plan
117.33 efforts to contain spending on health care services and administrative activities. The
117.34 commissioner may adopt plan-specific performance targets that take into account factors
117.35 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. ~~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 paragraph that is reasonably expected to be returned.~~

(d)~~(1)~~ 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 and general assistance medical care programs. 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.

~~(2) 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 paragraph.~~ The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

(e) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 3.5 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.

(f) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold four 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, 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.

(h) 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

119.1 for the prepaid medical assistance program. The withheld funds must be returned no
119.2 sooner than July 1 and no later than July 31 of the following year. The commissioner may
119.3 exclude special demonstration projects under subdivision 23.
119.4 (i) Effective for services rendered on or after January 1, 2014, the commissioner
119.5 shall withhold three percent of managed care plan payments under this section and
119.6 county-based purchasing plan payments under section 256B.692 for the prepaid medical
119.7 assistance and prepaid general assistance medical care programs. The withheld funds must
119.8 be returned no sooner than July 1 and no later than July 31 of the following year. The
119.9 commissioner may exclude special demonstration projects under subdivision 23.
119.10 (j) A managed care plan or a county-based purchasing plan under section 256B.692
119.11 may include as admitted assets under section 62D.044 any amount withheld under this
119.12 section that is reasonably expected to be returned.

119.13 Sec. 47. Minnesota Statutes 2008, section 256B.69, subdivision 5c, is amended to read:

119.14 Subd. 5c. **Medical education and research fund.** (a) Except as provided in
119.15 paragraph (c), the commissioner of human services shall transfer each year to the medical
119.16 education and research fund established under section 62J.692, the following:
119.17 (1) an amount equal to the reduction in the prepaid medical assistance and prepaid
119.18 general assistance medical care payments as specified in this clause. Until January 1,
119.19 2002, the county medical assistance and general assistance medical care capitation base
119.20 rate prior to plan specific adjustments and after the regional rate adjustments under section
119.21 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin County, two percent for
119.22 the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota
119.23 counties; and after January 1, 2002, the county medical assistance and general assistance
119.24 medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent
119.25 for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent
119.26 for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments
119.27 and demonstration project payments operating under subdivision 23 are excluded from
119.28 this reduction. The amount calculated under this clause shall not be adjusted for periods
119.29 already paid due to subsequent changes to the capitation payments;
119.30 (2) beginning July 1, 2003, ~~$2,157,000~~ $4,314,000 from the capitation rates paid
119.31 under this section ~~plus any federal matching funds on this amount~~;
119.32 (3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates
119.33 paid under this section; and
119.34 (4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid
119.35 under this section.

120.1 (b) This subdivision shall be effective upon approval of a federal waiver which
120.2 allows federal financial participation in the medical education and research fund. Effective
120.3 July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4),
120.4 shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first
120.5 reduce the amounts otherwise required to be transferred under paragraph (a), clauses
120.6 (2) to (4). Any excess following this reduction shall proportionally reduce the transfers
120.7 under paragraph (a), clause (1).

120.8 (c) Effective July 1, 2003, the amount reduced from the prepaid general assistance
120.9 medical care payments under paragraph (a), clause (1), shall be transferred to the general
120.10 fund.

120.11 (d) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall
120.12 transfer $21,714,000 each fiscal year to the medical education and research fund. The
120.13 balance of the transfers under paragraph (a) shall be transferred to the medical education
120.14 and research fund no earlier than July 1 of the following fiscal year.

120.15 Sec. 48. Minnesota Statutes 2008, section 256B.69, subdivision 5f, is amended to read:

120.16 Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid
120.17 under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the
120.18 capitation rates paid under this section are increased by $4,700,000 per year.

120.19 (b) Beginning July 1, 2009, the capitation rates paid under this section are increased
120.20 each year by the lesser of $21,714,000 or an amount equal to the difference between the
120.21 estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1),
120.22 and the amount of the limit described in subdivision 5c, paragraph (b).

120.23 Sec. 49. Minnesota Statutes 2008, section 256B.69, subdivision 23, is amended to read:

120.24 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
120.25 commissioner may implement demonstration projects to create alternative integrated
120.26 delivery systems for acute and long-term care services to elderly persons and persons
120.27 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
120.28 coordination, improve access to quality services, and mitigate future cost increases.
120.29 The commissioner may seek federal authority to combine Medicare and Medicaid
120.30 capitation payments for the purpose of such demonstrations and may contract with
120.31 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
120.32 services shall be administered according to the terms and conditions of the federal contract
120.33 and demonstration provisions. For the purpose of administering medical assistance funds,
120.34 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions

121.1 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
121.2 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
121.3 items B and C, which do not apply to persons enrolling in demonstrations under this
121.4 section. An initial open enrollment period may be provided. Persons who disenroll from
121.5 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
121.6 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
121.7 the health plan's participation is subsequently terminated for any reason, the person shall
121.8 be provided an opportunity to select a new health plan and shall have the right to change
121.9 health plans within the first 60 days of enrollment in the second health plan. Persons
121.10 required to participate in health plans under this section who fail to make a choice of
121.11 health plan shall not be randomly assigned to health plans under these demonstrations.
121.12 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
121.13 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
121.14 the commissioner may contract with managed care organizations, including counties, to
121.15 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
121.16 disabled persons only. For persons with a primary diagnosis of developmental disability,
121.17 serious and persistent mental illness, or serious emotional disturbance, the commissioner
121.18 must ensure that the county authority has approved the demonstration and contracting
121.19 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
121.20 commissioner shall not implement any demonstration project under this subdivision for
121.21 persons with a primary diagnosis of developmental disabilities, serious and persistent
121.22 mental illness, or serious emotional disturbance, without approval of the county board of
121.23 the county in which the demonstration is being implemented.

121.24 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
121.25 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
121.26 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
121.27 under this section projects for persons with developmental disabilities. The commissioner
121.28 may capitate payments for ICF/MR services, waivered services for developmental
121.29 disabilities, including case management services, day training and habilitation and
121.30 alternative active treatment services, and other services as approved by the state and by the
121.31 federal government. Case management and active treatment must be individualized and
121.32 developed in accordance with a person-centered plan. Costs under these projects may not
121.33 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
121.34 and until four years after the pilot project implementation date, subcontractor participation
121.35 in the long-term care developmental disability pilot is limited to a nonprofit long-term
121.36 care system providing ICF/MR services, home and community-based waiver services,

122.1 and in-home services to no more than 120 consumers with developmental disabilities in
122.2 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
122.3 prior to expansion of the developmental disability pilot project. This paragraph expires
122.4 four years after the implementation date of the pilot project.

122.5 (c) Before implementation of a demonstration project for disabled persons, the
122.6 commissioner must provide information to appropriate committees of the house of
122.7 representatives and senate and must involve representatives of affected disability groups
122.8 in the design of the demonstration projects.

122.9 (d) A nursing facility reimbursed under the alternative reimbursement methodology
122.10 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
122.11 provide services under paragraph (a). The commissioner shall amend the state plan and
122.12 seek any federal waivers necessary to implement this paragraph.

122.13 (e) The commissioner, in consultation with the commissioners of commerce and
122.14 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
122.15 according to federal laws and regulations governing that program and state laws or rules
122.16 applicable to participating providers. The process for approval of these programs shall
122.17 begin only after the commissioner receives grant money in an amount sufficient to cover
122.18 the state share of the administrative and actuarial costs to implement the programs during
122.19 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
122.20 account in the special revenue fund and are appropriated to the commissioner to be used
122.21 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
122.22 not required to be licensed or certified as a health plan company as defined in section
122.23 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
122.24 and found to be eligible for services under the elderly waiver or community alternatives
122.25 for disabled individuals or who are already eligible for Medicaid but meet level of
122.26 care criteria for receipt of waiver services may choose to enroll in the PACE program.
122.27 Medicare and Medicaid services will be provided according to this subdivision and
122.28 federal Medicare and Medicaid requirements governing PACE providers and programs.
122.29 PACE enrollees will receive Medicaid home and community-based services through the
122.30 PACE provider as an alternative to services for which they would otherwise be eligible
122.31 through home and community-based waiver programs and Medicaid State Plan Services.
122.32 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
122.33 costs that would have been incurred under fee-for-service or other relevant managed care
122.34 programs operated by the state.

122.35 (f) The commissioner shall seek federal approval to expand the Minnesota disability
122.36 health options (MnDHO) program established under this subdivision in stages, first to

123.1 regional population centers outside the seven-county metro area and then to all areas of
123.2 the state. Until July 1, 2009, expansion for MnDHO projects that include home and
123.3 community-based services is limited to the two projects and service areas in effect on
123.4 March 1, 2006. Enrollment in integrated MnDHO programs that include home and
123.5 community-based services shall remain voluntary. Costs for home and community-based
123.6 services included under MnDHO must not exceed costs that would have been incurred
123.7 under the fee-for-service program. Notwithstanding whether expansion occurs under
123.8 this paragraph, in determining MnDHO payment rates and risk adjustment methods for
123.9 contract years starting in 2012, the commissioner must consider the methods used to
123.10 determine county allocations for home and community-based program participants. If
123.11 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
123.12 for home and community-based services, the commissioner shall achieve the reduction by
123.13 maintaining the base rate for contract years 2010 and 2011 for services provided under the
123.14 community alternatives for disabled individuals waiver at the same level as for contract
123.15 year 2009. The commissioner may apply other reductions to MnDHO rates to implement
123.16 decreases in provider payment rates required by state law. In developing program
123.17 specifications for expansion of integrated programs, the commissioner shall involve and
123.18 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
123.19 including consultation on whether and how to include home and community-based waiver
123.20 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
123.21 of the house of representatives and senate committees with jurisdiction over health and
123.22 human services policy and finance by February 1, 2007.
123.23 (g) Notwithstanding section 256B.0261, health plans providing services under this
123.24 section are responsible for home care targeted case management and relocation targeted
123.25 case management. Services must be provided according to the terms of the waivers and
123.26 contracts approved by the federal government.

123.27 Sec. 50. **[256B.756] REIMBURSEMENT RATES FOR BIRTHS.**

123.28 Subdivision 1. **Facility rate.** (a) Notwithstanding section 256.969, effective for
123.29 services provided on or after October 1, 2009, the facility payment rate for the following
123.30 diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean
123.31 section without complicating diagnosis; (2) 372 vaginal delivery with complicating
123.32 diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be calculated
123.33 as provided in paragraph (b).
123.34 (b) The commissioner shall calculate a single rate for all of the diagnostic related
123.35 groups specified in paragraph (a) consistent with an increase in the proportion of births

124.1 by vaginal delivery and a reduction in the percentage of births by cesarean section. The
124.2 calculated single rate must be based on an expected increase in the number of vaginal
124.3 births and expected reduction in the number of cesarean section such that the reduction
124.4 in cesarean sections is less than or equal to one standard deviation below the average in
124.5 the frequency of cesarean births for Minnesota health care program clients at hospitals
124.6 performing greater than 50 deliveries per year.

124.7 (c) The rates described in this subdivision do not include newborn care.

124.8 Subd. 2. **Provider rate.** Notwithstanding section 256B.76, effective for services
124.9 provided on or after October 1, 2009, the payment rate for professional services related
124.10 to labor, delivery, and antepartum and postpartum care when provided for any of the
124.11 diagnostic categories identified in subdivision 1, paragraph (a), shall be calculated using
124.12 the methodology specified in subdivision 1, paragraph (b).

124.13 Subd. 3. **Health plans.** Payments to managed care and county-based purchasing
124.14 plans under sections 256B.69, 256B.692, or 256L.12 shall be reduced for services
124.15 provided on or after October 1, 2009, to reflect the adjustments in subdivisions 1 and 2.

124.16 Subd. 4. **Prior authorization.** Prior authorization shall not be required before
124.17 reimbursement is paid for a cesarean section delivery.

124.18 Sec. 51. Minnesota Statutes 2008, section 256B.76, subdivision 1, is amended to read:

124.19 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
124.20 or after October 1, 1992, the commissioner shall make payments for physician services
124.21 as follows:

124.22 (1) payment for level one Centers for Medicare and Medicaid Services' common
124.23 procedural coding system codes titled "office and other outpatient services," "preventive
124.24 medicine new and established patient," "delivery, antepartum, and postpartum care,"
124.25 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
124.26 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
124.27 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
124.28 30, 1992. If the rate on any procedure code within these categories is different than the
124.29 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
124.30 then the larger rate shall be paid;

124.31 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
124.32 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

124.33 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
124.34 percentile of 1989, less the percent in aggregate necessary to equal the above increases

125.1 except that payment rates for home health agency services shall be the rates in effect
125.2 on September 30, 1992.

125.3 (b) Effective for services rendered on or after January 1, 2000, payment rates for
125.4 physician and professional services shall be increased by three percent over the rates
125.5 in effect on December 31, 1999, except for home health agency and family planning
125.6 agency services. The increases in this paragraph shall be implemented January 1, 2000,
125.7 for managed care.

125.8 (c) Effective for services rendered on or after July 1, 2009, payment rates for
125.9 physician and professional services shall be reduced by five percent over the rates in effect
125.10 on June 30, 2009. This reduction does not apply to office or other outpatient services
125.11 (procedure codes 99201 to 99215), preventive medicine services (procedure codes 99381
125.12 to 99412) and family planning services billed by the following primary care specialties:
125.13 general practice, internal medicine, pediatrics, geriatrics, family practice, or by an
125.14 advanced practice registered nurse or physician assistant practicing in pediatrics, geriatrics,
125.15 or family practice. This reduction does not apply to federally qualified health centers,
125.16 rural health centers, and Indian health services. Effective October 1, 2009, payments
125.17 made to managed care plans and county-based purchasing plans under sections 256B.69,
125.18 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

125.19 Sec. 52. **[256B.766] REIMBURSEMENT FOR BASIC CARE SERVICES.**

125.20 (a) Effective for services provided on or after July 1, 2009, total payments for basic
125.21 care services, shall be reduced by three percent, prior to third-party liability and spenddown
125.22 calculation. Payments made to managed care plans and county-based purchasing plans
125.23 shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

125.24 (b) This section does not apply to physician and professional services, inpatient
125.25 hospital services, family planning services, mental health services, dental services,
125.26 prescription drugs, and medical transportation.

125.27 Sec. 53. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

125.28 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
125.29 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
125.30 care covers, except as provided in paragraph (c):

125.31 (1) inpatient hospital services;

125.32 (2) outpatient hospital services;

125.33 (3) services provided by Medicare certified rehabilitation agencies;

126.1 (4) prescription drugs and other products recommended through the process
126.2 established in section 256B.0625, subdivision 13;
126.3 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
126.4 for diabetics to monitor blood sugar level;
126.5 (6) eyeglasses and eye examinations provided by a physician or optometrist;
126.6 (7) hearing aids;
126.7 (8) prosthetic devices;
126.8 (9) laboratory and X-ray services;
126.9 (10) physician's services;
126.10 (11) medical transportation except special transportation;
126.11 (12) chiropractic services as covered under the medical assistance program;
126.12 (13) podiatric services;
126.13 (14) dental services as covered under the medical assistance program;
126.14 (15) mental health services covered under chapter 256B;
126.15 (16) prescribed medications for persons who have been diagnosed as mentally ill as
126.16 necessary to prevent more restrictive institutionalization;
126.17 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
126.18 deductible payments;
126.19 (18) medical equipment not specifically listed in this paragraph when the use of
126.20 the equipment will prevent the need for costlier services that are reimbursable under
126.21 this subdivision;
126.22 (19) services performed by a certified pediatric nurse practitioner, a certified family
126.23 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
126.24 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
126.25 practitioner in independent practice, if (1) the service is otherwise covered under this
126.26 chapter as a physician service, (2) the service provided on an inpatient basis is not included
126.27 as part of the cost for inpatient services included in the operating payment rate, and (3) the
126.28 service is within the scope of practice of the nurse practitioner's license as a registered
126.29 nurse, as defined in section 148.171;
126.30 (20) services of a certified public health nurse or a registered nurse practicing in
126.31 a public health nursing clinic that is a department of, or that operates under the direct
126.32 authority of, a unit of government, if the service is within the scope of practice of the
126.33 public health nurse's license as a registered nurse, as defined in section 148.171;
126.34 (21) telemedicine consultations, to the extent they are covered under section
126.35 256B.0625, subdivision 3b;

127.1 (22) care coordination and patient education services provided by a community
127.2 health worker according to section 256B.0625, subdivision 49; and
127.3 (23) regardless of the number of employees that an enrolled health care provider
127.4 may have, sign language interpreter services when provided by an enrolled health care
127.5 provider during the course of providing a direct, person-to-person covered health care
127.6 service to an enrolled recipient who has a hearing loss and uses interpreting services.
127.7 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
127.8 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
127.9 to inpatient hospital services, including physician services provided during the inpatient
127.10 hospital stay. A $1,000 deductible is required for each inpatient hospitalization.
127.11 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
127.12 subdivision.
127.13 (c) In order to contain costs, the commissioner of human services shall select
127.14 vendors of medical care who can provide the most economical care consistent with high
127.15 medical standards and shall where possible contract with organizations on a prepaid
127.16 capitation basis to provide these services. The commissioner shall consider proposals by
127.17 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
127.18 or other vendor payment mechanisms designed to provide services in an economical
127.19 manner or to control utilization, with safeguards to ensure that necessary services are
127.20 provided. Before implementing prepaid programs in counties with a county operated or
127.21 affiliated public teaching hospital or a hospital or clinic operated by the University of
127.22 Minnesota, the commissioner shall consider the risks the prepaid program creates for the
127.23 hospital and allow the county or hospital the opportunity to participate in the program in a
127.24 manner that reflects the risk of adverse selection and the nature of the patients served by
127.25 the hospital, provided the terms of participation in the program are competitive with the
127.26 terms of other participants considering the nature of the population served. Payment for
127.27 services provided pursuant to this subdivision shall be as provided to medical assistance
127.28 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
127.29 payments made during fiscal year 1990 and later years, the commissioner shall consult
127.30 with an independent actuary in establishing prepayment rates, but shall retain final control
127.31 over the rate methodology.
127.32 (d) Effective January 1, 2008, drug coverage under general assistance medical
127.33 care is limited to prescription drugs that:
127.34 (i) are covered under the medical assistance program as described in section
127.35 256B.0625, subdivisions 13 and 13d; and

128.1 (ii) are provided by manufacturers that have fully executed general assistance
128.2 medical care rebate agreements with the commissioner and comply with the agreements.
128.3 Prescription drug coverage under general assistance medical care must conform to
128.4 coverage under the medical assistance program according to section 256B.0625,
128.5 subdivisions 13 to 13g.

128.6 (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
128.7 co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

128.8 (1) $25 for eyeglasses;

128.9 (2) $25 for nonemergency visits to a hospital-based emergency room;

128.10 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
128.11 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
128.12 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

128.13 (4) 50 percent coinsurance on restorative dental services.

128.14 (f) Recipients eligible under subdivision 3, paragraph (a), shall include the following
128.15 co-payments for services provided on or after January 1, 2009:

128.16 (1) $25 for nonemergency visits to a hospital-based emergency room; and

128.17 (2) $3 per brand-name drug prescription and $1 per generic drug prescription,
128.18 subject to a $7 per month maximum for prescription drug co-payments. No co-payments
128.19 shall apply to antipsychotic drugs when used for the treatment of mental illness.

128.20 (g) MS 2007 Supp [Expired]

128.21 (h) Effective January 1, 2009, co-payments shall be limited to one per day per
128.22 provider for nonemergency visits to a hospital-based emergency room. Recipients of
128.23 general assistance medical care are responsible for all co-payments in this subdivision.
128.24 The general assistance medical care reimbursement to the provider shall be reduced by the
128.25 amount of the co-payment, except that reimbursement for prescription drugs shall not be
128.26 reduced once a recipient has reached the $7 per month maximum for prescription drug
128.27 co-payments. The provider collects the co-payment from the recipient. Providers may not
128.28 deny services to recipients who are unable to pay the co-payment.

128.29 (i) General assistance medical care reimbursement to fee-for-service providers
128.30 and payments to managed care plans shall not be increased as a result of the removal of
128.31 the co-payments effective January 1, 2009.

128.32 (j) Any county may, from its own resources, provide medical payments for which
128.33 state payments are not made.

128.34 (k) Chemical dependency services that are reimbursed under chapter 254B must not
128.35 be reimbursed under general assistance medical care.

129.1 (l) The maximum payment for new vendors enrolled in the general assistance
129.2 medical care program after the base year shall be determined from the average usual and
129.3 customary charge of the same vendor type enrolled in the base year.

129.4 (m) The conditions of payment for services under this subdivision are the same
129.5 as the conditions specified in rules adopted under chapter 256B governing the medical
129.6 assistance program, unless otherwise provided by statute or rule.

129.7 (n) Inpatient and outpatient payments shall be reduced by five percent, effective July
129.8 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
129.9 and incorporated by reference in paragraph (l).

129.10 (o) Payments for all other health services except inpatient, outpatient, and pharmacy
129.11 services shall be reduced by five percent, effective July 1, 2003.

129.12 (p) Payments to managed care plans shall be reduced by five percent for services
129.13 provided on or after October 1, 2003.

129.14 (q) A hospital receiving a reduced payment as a result of this section may apply the
129.15 unpaid balance toward satisfaction of the hospital's bad debts.

129.16 (r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for
129.17 services provided on or after January 1, 2006. For purposes of this subdivision, a visit
129.18 means an episode of service which is required because of a recipient's symptoms,
129.19 diagnosis, or established illness, and which is delivered in an ambulatory setting by
129.20 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
129.21 audiologist, optician, or optometrist.

129.22 (s) Payments to managed care plans shall not be increased as a result of the removal
129.23 of the $3 nonpreventive visit co-payment effective January 1, 2006.

129.24 (t) Payments for mental health services added as covered benefits after December
129.25 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

129.26 (u) Effective for services provided on or after July 1, 2009, total payment rates for
129.27 basic care services shall be reduced by three percent, in accordance with section 256B.766.
129.28 Payments made to managed care plans shall be reduced for services provided on or after
129.29 October 1, 2009, to reflect this reduction.

129.30 (v) Effective for services provided on or after July 1, 2009, payment rates for
129.31 physician and professional services shall be reduced as described under section 256B.76,
129.32 subdivision 1, paragraph (c). Payments made to managed care plans shall be reduced for
129.33 services provided on or after October 1, 2009, to reflect this reduction.

129.34 Sec. 54. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision
129.35 to read:

130.1 Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic
130.2 services: medically necessary exams, manual manipulation of the spine, and x-rays.

130.3 **EFFECTIVE DATE.** This section is effective January 1, 2010.

130.4 Sec. 55. Minnesota Statutes 2008, section 256L.04, subdivision 1, is amended to read:

130.5 Subdivision 1. **Families with children.** (a) Families with children with family
130.6 income equal to or less than 275 percent of the federal poverty guidelines for the
130.7 applicable family size shall be eligible for MinnesotaCare according to this section. All
130.8 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
130.9 to enrollment under section 256L.07, shall apply unless otherwise specified.
130.10 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
130.11 if the children are eligible. Children may be enrolled separately without enrollment by
130.12 parents. However, if one parent in the household enrolls, both parents must enroll, unless
130.13 other insurance is available. If one child from a family is enrolled, all children must
130.14 be enrolled, unless other insurance is available. If one spouse in a household enrolls,
130.15 the other spouse in the household must also enroll, unless other insurance is available.
130.16 Families cannot choose to enroll only certain uninsured members.
130.17 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies
130.18 to the MinnesotaCare program. These persons are no longer counted in the parental
130.19 household and may apply as a separate household.
130.20 (d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are
130.21 not eligible for MinnesotaCare if their gross income exceeds $57,500.
130.22 (e) Children formerly enrolled in medical assistance and automatically deemed
130.23 eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt
130.24 from the requirements of this section until renewal.
130.25 (f) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision
130.26 8, are exempt from the eligibility requirements of this subdivision.

130.27 Sec. 56. Minnesota Statutes 2008, section 256L.04, is amended by adding a subdivision
130.28 to read:

130.29 Subd. 1b. **Children with family income greater than 275 percent of federal**
130.30 **poverty guidelines.** Children with family income greater than 275 percent of federal
130.31 poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All
130.32 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
130.33 to enrollment under section 256L.07, shall apply unless otherwise specified.

131.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
131.2 approval, whichever is later.

131.3 Sec. 57. Minnesota Statutes 2008, section 256L.04, subdivision 7a, is amended to read:

131.4 Subd. 7a. **Ineligibility.** ~~Applicants~~ Adults whose income is greater than the limits
131.5 established under this section may not enroll in the MinnesotaCare program.

131.6 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
131.7 approval, whichever is later.

131.8 Sec. 58. Minnesota Statutes 2008, section 256L.04, subdivision 10a, is amended to
131.9 read:

131.10 Subd. 10a. **Sponsor's income and resources deemed available; documentation.**
131.11 When determining eligibility for any federal or state benefits under sections 256L.01 to
131.12 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of
131.13 support as defined under United States Code, title 8, section 1183a, shall be deemed to
131.14 include their sponsors' income and resources as defined in the Personal Responsibility
131.15 and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections
131.16 421 and 422, and subsequently set out in federal rules. To be eligible for the program,
131.17 noncitizens must provide documentation of their immigration status. Beginning July
131.18 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply
131.19 to pregnant women and children who are qualified noncitizens, as described in section
131.20 256B.06, subdivision 4, paragraph (b).

131.21 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
131.22 approval, whichever is later. The commissioner shall notify the revisor of statutes when
131.23 federal approval has been obtained.

131.24 Sec. 59. Minnesota Statutes 2008, section 256L.05, subdivision 1, is amended to read:

131.25 Subdivision 1. **Application assistance and information availability.** (a)
131.26 Applications and application assistance must be made available at provider offices, local
131.27 human services agencies, school districts, public and private elementary schools in which
131.28 25 percent or more of the students receive free or reduced price lunches, community health
131.29 offices, Women, Infants and Children (WIC) program sites, Head Start program sites,
131.30 public housing councils, crisis nurseries, child care centers, early childhood education
131.31 and preschool program sites, legal aid offices, and libraries. These sites may accept
131.32 applications and forward the forms to the commissioner or local county human services

132.1 agencies that choose to participate as an enrollment site. Otherwise, applicants may apply
132.2 directly to the commissioner or to participating local county human services agencies.
132.3 (b) Application assistance must be available for applicants choosing to file an
132.4 online application.

132.5 Sec. 60. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
132.6 to read:

132.7 Subd. 1c. **Open enrollment and streamlined application and enrollment**
132.8 **process.** (a) The commissioner and local agencies working in partnership must develop a
132.9 streamlined and efficient application and enrollment process for medical assistance and
132.10 MinnesotaCare enrollees that meets the criteria specified in this subdivision.
132.11 (b) The commissioners of human services and education shall provide
132.12 recommendations to the legislature by January 15, 2010, on the creation of an open
132.13 enrollment process for medical assistance and MinnesotaCare that is coordinated with
132.14 the public education system. The recommendations must:
132.15 (1) be developed in consultation with medical assistance and MinnesotaCare
132.16 enrollees and representatives from organizations that advocate on behalf of children and
132.17 families, low-income persons and minority populations, counties, school administrators
132.18 and nurses, health plans, and health care providers;
132.19 (2) be based on enrollment and renewal procedures best practices, including express
132.20 lane eligibility as required under subdivision 1d;
132.21 (3) simplify the enrollment and renewal processes wherever possible; and
132.22 (4) establish a process:
132.23 (i) to disseminate information on medical assistance and MinnesotaCare to all
132.24 children in the public education system, including prekindergarten programs; and
132.25 (ii) for the commissioner of human services to enroll children and other household
132.26 members who are eligible.
132.27 The commissioner of human services in coordination with the commissioner of
132.28 education shall implement an open enrollment process by August 1, 2010, to be effective
132.29 beginning with the 2010-2011 school year.
132.30 (c) The commissioner and local agencies shall develop an online application process
132.31 for medical assistance and MinnesotaCare.
132.32 (d) The commissioner shall develop an application that is easily understandable
132.33 and does not exceed four pages in length.

133.1 (e) The commissioner of human services shall present to the legislature, by January
133.2 15, 2010, an implementation plan for the open enrollment period and online application
133.3 process.

133.4 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
133.5 approval, which must be requested by the commissioner, whichever is later.

133.6 Sec. 61. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

133.7 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
133.8 first day of the month following the month in which eligibility is approved and the first
133.9 premium payment has been received. As provided in section 256B.057, coverage for
133.10 newborns is automatic from the date of birth and must be coordinated with other health
133.11 coverage. The effective date of coverage for eligible newly adoptive children added to a
133.12 family receiving covered health services is the month of placement. The effective date
133.13 of coverage for other new members added to the family is the first day of the month
133.14 following the month in which the change is reported. All eligibility criteria must be met
133.15 by the family at the time the new family member is added. The income of the new family
133.16 member is included with the family's gross income and the adjusted premium begins in
133.17 the month the new family member is added.

133.18 (b) The initial premium must be received by the last working day of the month for
133.19 coverage to begin the first day of the following month.

133.20 (c) Benefits are not available until the day following discharge if an enrollee is
133.21 hospitalized on the first day of coverage.

133.22 (d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
133.23 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
133.24 person may have coverage and the commissioner shall use cost avoidance techniques to
133.25 ensure coordination of any other health coverage for eligible persons. The commissioner
133.26 shall identify eligible persons who may have coverage or benefits under other plans of
133.27 insurance or who become eligible for medical assistance.

133.28 (e) The effective date of coverage for single adults and households with no children
133.29 formerly enrolled in general assistance medical care and enrolled in MinnesotaCare
133.30 according to section 256D.03, subdivision 3, is the first day of the month following the
133.31 last day of general assistance medical care coverage.

133.32 (f) The effective date of coverage for children eligible under section 256L.07,
133.33 subdivision 8, is the first day of the month following the date of termination from foster
133.34 care or release from a juvenile residential correctional facility.

134.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
134.2 approval, whichever is later.

134.3 Sec. 62. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

134.4 Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility
134.5 must be renewed every 12 months. The 12-month period begins in the month after the
134.6 month the application is approved.

134.7 (b) Each new period of eligibility must take into account any changes in
134.8 circumstances that impact eligibility and premium amount. An enrollee must provide all
134.9 the information needed to redetermine eligibility by the first day of the month that ends
134.10 the eligibility period. If there is no change in circumstances, the enrollee may renew
134.11 eligibility at designated locations that include community clinics and health care providers'
134.12 offices. The designated sites shall forward the renewal forms to the commissioner. The
134.13 commissioner may establish criteria and timelines for sites to forward applications to the
134.14 commissioner or county agencies. The premium for the new period of eligibility must be
134.15 received as provided in section 256L.06 in order for eligibility to continue.

134.16 (c) For single adults and households with no children formerly enrolled in general
134.17 assistance medical care and enrolled in MinnesotaCare according to section 256D.03,
134.18 subdivision 3, the first period of eligibility begins the month the enrollee submitted the
134.19 application or renewal for general assistance medical care.

134.20 (d) ~~An enrollee~~ Notwithstanding paragraph (e), an enrollee who fails to submit
134.21 renewal forms and related documentation necessary for verification of continued eligibility
134.22 in a timely manner shall remain eligible for one additional month beyond the end of the
134.23 current eligibility period before being disenrolled. The enrollee remains responsible for
134.24 MinnesotaCare premiums for the additional month.

134.25 (e) Children in families with family income equal to or below 275 percent of federal
134.26 poverty guidelines who fail to submit renewal forms and related documentation necessary
134.27 for verification of continued eligibility in a timely manner shall remain eligible for the
134.28 program. The commissioner shall use the means described in subdivision 2 or any other
134.29 means available to verify family income. If the commissioner determines that there has
134.30 been a change in income in which premium payment is required to remain enrolled, the
134.31 commissioner shall notify the family of the premium payment, and that the children
134.32 will be disenrolled if the premium payment is not received effective the first day of the
134.33 calendar month following the calendar month for which the premium is due.

134.34 (f) For children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the
134.35 first period of renewal begins the month the enrollee turns 21 years of age.

135.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
135.2 approval, whichever is later.

135.3 Sec. 63. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

135.4 Subdivision 1. **General requirements.** (a) Children enrolled in the original
135.5 children's health plan as of September 30, 1992, children who enrolled in the
135.6 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
135.7 article 4, section 17, and children who have family gross incomes that are equal to or
135.8 less than ~~150~~ 200 percent of the federal poverty guidelines are eligible without meeting
135.9 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
135.10 long as they maintain continuous coverage in the MinnesotaCare program or medical
135.11 assistance. ~~Children who apply for MinnesotaCare on or after the implementation date~~
135.12 ~~of the employer-subsidized health coverage program as described in Laws 1998, chapter~~
135.13 ~~407, article 5, section 45, who have family gross incomes that are equal to or less than 150~~
135.14 ~~percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to~~
135.15 ~~be eligible for MinnesotaCare.~~

135.16 ~~Families~~ Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1,
135.17 whose income increases above 275 percent of the federal poverty guidelines, are no longer
135.18 eligible for the program and shall be disenrolled by the commissioner. Beginning January
135.19 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision
135.20 7, whose income increases above 200 percent of the federal poverty guidelines or 250
135.21 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for
135.22 the program and shall be disenrolled by the commissioner. For persons disenrolled under
135.23 this subdivision, MinnesotaCare coverage terminates the last day of the calendar month
135.24 following the month in which the commissioner determines that the income of a family or
135.25 individual exceeds program income limits.

135.26 (b) ~~Notwithstanding paragraph (a),~~ Children may remain enrolled in MinnesotaCare
135.27 if ~~ten percent of~~ their ~~gross individual or~~ gross family income as defined in section
135.28 256L.01, subdivision 4, is ~~less than the annual premium for a policy with a $500~~
135.29 ~~deductible available through the Minnesota Comprehensive Health Association. Children~~
135.30 ~~who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month~~
135.31 ~~notice period from the date that ineligibility is determined before disenrollment~~ greater
135.32 than 275 percent of federal poverty guidelines. The premium for children remaining
135.33 eligible under this ~~clause~~ paragraph shall be the maximum premium determined under
135.34 section 256L.15, subdivision 2, paragraph (b).

136.1 (c) Notwithstanding ~~paragraphs~~ paragraph (a) ~~and (b)~~, parents are not eligible for
136.2 MinnesotaCare if gross household income exceeds $57,500 for the 12-month period
136.3 of eligibility.

136.4 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
136.5 approval, whichever is later.

136.6 Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

136.7 Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be
136.8 eligible, a family or individual must not have access to subsidized health coverage through
136.9 an employer and must not have had access to employer-subsidized coverage through
136.10 a current employer for 18 months prior to application or reapplication. A family or
136.11 individual whose employer-subsidized coverage is lost due to an employer terminating
136.12 health care coverage as an employee benefit during the previous 18 months is not eligible.
136.13 (b) This subdivision does not apply to a family or individual who was enrolled
136.14 in MinnesotaCare within six months or less of reapplication and who no longer has
136.15 employer-subsidized coverage due to the employer terminating health care coverage as an
136.16 employee benefit. This subdivision does not apply to children with family gross incomes
136.17 that are equal to or less than 200 percent of federal poverty guidelines.
136.18 (c) For purposes of this requirement, subsidized health coverage means health
136.19 coverage for which the employer pays at least 50 percent of the cost of coverage for
136.20 the employee or dependent, or a higher percentage as specified by the commissioner.
136.21 Children are eligible for employer-subsidized coverage through either parent, including
136.22 the noncustodial parent. The commissioner must treat employer contributions to Internal
136.23 Revenue Code Section 125 plans and any other employer benefits intended to pay
136.24 health care costs as qualified employer subsidies toward the cost of health coverage for
136.25 employees for purposes of this subdivision.

136.26 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
136.27 approval, whichever is later.

136.28 Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

136.29 Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the
136.30 MinnesotaCare program must have no health coverage while enrolled ~~or for at least four~~
136.31 ~~months prior to application and renewal~~. Children with family gross incomes equal to or
136.32 greater than 200 percent of federal poverty guidelines, and adults, must have had no health
136.33 coverage for at least four months prior to application and renewal. Children enrolled in the
136.34 original children's health plan and children in families with income equal to or less than

137.1 ~~150~~ 200 percent of the federal poverty guidelines, who have other health insurance, are
137.2 eligible if the coverage:
137.3 (1) lacks two or more of the following:
137.4 (i) basic hospital insurance;
137.5 (ii) medical-surgical insurance;
137.6 (iii) prescription drug coverage;
137.7 (iv) dental coverage; or
137.8 (v) vision coverage;
137.9 (2) requires a deductible of $100 or more per person per year; or
137.10 (3) lacks coverage because the child has exceeded the maximum coverage for a
137.11 particular diagnosis or the policy excludes a particular diagnosis.
137.12 The commissioner may change this eligibility criterion for sliding scale premiums
137.13 in order to remain within the limits of available appropriations. The requirement of no
137.14 health coverage does not apply to newborns.
137.15 (b) Medical assistance, general assistance medical care, and the Civilian Health and
137.16 Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under
137.17 United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or
137.18 health coverage for purposes of the four-month requirement described in this subdivision.
137.19 (c) For purposes of this subdivision, an applicant or enrollee who is entitled to
137.20 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
137.21 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to
137.22 have health coverage. An applicant or enrollee who is entitled to premium-free Medicare
137.23 Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility
137.24 for MinnesotaCare.
137.25 (d) Applicants who were recipients of medical assistance or general assistance
137.26 medical care within one month of application must meet the provisions of this subdivision
137.27 and subdivision 2.
137.28 (e) Cost-effective health insurance that was paid for by medical assistance is not
137.29 considered health coverage for purposes of the four-month requirement under this
137.30 section, except if the insurance continued after medical assistance no longer considered it
137.31 cost-effective or after medical assistance closed.

137.32 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
137.33 approval, whichever is later.

137.34 Sec. 66. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision
137.35 to read:

138.1 Subd. 8. **Automatic eligibility for certain children.** Any child who was residing
138.2 in foster care or a juvenile residential correctional facility on the child's 18th birthday is
138.3 automatically deemed eligible for MinnesotaCare upon termination or release until the
138.4 child reaches the age of 21, and is exempt from the requirements of this section and
138.5 section 256L.15. To be enrolled under this section, a child must complete an initial
138.6 application for MinnesotaCare. The commissioner shall contact individuals enrolled
138.7 under this section annually to ensure the individual continues to reside in the state and is
138.8 interested in continuing MinnesotaCare coverage.

138.9 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
138.10 approval, whichever is later.

138.11 Sec. 67. Minnesota Statutes 2008, section 256L.11, subdivision 1, is amended to read:

138.12 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under
138.13 sections 256L.01 to 256L.11 shall be at the same rates and conditions established for
138.14 medical assistance, except as provided in subdivisions 2 to 6.
138.15 (b) Effective for services provided on or after July 1, 2009, total payments for basic
138.16 care services shall be reduced by three percent, in accordance with section 256B.766.
138.17 Payments made to managed care plans shall be reduced for services provided on or after
138.18 October 1, 2009, to reflect this reduction.

138.19 Sec. 68. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

138.20 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
138.21 commissioner shall establish a sliding fee scale to determine the percentage of monthly
138.22 gross individual or family income that households at different income levels must pay to
138.23 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
138.24 on the enrollee's monthly gross individual or family income. The sliding fee scale must
138.25 contain separate tables based on enrollment of one, two, or three or more persons. Until
138.26 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
138.27 individual or family income for individuals or families with incomes below the limits for
138.28 the medical assistance program for families and children in effect on January 1, 1999, and
138.29 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
138.30 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
138.31 the medical assistance income limit for families and children in effect on January 1, 1999,
138.32 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
138.33 family size of five. The sliding fee scale for a family of five must be used for families of
138.34 more than five. The sliding fee scale and percentages are not subject to the provisions of

chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below ~~150~~ 200 percent of the federal poverty guidelines shall pay ~~a monthly premium of $4~~ no premiums. For purposes of paragraph (d), "minimum" means a monthly premium of $4.

(d) The following premium scale is established for individuals and families with gross family incomes of 300 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	1.1%
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274%	7.2%
275-300%	8.0%

140.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
140.2 approval, whichever is later.

140.3 Sec. 69. Minnesota Statutes 2008, section 256L.15, subdivision 3, is amended to read:

140.4 Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below
140.5 ~~150~~ 200 percent of the federal poverty guidelines shall pay ~~a~~ no monthly ~~premium of~~
140.6 ~~$4~~ premiums.

140.7 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
140.8 approval, whichever is later.

140.9 Sec. 70. Minnesota Statutes 2008, section 256L.17, subdivision 3, is amended to read:

140.10 Subd. 3. **Documentation.** (a) The commissioner of human services shall require
140.11 individuals and families, at the time of application or renewal, to indicate on a ~~checkoff~~
140.12 form developed by the commissioner whether they satisfy the MinnesotaCare asset
140.13 requirement.

140.14 (b) The commissioner may require individuals and families to provide any
140.15 information the commissioner determines necessary to verify compliance with the asset
140.16 requirement, if the commissioner determines that there is reason to believe that an
140.17 individual or family has assets that exceed the program limit.

140.18 Sec. 71. Minnesota Statutes 2008, section 256L.17, subdivision 5, is amended to read:

140.19 Subd. 5. **Exemption.** This section does not apply to pregnant women or children.
140.20 For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

140.21 Sec. 72. Minnesota Statutes 2008, section 501B.89, is amended by adding a
140.22 subdivision to read:

140.23 Subd. 4. **Annual filing requirement for supplemental needs trusts.** (a) A trustee
140.24 of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or
140.25 (C), shall submit to the commissioner of human services, at the time of a beneficiary's
140.26 request for medical assistance, the following information about the trust:

140.27 (1) a copy of the trust instrument; and

140.28 (2) an inventory of the beneficiary's trust account assets and the value of those assets.

140.29 (b) A trustee of a trust under subdivision 3 and United States Code, title 42, section
140.30 1396p(d)(4)(A) or (C), shall submit an accounting of the beneficiary's trust account to the
140.31 commissioner of human services at least annually until the trust, or the beneficiary's
140.32 interest in the trust, terminates. Accountings are due on the anniversary of the execution

141.1 date of the trust unless another annual date is established by the terms of the trust. The
141.2 accounting must include the following information for the accounting period:
141.3 (1) an inventory of trust assets and the value of those assets at the beginning of the
141.4 accounting period;
141.5 (2) additions to the trust during the accounting period and the source of those
141.6 additions;
141.7 (3) itemized distributions from the trust during the accounting period, including the
141.8 purpose of the distributions and to whom the distributions were made;
141.9 (4) an inventory of trust assets and the value of those assets at the end of the
141.10 accounting period; and
141.11 (5) changes to the trust instrument during the accounting period.
141.12 (c) For the purpose of paragraph (b), an accounting period is 12 months unless an
141.13 accounting period of a different length is permitted by the commissioner.

141.14 **EFFECTIVE DATE.** This section is effective for applications for medical
141.15 assistance and renewals of medical assistance submitted on or after July 1, 2009.

141.16 Sec. 73. Minnesota Statutes 2008, section 519.05, is amended to read:

141.17 **519.05 LIABILITY OF HUSBAND AND WIFE.**

141.18 (a) A spouse is not liable to a creditor for any debts of the other spouse. Where
141.19 husband and wife are living together, they shall be jointly and severally liable for
141.20 necessary medical services that have been furnished to either spouse, including any claims
141.21 arising under section 246.53, 256B.15, 256D.16, or 261.04, and necessary household
141.22 articles and supplies furnished to and used by the family. Notwithstanding this paragraph,
141.23 in a proceeding under chapter 518 the court may apportion such debt between the spouses.
141.24 (b) Either spouse may close a credit card account or other unsecured consumer line
141.25 of credit on which both spouses are contractually liable, by giving written notice to the
141.26 creditor.

141.27 Sec. 74. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
141.28 1, as amended by Laws 2004, chapter 272, article 2, section 2, is amended to read:

141.29 Subdivision 1. **Total Appropriation**		**$ 3,848,049,000**	**$ 4,135,780,000**
141.30	Summary by Fund		
141.31 General	3,301,811,000	3,561,055,000	

142.1 State Government

142.2 Special Revenue	534,000	534,000
142.3 Health Care Access	273,723,000	302,272,000
142.4 Federal TANF	270,425,000	270,363,000
142.5 Lottery Cash Flow	1,556,000	1,556,000

142.6 **Federal Contingency Appropriation.** (a)
142.7 Federal Medicaid funds made available
142.8 under title IV of the federal Jobs and Growth
142.9 Tax Relief Reconciliation Act of 2003
142.10 are appropriated to the commissioner of
142.11 human services for use in the state's medical
142.12 assistance and MinnesotaCare programs.
142.13 The commissioners of human services and
142.14 finance shall report to the legislative advisory
142.15 committee on the additional federal Medicaid
142.16 matching funds that will be available to the
142.17 state.

142.18 (b) Because of the availability of these funds,
142.19 the following policies shall become effective:

142.20 (1) medical assistance and MinnesotaCare
142.21 eligibility and local financial participation
142.22 changes provided for in this act may be
142.23 implemented prior to September 2, 2003, or
142.24 may be delayed as necessary to maximize
142.25 the use of federal funds received under
142.26 title IV of the Jobs and Growth Tax Relief
142.27 Reconciliation Act of 2003;

142.28 (2) the aggregate cap on the services
142.29 identified in Minnesota Statutes, section
142.30 256L.035, paragraph (a), clause (3), shall
142.31 be increased from $2,000 to $5,000. This
142.32 increase shall expire at the end of fiscal year
142.33 2007. Funds may be transferred from the

143.1 general fund to the health care access fund as
143.2 necessary to implement this provision; and

143.3 (3) the following payment shifts shall not be
143.4 implemented:

143.5 (i) MFIP payment shift found in subdivision
143.6 11;

143.7 (ii) the county payment shift found in
143.8 subdivision 1; and

143.9 (iii) the delay in medical assistance
143.10 and general assistance medical care
143.11 fee-for-service payments found in
143.12 subdivision 6.

143.13 (c) Notwithstanding section 14, paragraphs
143.14 (a) and (b) shall expire June 30, 2007.

143.15 **Receipts for Systems Projects.**
143.16 Appropriations and federal receipts for
143.17 information system projects for MAXIS,
143.18 PRISM, MMIS, and SSIS must be deposited
143.19 in the state system account authorized in
143.20 Minnesota Statutes, section 256.014. Money
143.21 appropriated for computer projects approved
143.22 by the Minnesota office of technology,
143.23 funded by the legislature, and approved
143.24 by the commissioner of finance may be
143.25 transferred from one project to another
143.26 and from development to operations as the
143.27 commissioner of human services considers
143.28 necessary. Any unexpended balance in
143.29 the appropriation for these projects does
143.30 not cancel but is available for ongoing
143.31 development and operations.

143.32 **Gifts.** Notwithstanding Minnesota Statutes,
143.33 chapter 7, the commissioner may accept
143.34 on behalf of the state additional funding

144.1 from sources other than state funds for the
144.2 purpose of financing the cost of assistance
144.3 program grants or nongrant administration.
144.4 All additional funding is appropriated to the
144.5 commissioner for use as designated by the
144.6 grantor of funding.

144.7 **Systems Continuity.** In the event of
144.8 disruption of technical systems or computer
144.9 operations, the commissioner may use
144.10 available grant appropriations to ensure
144.11 continuity of payments for maintaining the
144.12 health, safety, and well-being of clients
144.13 served by programs administered by the
144.14 department of human services. Grant funds
144.15 must be used in a manner consistent with the
144.16 original intent of the appropriation.

144.17 **Nonfederal Share Transfers.** The
144.18 nonfederal share of activities for which
144.19 federal administrative reimbursement is
144.20 appropriated to the commissioner may be
144.21 transferred to the special revenue fund.

144.22 **TANF Funds Appropriated to Other**
144.23 **Entities.** Any expenditures from the TANF
144.24 block grant shall be expended in accordance
144.25 with the requirements and limitations of part
144.26 A of title IV of the Social Security Act, as
144.27 amended, and any other applicable federal
144.28 requirement or limitation. Prior to any
144.29 expenditure of these funds, the commissioner
144.30 shall assure that funds are expended in
144.31 compliance with the requirements and
144.32 limitations of federal law and that any
144.33 reporting requirements of federal law are
144.34 met. It shall be the responsibility of any entity
144.35 to which these funds are appropriated to

145.1 implement a memorandum of understanding
145.2 with the commissioner that provides the
145.3 necessary assurance of compliance prior to
145.4 any expenditure of funds. The commissioner
145.5 shall receipt TANF funds appropriated
145.6 to other state agencies and coordinate all
145.7 related interagency accounting transactions
145.8 necessary to implement these appropriations.
145.9 Unexpended TANF funds appropriated to
145.10 any state, local, or nonprofit entity cancel
145.11 at the end of the state fiscal year unless
145.12 appropriating language permits otherwise.

145.13 **TANF Funds Transferred to Other Federal**
145.14 **Grants.** The commissioner must authorize
145.15 transfers from TANF to other federal block
145.16 grants so that funds are available to meet the
145.17 annual expenditure needs as appropriated.
145.18 Transfers may be authorized prior to the
145.19 expenditure year with the agreement of the
145.20 receiving entity. Transferred funds must be
145.21 expended in the year for which the funds
145.22 were appropriated unless appropriation
145.23 language permits otherwise. In accelerating
145.24 transfer authorizations, the commissioner
145.25 must aim to preserve the future potential
145.26 transfer capacity from TANF to other block
145.27 grants.

145.28 **TANF Maintenance of Effort.** (a) In
145.29 order to meet the basic maintenance of
145.30 effort (MOE) requirements of the TANF
145.31 block grant specified under Code of Federal
145.32 Regulations, title 45, section 263.1, the
145.33 commissioner may only report nonfederal
145.34 money expended for allowable activities
145.35 listed in the following clauses as TANF/MOE
145.36 expenditures:

146.1 (1) MFIP cash, diversionary work program,
146.2 and food assistance benefits under Minnesota
146.3 Statutes, chapter 256J;

146.4 (2) the child care assistance programs
146.5 under Minnesota Statutes, sections 119B.03
146.6 and 119B.05, and county child care
146.7 administrative costs under Minnesota
146.8 Statutes, section 119B.15;

146.9 (3) state and county MFIP administrative
146.10 costs under Minnesota Statutes, chapters
146.11 256J and 256K;

146.12 (4) state, county, and tribal MFIP
146.13 employment services under Minnesota
146.14 Statutes, chapters 256J and 256K;

146.15 (5) expenditures made on behalf of
146.16 noncitizen MFIP recipients who qualify
146.17 for the medical assistance without federal
146.18 financial participation program under
146.19 Minnesota Statutes, section 256B.06,
146.20 subdivision 4, paragraphs (d), (e), and (j);
146.21 and

146.22 (6) qualifying working family credit
146.23 expenditures under Minnesota Statutes,
146.24 section 290.0671.

146.25 (b) The commissioner shall ensure that
146.26 sufficient qualified nonfederal expenditures
146.27 are made each year to meet the state's
146.28 TANF/MOE requirements. For the activities
146.29 listed in paragraph (a), clauses (2) to
146.30 (6), the commissioner may only report
146.31 expenditures that are excluded from the
146.32 definition of assistance under Code of
146.33 Federal Regulations, title 45, section 260.31.

147.1 (c) By August 31 of each year, the
147.2 commissioner shall make a preliminary
147.3 calculation to determine the likelihood
147.4 that the state will meet its annual federal
147.5 work participation requirement under Code
147.6 of Federal Regulations, title 45, sections
147.7 261.21 and 261.23, after adjustment for any
147.8 caseload reduction credit under Code of
147.9 Federal Regulations, title 45, section 261.41.
147.10 If the commissioner determines that the
147.11 state will meet its federal work participation
147.12 rate for the federal fiscal year ending that
147.13 September, the commissioner may reduce the
147.14 expenditure under paragraph (a), clause (1),
147.15 to the extent allowed under Code of Federal
147.16 Regulations, title 45, section 263.1(a)(2).

147.17 (d) For fiscal years beginning with state
147.18 fiscal year 2003, the commissioner shall
147.19 assure that the maintenance of effort used
147.20 by the commissioner of finance for the
147.21 February and November forecasts required
147.22 under Minnesota Statutes, section 16A.103,
147.23 contains expenditures under paragraph (a),
147.24 clause (1), equal to at least 25 percent of
147.25 the total required under Code of Federal
147.26 Regulations, title 45, section 263.1.

147.27 (e) If nonfederal expenditures for the
147.28 programs and purposes listed in paragraph
147.29 (a) are insufficient to meet the state's
147.30 TANF/MOE requirements, the commissioner
147.31 shall recommend additional allowable
147.32 sources of nonfederal expenditures to the
147.33 legislature, if the legislature is or will be in
147.34 session to take action to specify additional
147.35 sources of nonfederal expenditures for
147.36 TANF/MOE before a federal penalty is

148.1 imposed. The commissioner shall otherwise
148.2 provide notice to the legislative commission
148.3 on planning and fiscal policy under paragraph
148.4 (g).

148.5 (f) If the commissioner uses authority
148.6 granted under section 11, or similar authority
148.7 granted by a subsequent legislature, to
148.8 meet the state's TANF/MOE requirement
148.9 in a reporting period, the commissioner
148.10 shall inform the chairs of the appropriate
148.11 legislative committees about all transfers
148.12 made under that authority for this purpose.

148.13 (g) If the commissioner determines that
148.14 nonfederal expenditures under paragraph
148.15 (a) are insufficient to meet TANF/MOE
148.16 expenditure requirements, and if the
148.17 legislature is not or will not be in
148.18 session to take timely action to avoid a
148.19 federal penalty, the commissioner may
148.20 report nonfederal expenditures from
148.21 other allowable sources as TANF/MOE
148.22 expenditures after the requirements of this
148.23 paragraph are met. The commissioner
148.24 may report nonfederal expenditures
148.25 in addition to those specified under
148.26 paragraph (a) as nonfederal TANF/MOE
148.27 expenditures, but only ten days after the
148.28 commissioner of finance has first submitted
148.29 the commissioner's recommendations for
148.30 additional allowable sources of nonfederal
148.31 TANF/MOE expenditures to the members of
148.32 the legislative commission on planning and
148.33 fiscal policy for their review.

148.34 (h) The commissioner of finance shall not
148.35 incorporate any changes in federal TANF

149.1 expenditures or nonfederal expenditures for
149.2 TANF/MOE that may result from reporting
149.3 additional allowable sources of nonfederal
149.4 TANF/MOE expenditures under the interim
149.5 procedures in paragraph (g) into the February
149.6 or November forecasts required under
149.7 Minnesota Statutes, section 16A.103, unless
149.8 the commissioner of finance has approved
149.9 the additional sources of expenditures under
149.10 paragraph (g).

149.11 (i) Minnesota Statutes, section 256.011,
149.12 subdivision 3, which requires that federal
149.13 grants or aids secured or obtained under that
149.14 subdivision be used to reduce any direct
149.15 appropriations provided by law, do not apply
149.16 if the grants or aids are federal TANF funds.

149.17 (j) Notwithstanding section 14, paragraph
149.18 (a), clauses (1) to (6), and paragraphs (b) to
149.19 (j) expire June 30, 2007.

149.20 **Working Family Credit Expenditures as**
149.21 **TANF MOE.** The commissioner may claim
149.22 as TANF maintenance of effort up to the
149.23 following amounts of working family credit
149.24 expenditures for the following fiscal years:

149.25 (1) fiscal year 2004, $7,013,000;

149.26 (2) fiscal year 2005, $25,133,000;

149.27 (3) fiscal year 2006, $6,942,000; and

149.28 (4) fiscal year 2007, $6,707,000.

149.29 **Fiscal Year 2003 Appropriations**
149.30 **Carryforward.** Effective the day following
149.31 final enactment, notwithstanding Minnesota
149.32 Statutes, section 16A.28, or any other law to
149.33 the contrary, state agencies and constitutional
149.34 offices may carry forward unexpended

150.1 and unencumbered nongrant operating
150.2 balances from fiscal year 2003 general fund
150.3 appropriations into fiscal year 2004 to offset
150.4 general budget reductions.

150.5 **Transfer of Grant Balances.** Effective
150.6 the day following final enactment, the
150.7 commissioner of human services, with
150.8 the approval of the commissioner of
150.9 finance and after notification of the chair
150.10 of the senate health, human services and
150.11 corrections budget division and the chair
150.12 of the house of representatives health
150.13 and human services finance committee,
150.14 may transfer unencumbered appropriation
150.15 balances for the biennium ending June 30,
150.16 2003, in fiscal year 2003 among the MFIP,
150.17 MFIP child care assistance under Minnesota
150.18 Statutes, section 119B.05, general assistance,
150.19 general assistance medical care, medical
150.20 assistance, Minnesota supplemental aid,
150.21 and group residential housing programs,
150.22 and the entitlement portion of the chemical
150.23 dependency consolidated treatment fund, and
150.24 between fiscal years of the biennium.

150.25 **TANF Appropriation Cancellation.**
150.26 Notwithstanding the provisions of Laws
150.27 2000, chapter 488, article 1, section 16,
150.28 any prior appropriations of TANF funds
150.29 to the department of trade and economic
150.30 development or to the job skills partnership
150.31 board or any transfers of TANF funds from
150.32 another agency to the department of trade
150.33 and economic development or to the job
150.34 skills partnership board are not available
150.35 until expended, and if unobligated as of June

151.1 30, 2003, these appropriations or transfers
151.2 shall cancel to the TANF fund.

151.3 **Shift County Payment.** The commissioner
151.4 shall make up to 100 percent of the
151.5 calendar year 2005 payments to counties for
151.6 developmental disabilities semi-independent
151.7 living services grants, developmental
151.8 disabilities family support grants, and
151.9 adult mental health grants from fiscal year
151.10 2006 appropriations. This is a onetime
151.11 payment shift. Calendar year 2006 and future
151.12 payments for these grants are not affected by
151.13 this shift. This provision expires June 30,
151.14 2006.

151.15 **Capitation Rate Increase.** Of the health care
151.16 access fund appropriations to the University
151.17 of Minnesota in the higher education
151.18 omnibus appropriation bill, ~~$2,157,000 in~~
151.19 ~~fiscal year 2004 and $2,157,000 in fiscal year~~
151.20 ~~2005 are to be used to increase the capitation~~
151.21 ~~payments under~~ for fiscal years beginning
151.22 July 1, 2003, and thereafter, $2,157,000 each
151.23 year shall be transferred to the commissioner
151.24 for purposes of Minnesota Statutes, section
151.25 256B.69. Notwithstanding the provisions of
151.26 section 14, this provision shall not expire.

151.27 Sec. 75. **ASTHMA COVERAGE DEMONSTRATION PROJECT.**

151.28 Subdivision 1. **Medical assistance coverage.** The commissioner of human services
151.29 shall establish a demonstration project to provide additional medical assistance coverage
151.30 for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth
151.31 who are burdened by health disparities associated with the cumulative health impact of
151.32 toxic environmental exposures. Under this demonstration project, the additional medical
151.33 assistance coverage for this population must include, but is not limited to, the following
151.34 durable medical equipment: high efficiency particulate air (HEPA) cleaners, HEPA
151.35 vacuum cleaners, allergy bed and pillow encasements, high filtration filters for forced air

152.1 gas furnaces, and dehumidifiers with medical tubing to connect the appliance to a floor
152.2 drain, if the listed item is medically necessary to reduce asthma symptoms. Provision
152.3 of these items must be preceded by a home environmental assessment for triggers of
152.4 asthma and in-home asthma education on the proper medical management of asthma by a
152.5 Certified Asthma Educator or public health nurse with asthma management training.

152.6 Subd. 2. **Report.** (a) Two years following implementation of the medical assistance
152.7 coverage demonstration project established under this section, the commissioner of health,
152.8 in collaboration with the Department of Human Services, must report to the legislature
152.9 on the number of asthma-related hospital admittances that occurred in the population of
152.10 children described in subdivision 1, before and after implementation of the demonstration
152.11 project, and whether the demonstration project had an impact on asthma-related school
152.12 absenteeism for this population of children.

152.13 (b) The commissioner of health must seek nonstate funding to conduct this report.
152.14 The reporting requirement is contingent upon the availability of nonstate funds.

152.15 Sec. 76. **CLAIMS AND UTILIZATION DATA.**

152.16 The commissioner of human services, in consultation with the Health Services
152.17 Policy Committee, shall develop and provide to the legislature by December 15, 2009, a
152.18 methodology and any draft legislation necessary to allow for the release, upon request, of
152.19 summary data as defined in Minnesota Statutes, section 13.02, subdivision 19, on claims
152.20 and utilization for medical assistance, general assistance medical care, and MinnesotaCare
152.21 enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical
152.22 School, Northwestern Health Sciences University, the Institute for Clinical Systems
152.23 Improvement, and other research institutions, to conduct analyses of health care outcomes
152.24 and treatment effectiveness, provided the research institutions do not release private or
152.25 nonpublic data, or data for which dissemination is prohibited by law.

152.26 Sec. 77. **ADMINISTRATION OF PUBLICLY FUNDED HEALTH CARE**
152.27 **PROGRAMS.**

152.28 (a) The commissioner of human services, in cooperation with the representatives
152.29 of county human services agencies and with input from organizations that advocate on
152.30 behalf of families and children, shall develop a plan that, to the extent feasible, seeks to
152.31 align standards, income and asset methodologies, and procedures for families and children
152.32 under medical assistance and MinnesotaCare. The commissioner shall evaluate the impact
152.33 of different approaches toward alignment on the number of potential medical assistance
152.34 and MinnesotaCare enrollees who are families and children, and on administrative, health

153.1 care, and other costs to the state. The commissioner shall present recommendations to the
153.2 legislative committees with jurisdiction over health care by September 15, 2010.
153.3 (b) The commissioner shall report in detail to the chair of the Health Care and
153.4 Human Services Finance Committee of the house of representatives and to the chair of
153.5 the Health and Human Services Division of the Finance Committee of the senate, prior
153.6 to entering into any contracts involving counties for streamlined electronic enrollment
153.7 and eligibility determinations for publicly funded health care programs, if such contracts
153.8 would require payment from either the general fund, or the health care access fund, as
153.9 described in Minnesota Statutes, sections 295.58 and 297I.05.

153.10 Sec. 78. **COBRA PREMIUM STATE SUBSIDY.**

153.11 Subdivision 1. **Eligibility.** (a) An individual and the individual's qualified
153.12 beneficiaries shall be eligible for a state premium subsidy equal to 35 percent of the
153.13 premiums the individual is required to pay for the continuation of health care coverage
153.14 under COBRA, if the individual and the individual's qualified beneficiaries:
153.15 (1) are eligible for the 65 percent COBRA continuation premium subsidy for health
153.16 care coverage under the American Recovery and Reinvestment Act of 2009;
153.17 (2) elect COBRA continuation health care coverage; and
153.18 (3) are eligible for medical assistance under Minnesota Statutes, chapter 256B;
153.19 general assistance medical care under Minnesota Statutes, section 256D.03; or
153.20 MinnesotaCare under Minnesota Statutes, chapter 256L, except for the four-month barrier
153.21 requirement under Minnesota Statutes, section 256L.07, subdivision 3.
153.22 (b) Eligibility for the state subsidy shall continue for as long as the individual
153.23 remains eligible for the COBRA premium subsidies provided under the American
153.24 Recovery and Reinvestment Act of 2009.

153.25 Subd. 2. **Subsidy.** (a) The commissioner of human services shall pay 35 percent of
153.26 the COBRA premiums that the individual must pay for continuation health care coverage
153.27 for the individual and the individual's qualified beneficiaries, if the individual and the
153.28 individual's qualified beneficiaries meet the requirements in subdivision 1.
153.29 (b) The state subsidy payment required under this section shall be made directly to
153.30 the entity to which the individual is required to make COBRA premium payments.
153.31 (c) If any eligible individual has paid either the full amount of the COBRA premiums
153.32 or 35 percent of the COBRA premiums before the date of enactment of this section, the
153.33 individual is not entitled to a reimbursement of any premium paid.

153.34 Subd. 3. **Notification.** (a) All employers and plan administrators who are required to
153.35 provide notice to all qualified individuals under the American Recovery and Reinvestment

154.1 Act of 2009 must include information to qualified individuals residing in Minnesota of
154.2 the availability of the state subsidy available under this section. The notice shall include
154.3 the eligibility requirements for the state subsidy and that the individual must apply to the
154.4 commissioner of human services to receive the state subsidy.

154.5 (b) The commissioner of employment and economic development must inform an
154.6 applicant for unemployment benefits of the availability of a state subsidy if the applicant
154.7 elects COBRA continuation coverage and the applicant meets the eligibility requirements
154.8 of this section.

154.9 Subd. 4. **Exemption.** Any individual who receives a state subsidy under this
154.10 section is exempt from the four-month requirement under Minnesota Statutes, section
154.11 256L.07, subdivision 3, if the individual or the individual's qualified beneficiaries apply
154.12 for MinnesotaCare after the individual no longer receives COBRA continuation coverage.

154.13 Subd. 5. **Expiration.** This section expires December 31, 2010.

154.14 Sec. 79. **FEDERAL APPROVAL.**

154.15 The commissioner of human services shall resubmit for federal approval the
154.16 elimination of depreciation for self-employed farmers in determining income eligibility
154.17 for MinnesotaCare passed in Laws 2007, chapter 147, article 5, section 19.

154.18 Sec. 80. **REPEALER.**

154.19 Minnesota Statutes 2008, sections 256.962, subdivision 7; and 256L.17, subdivision
154.20 6, are repealed.

154.21 **ARTICLE 6**
154.22 **TECHNICAL**

154.23 Section 1. Minnesota Statutes 2008, section 144A.46, subdivision 1, is amended to
154.24 read:

154.25 Subdivision 1. **License required.** (a) A home care provider may not operate in the
154.26 state without a current license issued by the commissioner of health. A home care provider
154.27 may hold a separate license for each class of home care licensure.

154.28 (b) Within ten days after receiving an application for a license, the commissioner
154.29 shall acknowledge receipt of the application in writing. The acknowledgment must
154.30 indicate whether the application appears to be complete or whether additional information
154.31 is required before the application will be considered complete. Within 90 days after
154.32 receiving a complete application, the commissioner shall either grant or deny the license.
154.33 If an applicant is not granted or denied a license within 90 days after submitting a

155.1 complete application, the license must be deemed granted. An applicant whose license has
155.2 been deemed granted must provide written notice to the commissioner before providing a
155.3 home care service.

155.4 (c) Each application for a home care provider license, or for a renewal of a license,
155.5 shall be accompanied by a fee to be set by the commissioner under section 144.122.

155.6 (d) The commissioner of health, in consultation with the commissioner of human
155.7 services, shall provide recommendations to the legislature by February 15, 2009, for
155.8 provider standards for personal care assistant services as described in section ~~256B.0655~~
155.9 256B.0659.

155.10 Sec. 2. Minnesota Statutes 2008, section 176.011, subdivision 9, is amended to read:

155.11 Subd. 9. **Employee.** "Employee" means any person who performs services for
155.12 another for hire including the following:

155.13 (1) an alien;

155.14 (2) a minor;

155.15 (3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and
155.16 peace officer while engaged in the enforcement of peace or in the pursuit or capture of a
155.17 person charged with or suspected of crime;

155.18 (4) a person requested or commanded to aid an officer in arresting or retaking a
155.19 person who has escaped from lawful custody, or in executing legal process, in which
155.20 cases, for purposes of calculating compensation under this chapter, the daily wage of the
155.21 person shall be the prevailing wage for similar services performed by paid employees;

155.22 (5) a county assessor;

155.23 (6) an elected or appointed official of the state, or of a county, city, town, school
155.24 district, or governmental subdivision in the state. An officer of a political subdivision
155.25 elected or appointed for a regular term of office, or to complete the unexpired portion of a
155.26 regular term, shall be included only after the governing body of the political subdivision
155.27 has adopted an ordinance or resolution to that effect;

155.28 (7) an executive officer of a corporation, except those executive officers excluded
155.29 by section 176.041;

155.30 (8) a voluntary uncompensated worker, other than an inmate, rendering services in
155.31 state institutions under the commissioners of human services and corrections similar to
155.32 those of officers and employees of the institutions, and whose services have been accepted
155.33 or contracted for by the commissioner of human services or corrections as authorized by
155.34 law. In the event of injury or death of the worker, the daily wage of the worker, for the
155.35 purpose of calculating compensation under this chapter, shall be the usual wage paid at

156.1 the time of the injury or death for similar services in institutions where the services are
156.2 performed by paid employees;
156.3 (9) a voluntary uncompensated worker engaged in emergency management as
156.4 defined in section 12.03, subdivision 4, who is:
156.5 (i) registered with the state or any political subdivision of it, according to the
156.6 procedures set forth in the state or political subdivision emergency operations plan; and
156.7 (ii) acting under the direction and control of, and within the scope of duties approved
156.8 by, the state or political subdivision.
156.9 The daily wage of the worker, for the purpose of calculating compensation under this
156.10 chapter, shall be the usual wage paid at the time of the injury or death for similar services
156.11 performed by paid employees;
156.12 (10) a voluntary uncompensated worker participating in a program established by a
156.13 local social services agency. For purposes of this clause, "local social services agency"
156.14 means any agency established under section 393.01. In the event of injury or death of the
156.15 worker, the wage of the worker, for the purpose of calculating compensation under this
156.16 chapter, shall be the usual wage paid in the county at the time of the injury or death for
156.17 similar services performed by paid employees working a normal day and week;
156.18 (11) a voluntary uncompensated worker accepted by the commissioner of natural
156.19 resources who is rendering services as a volunteer pursuant to section 84.089. The daily
156.20 wage of the worker for the purpose of calculating compensation under this chapter, shall
156.21 be the usual wage paid at the time of injury or death for similar services performed by
156.22 paid employees;
156.23 (12) a voluntary uncompensated worker in the building and construction industry
156.24 who renders services for joint labor-management nonprofit community service projects.
156.25 The daily wage of the worker for the purpose of calculating compensation under this
156.26 chapter shall be the usual wage paid at the time of injury or death for similar services
156.27 performed by paid employees;
156.28 (13) a member of the military forces, as defined in section 190.05, while in state
156.29 active service, as defined in section 190.05, subdivision 5a. The daily wage of the member
156.30 for the purpose of calculating compensation under this chapter shall be based on the
156.31 member's usual earnings in civil life. If there is no evidence of previous occupation or
156.32 earning, the trier of fact shall consider the member's earnings as a member of the military
156.33 forces;
156.34 (14) a voluntary uncompensated worker, accepted by the director of the Minnesota
156.35 Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily
156.36 wage of the worker, for the purposes of calculating compensation under this chapter,

157.1 shall be the usual wage paid at the time of injury or death for similar services performed
157.2 by paid employees;

157.3 (15) a voluntary uncompensated worker, other than a student, who renders services
157.4 at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the
157.5 Blind, and whose services have been accepted or contracted for by the commissioner of
157.6 education, as authorized by law. In the event of injury or death of the worker, the daily
157.7 wage of the worker, for the purpose of calculating compensation under this chapter, shall
157.8 be the usual wage paid at the time of the injury or death for similar services performed in
157.9 institutions by paid employees;

157.10 (16) a voluntary uncompensated worker, other than a resident of the veterans home,
157.11 who renders services at a Minnesota veterans home, and whose services have been
157.12 accepted or contracted for by the commissioner of veterans affairs, as authorized by law.
157.13 In the event of injury or death of the worker, the daily wage of the worker, for the purpose
157.14 of calculating compensation under this chapter, shall be the usual wage paid at the time of
157.15 the injury or death for similar services performed in institutions by paid employees;

157.16 (17) a worker performing services under section ~~256B.0655~~ 256B.0659 for a
157.17 recipient in the home of the recipient or in the community under section 256B.0625,
157.18 subdivision 19a, who is paid from government funds through a fiscal intermediary under
157.19 section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33. For purposes of maintaining
157.20 workers' compensation insurance, the employer of the worker is as designated in law
157.21 by the commissioner of the Department of Human Services, notwithstanding any other
157.22 law to the contrary;

157.23 (18) students enrolled in and regularly attending the Medical School of the
157.24 University of Minnesota in the graduate school program or the postgraduate program. The
157.25 students shall not be considered employees for any other purpose. In the event of the
157.26 student's injury or death, the weekly wage of the student for the purpose of calculating
157.27 compensation under this chapter, shall be the annualized educational stipend awarded to
157.28 the student, divided by 52 weeks. The institution in which the student is enrolled shall
157.29 be considered the "employer" for the limited purpose of determining responsibility for
157.30 paying benefits under this chapter;

157.31 (19) a faculty member of the University of Minnesota employed for an academic
157.32 year is also an employee for the period between that academic year and the succeeding
157.33 academic year if:

157.34 (a) the member has a contract or reasonable assurance of a contract from the
157.35 University of Minnesota for the succeeding academic year; and

158.1 (b) the personal injury for which compensation is sought arises out of and in the
158.2 course of activities related to the faculty member's employment by the University of
158.3 Minnesota;

158.4 (20) a worker who performs volunteer ambulance driver or attendant services is an
158.5 employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other
158.6 entity for which the worker performs the services. The daily wage of the worker for the
158.7 purpose of calculating compensation under this chapter shall be the usual wage paid at the
158.8 time of injury or death for similar services performed by paid employees;

158.9 (21) a voluntary uncompensated worker, accepted by the commissioner of
158.10 administration, rendering services as a volunteer at the Department of Administration. In
158.11 the event of injury or death of the worker, the daily wage of the worker, for the purpose of
158.12 calculating compensation under this chapter, shall be the usual wage paid at the time of the
158.13 injury or death for similar services performed in institutions by paid employees;

158.14 (22) a voluntary uncompensated worker rendering service directly to the Pollution
158.15 Control Agency. The daily wage of the worker for the purpose of calculating compensation
158.16 payable under this chapter is the usual going wage paid at the time of injury or death for
158.17 similar services if the services are performed by paid employees;

158.18 (23) a voluntary uncompensated worker while volunteering services as a first
158.19 responder or as a member of a law enforcement assistance organization while acting
158.20 under the supervision and authority of a political subdivision. The daily wage of the
158.21 worker for the purpose of calculating compensation payable under this chapter is the
158.22 usual going wage paid at the time of injury or death for similar services if the services
158.23 are performed by paid employees;

158.24 (24) a voluntary uncompensated member of the civil air patrol rendering service on
158.25 the request and under the authority of the state or any of its political subdivisions. The
158.26 daily wage of the member for the purposes of calculating compensation payable under this
158.27 chapter is the usual going wage paid at the time of injury or death for similar services if
158.28 the services are performed by paid employees; and

158.29 (25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in
158.30 sections 145A.04 and 145A.06, responding at the request of or engaged in training
158.31 conducted by the commissioner of health. The daily wage of the volunteer for the purposes
158.32 of calculating compensation payable under this chapter is established in section 145A.06.
158.33 A person who qualifies under this clause and who may also qualify under another clause
158.34 of this subdivision shall receive benefits in accordance with this clause.

158.35 If it is difficult to determine the daily wage as provided in this subdivision, the trier
158.36 of fact may determine the wage upon which the compensation is payable.

Sec. 3. Minnesota Statutes 2008, section 245C.03, subdivision 2, is amended to read:

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 to have a background study completed under this chapter.

Sec. 4. Minnesota Statutes 2008, section 245C.04, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 2, at least upon application for initial enrollment under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659.

(b) Organizations required to initiate background studies under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 for individuals described in section 245C.03, subdivision 2, must submit a completed background study form to the commissioner before those individuals begin a position allowing direct contact with persons served by the organization.

Sec. 5. Minnesota Statutes 2008, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 6. Minnesota Statutes 2008, section 256B.04, subdivision 16, is amended to read:

Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

160.1 The commissioner of human services shall establish an advisory group including
160.2 personal care consumers and providers to provide advice regarding which standards or
160.3 modifications should be adopted. The advisory group membership must include not less
160.4 than 15 members, of which at least 60 percent must be consumers of personal care services
160.5 and representatives of recipients with various disabilities and diagnoses and ages. At least
160.6 51 percent of the members of the advisory group must be recipients of personal care.

160.7 The commissioner of human services may contract with the commissioner of health
160.8 to enforce the jointly promulgated licensure rules for personal care service providers.

160.9 Prior to final promulgation of the joint rule the commissioner of human services
160.10 shall report preliminary findings along with any comments of the advisory group and a
160.11 plan for monitoring and enforcement by the Department of Health to the legislature by
160.12 February 15, 1992.

160.13 Limits on the extent of personal care services that may be provided to an individual
160.14 must be based on the cost-effectiveness of the services in relation to the costs of inpatient
160.15 hospital care, nursing home care, and other available types of care. The rules must
160.16 provide, at a minimum:

160.17 (1) that agencies be selected to contract with or employ and train staff to provide and
160.18 supervise the provision of personal care services;

160.19 (2) that agencies employ or contract with a qualified applicant that a qualified
160.20 recipient proposes to the agency as the recipient's choice of assistant;

160.21 (3) that agencies bill the medical assistance program for a personal care service
160.22 by a personal care assistant and supervision by a qualified professional supervising the
160.23 personal care assistant unless the recipient selects the fiscal agent option under section
160.24 ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33;

160.25 (4) that agencies establish a grievance mechanism; and

160.26 (5) that agencies have a quality assurance program.

160.27 (b) The commissioner may waive the requirement for the provision of personal care
160.28 services through an agency in a particular county, when there are less than two agencies
160.29 providing services in that county and shall waive the requirement for personal care
160.30 assistants required to join an agency for the first time during 1993 when personal care
160.31 services are provided under a relative hardship waiver under Minnesota Statutes 1992,
160.32 section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies
160.33 providing personal care services have refused to employ or contract with the independent
160.34 personal care assistant.

160.35 Sec. 7. Minnesota Statutes 2008, section 256B.055, subdivision 12, is amended to read:

161.1 Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the
161.2 person is under age 19 and qualifies as a disabled individual under United States Code,
161.3 title 42, section 1382c(a), and would be eligible for medical assistance under the state
161.4 plan if residing in a medical institution, and the child requires a level of care provided in
161.5 a hospital, nursing facility, or intermediate care facility for persons with developmental
161.6 disabilities, for whom home care is appropriate, provided that the cost to medical
161.7 assistance under this section is not more than the amount that medical assistance would pay
161.8 for if the child resides in an institution. After the child is determined to be eligible under
161.9 this section, the commissioner shall review the child's disability under United States Code,
161.10 title 42, section 1382c(a) and level of care defined under this section no more often than
161.11 annually and may elect, based on the recommendation of health care professionals under
161.12 contract with the state medical review team, to extend the review of disability and level of
161.13 care up to a maximum of four years. The commissioner's decision on the frequency of
161.14 continuing review of disability and level of care is not subject to administrative appeal
161.15 under section 256.045. The county agency shall send a notice of disability review to the
161.16 enrollee six months prior to the date the recertification of disability is due. Nothing in this
161.17 subdivision shall be construed as affecting other redeterminations of medical assistance
161.18 eligibility under this chapter and annual cost-effective reviews under this section.

161.19 (b) For purposes of this subdivision, "hospital" means an institution as defined
161.20 in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part
161.21 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this
161.22 subdivision, a child requires a level of care provided in a hospital if the child is determined
161.23 by the commissioner to need an extensive array of health services, including mental health
161.24 services, for an undetermined period of time, whose health condition requires frequent
161.25 monitoring and treatment by a health care professional or by a person supervised by a
161.26 health care professional, who would reside in a hospital or require frequent hospitalization
161.27 if these services were not provided, and the daily care needs are more complex than
161.28 a nursing facility level of care.

161.29 A child with serious emotional disturbance requires a level of care provided in a
161.30 hospital if the commissioner determines that the individual requires 24-hour supervision
161.31 because the person exhibits recurrent or frequent suicidal or homicidal ideation or
161.32 behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that
161.33 may become life threatening, recurrent or frequent severe socially unacceptable behavior
161.34 associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing
161.35 and chronic developmental problems requiring continuous skilled observation, or severe

162.1 disabling symptoms for which office-centered outpatient treatment is not adequate, and
162.2 which overall severely impact the individual's ability to function.
162.3 (c) For purposes of this subdivision, "nursing facility" means a facility which
162.4 provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to
162.5 sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative
162.6 treatment; is in need of special treatments provided or supervised by a licensed nurse; or
162.7 has unpredictable episodes of active disease processes requiring immediate judgment
162.8 by a licensed nurse. For purposes of this subdivision, a child requires the level of care
162.9 provided in a nursing facility if the child is determined by the commissioner to meet
162.10 the requirements of the preadmission screening assessment document under section
162.11 256B.0911 ~~and the home care independent rating document under section 256B.0655,~~
162.12 ~~subdivision 4, clause (3)~~, adjusted to address age-appropriate standards for children age 18
162.13 and under~~, pursuant to section 256B.0655, subdivision 3~~.
162.14 (d) For purposes of this subdivision, "intermediate care facility for persons with
162.15 developmental disabilities" or "ICF/MR" means a program licensed to provide services to
162.16 persons with developmental disabilities under section 252.28, and chapter 245A, and a
162.17 physical plant licensed as a supervised living facility under chapter 144, which together
162.18 are certified by the Minnesota Department of Health as meeting the standards in Code of
162.19 Federal Regulations, title 42, part 483, for an intermediate care facility which provides
162.20 services for persons with developmental disabilities who require 24-hour supervision
162.21 and active treatment for medical, behavioral, or habilitation needs. For purposes of this
162.22 subdivision, a child requires a level of care provided in an ICF/MR if the commissioner
162.23 finds that the child has a developmental disability in accordance with section 256B.092,
162.24 is in need of a 24-hour plan of care and active treatment similar to persons with
162.25 developmental disabilities, and there is a reasonable indication that the child will need
162.26 ICF/MR services.
162.27 (e) For purposes of this subdivision, a person requires the level of care provided
162.28 in a nursing facility if the person requires 24-hour monitoring or supervision and a plan
162.29 of mental health treatment because of specific symptoms or functional impairments
162.30 associated with a serious mental illness or disorder diagnosis, which meet severity criteria
162.31 for mental health established by the commissioner and published in March 1997 as
162.32 the Minnesota Mental Health Level of Care for Children and Adolescents with Severe
162.33 Emotional Disorders.
162.34 (f) The determination of the level of care needed by the child shall be made by
162.35 the commissioner based on information supplied to the commissioner by the parent or
162.36 guardian, the child's physician or physicians, and other professionals as requested by the

163.1 commissioner. The commissioner shall establish a screening team to conduct the level of
163.2 care determinations according to this subdivision.

163.3 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
163.4 must assess the case to determine whether:

163.5 (1) the child qualifies as a disabled individual under United States Code, title 42,
163.6 section 1382c(a), and would be eligible for medical assistance if residing in a medical
163.7 institution; and

163.8 (2) the cost of medical assistance services for the child, if eligible under this
163.9 subdivision, would not be more than the cost to medical assistance if the child resides in a
163.10 medical institution to be determined as follows:

163.11 (i) for a child who requires a level of care provided in an ICF/MR, the cost of
163.12 care for the child in an institution shall be determined using the average payment rate
163.13 established for the regional treatment centers that are certified as ICF's/MR;

163.14 (ii) for a child who requires a level of care provided in an inpatient hospital setting
163.15 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
163.16 Rules, part 9505.3520, items F and G; and

163.17 (iii) for a child who requires a level of care provided in a nursing facility according
163.18 to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota
163.19 Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to
163.20 reflect rates which would be paid for children under age 16. The commissioner may
163.21 authorize an amount up to the amount medical assistance would pay for a child referred to
163.22 the commissioner by the preadmission screening team under section 256B.0911.

163.23 (h) Children eligible for medical assistance services under section 256B.055,
163.24 subdivision 12, as of June 30, 1995, must be screened according to the criteria in this
163.25 subdivision prior to January 1, 1996. Children found to be ineligible may not be removed
163.26 from the program until January 1, 1996.

163.27 Sec. 8. Minnesota Statutes 2008, section 256B.0621, subdivision 2, is amended to read:

163.28 Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3
163.29 to 10, the following terms have the meanings given them:

163.30 (1) "home care service recipients" means those individuals receiving the following
163.31 services under sections 256B.0651 to 256B.0656 and 256B.0659: skilled nursing visits,
163.32 home health aide visits, private duty nursing, personal care assistants, or therapies
163.33 provided through a home health agency;

164.1 (2) "home care targeted case management" means the provision of targeted case
164.2 management services for the purpose of assisting home care service recipients to gain
164.3 access to needed services and supports so that they may remain in the community;
164.4 (3) "institutions" means hospitals, consistent with Code of Federal Regulations, title
164.5 42, section 440.10; regional treatment center inpatient services, consistent with section
164.6 245.474; nursing facilities; and intermediate care facilities for persons with developmental
164.7 disabilities;
164.8 (4) "relocation targeted case management" includes the provision of both county
164.9 targeted case management and public or private vendor service coordination services
164.10 for the purpose of assisting recipients to gain access to needed services and supports if
164.11 they choose to move from an institution to the community. Relocation targeted case
164.12 management may be provided during the lesser of:
164.13 (i) the last 180 consecutive days of an eligible recipient's institutional stay; or
164.14 (ii) the limits and conditions which apply to federal Medicaid funding for this
164.15 service; and
164.16 (5) "targeted case management" means case management services provided to help
164.17 recipients gain access to needed medical, social, educational, and other services and
164.18 supports.

164.19 Sec. 9. Minnesota Statutes 2008, section 256B.0652, subdivision 3, is amended to read:

164.20 Subd. 3. **Assessment and prior authorization process.** Effective January 1, 1996,
164.21 for purposes of providing informed choice, coordinating of local planning decisions, and
164.22 streamlining administrative requirements, the assessment and prior authorization process
164.23 for persons receiving both home care and home and community-based waivered services
164.24 for persons with developmental disabilities shall meet the requirements of sections
164.25 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 with the following exceptions:
164.26 (a) Upon request for home care services and subsequent assessment by the public
164.27 health nurse under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659,
164.28 the public health nurse shall participate in the screening process, as appropriate, and,
164.29 if home care services are determined to be necessary, participate in the development
164.30 of a service plan coordinating the need for home care and home and community-based
164.31 waivered services with the assigned county case manager, the recipient of services, and
164.32 the recipient's legal representative, if any.
164.33 (b) The public health nurse shall give prior authorization for home care services
164.34 to the extent that home care services are:
164.35 (1) medically necessary;

165.1 (2) chosen by the recipient and their legal representative, if any, from the array of
165.2 home care and home and community-based waivered services available;
165.3 (3) coordinated with other services to be received by the recipient as described
165.4 in the service plan; and
165.5 (4) provided within the county's reimbursement limits for home care and home and
165.6 community-based waivered services for persons with developmental disabilities.
165.7 (c) If the public health agency is or may be the provider of home care services to the
165.8 recipient, the public health agency shall provide the commissioner of human services with
165.9 a written plan that specifies how the assessment and prior authorization process will be
165.10 held separate and distinct from the provision of services.

165.11 Sec. 10. Minnesota Statutes 2008, section 256B.0657, subdivision 2, is amended to
165.12 read:

165.13 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
165.14 who:
165.15 (1) is a recipient of medical assistance as determined under sections 256B.055,
165.16 256B.056, and 256B.057, subdivision 9;
165.17 (2) is eligible for personal care assistant services under section ~~256B.0655~~
165.18 256B.0659;
165.19 (3) lives in the person's own apartment or home, which is not owned, operated, or
165.20 controlled by a provider of services not related by blood or marriage;
165.21 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
165.22 manage the individuals providing services, and to choose and obtain items, related
165.23 services, and supports as described in the participant's plan. If the recipient is not able to
165.24 carry out these functions but has a legal guardian or parent to carry them out, the guardian
165.25 or parent may fulfill these functions on behalf of the recipient; and
165.26 (5) has not been excluded or disenrolled by the commissioner.
165.27 (b) The commissioner may disenroll or exclude recipients, including guardians and
165.28 parents, under the following circumstances:
165.29 (1) recipients who have been restricted by the Primary Care Utilization Review
165.30 Committee may be excluded for a specified time period;
165.31 (2) recipients who exit the self-directed supports option during the recipient's
165.32 service plan year shall not access the self-directed supports option for the remainder of
165.33 that service plan year; and
165.34 (3) when the department determines that the recipient cannot manage recipient
165.35 responsibilities under the program.

166.1 Sec. 11. Minnesota Statutes 2008, section 256B.0657, subdivision 6, is amended to
166.2 read:

166.3 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
166.4 option include:
166.5 (1) personal care assistant services under section ~~256B.0655~~ 256B.0659; and
166.6 (2) items, related services, and supports, including assistive technology, that increase
166.7 independence or substitute for human assistance to the extent expenditures would
166.8 otherwise be used for human assistance.
166.9 (b) Items, supports, and related services purchased under this option shall not be
166.10 considered home care services for the purposes of section 144A.43.

166.11 Sec. 12. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to
166.12 read:

166.13 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
166.14 self-directed service option shall be equal to the greater of either:
166.15 (1) the annual amount of personal care assistant services under section ~~256B.0655~~
166.16 256B.0659 that the recipient has used in the most recent 12-month period; or
166.17 (2) the amount determined using the consumer support grant methodology under
166.18 section 256.476, subdivision 11, except that the budget amount shall include the federal
166.19 and nonfederal share of the average service costs.

166.20 Sec. 13. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

166.21 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
166.22 that the average per capita expenditures estimated in any fiscal year for home and
166.23 community-based waiver recipients does not exceed the average per capita expenditures
166.24 that would have been made to provide institutional services for recipients in the absence
166.25 of the waiver.
166.26 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
166.27 need-based methods for allocating to local agencies the home and community-based
166.28 waivered service resources available to support recipients with disabilities in need of
166.29 the level of care provided in a nursing facility or a hospital. The commissioner shall
166.30 allocate resources to single counties and county partnerships in a manner that reflects
166.31 consideration of:
166.32 (1) an incentive-based payment process for achieving outcomes;
166.33 (2) the need for a state-level risk pool;
166.34 (3) the need for retention of management responsibility at the state agency level; and

167.1 (4) a phase-in strategy as appropriate.
167.2 (c) Until the allocation methods described in paragraph (b) are implemented, the
167.3 annual allowable reimbursement level of home and community-based waiver services
167.4 shall be the greater of:
167.5 (1) the statewide average payment amount which the recipient is assigned under the
167.6 waiver reimbursement system in place on June 30, 2001, modified by the percentage of
167.7 any provider rate increase appropriated for home and community-based services; or
167.8 (2) an amount approved by the commissioner based on the recipient's extraordinary
167.9 needs that cannot be met within the current allowable reimbursement level. The
167.10 increased reimbursement level must be necessary to allow the recipient to be discharged
167.11 from an institution or to prevent imminent placement in an institution. The additional
167.12 reimbursement may be used to secure environmental modifications; assistive technology
167.13 and equipment; and increased costs for supervision, training, and support services
167.14 necessary to address the recipient's extraordinary needs. The commissioner may approve
167.15 an increased reimbursement level for up to one year of the recipient's relocation from an
167.16 institution or up to six months of a determination that a current waiver recipient is at
167.17 imminent risk of being placed in an institution.
167.18 (d) Beginning July 1, 2001, medically necessary private duty nursing services
167.19 will be authorized under this section as complex and regular care according to sections
167.20 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. The rate established by the
167.21 commissioner for registered nurse or licensed practical nurse services under any home and
167.22 community-based waiver as of January 1, 2001, shall not be reduced.

167.23 Sec. 14. Minnesota Statutes 2008, section 256B.501, subdivision 4a, is amended to
167.24 read:

167.25 Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner
167.26 shall adjust the limits of the established average daily reimbursement rates for waivered
167.27 services to include the cost of home care services that may be provided to waivered
167.28 services recipients. This adjustment must be used to maintain or increase services and
167.29 shall not be used by county agencies for inflation increases for waivered services vendors.
167.30 Home care services referenced in this section are those listed in section 256B.0651,
167.31 subdivision 2. The average daily reimbursement rates established in accordance with
167.32 the provisions of this subdivision apply only to the combined average, daily costs of
167.33 waivered and home care services and do not change home care limitations under sections
167.34 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Waivered services recipients

168.1 receiving home care as of June 30, 1992, shall not have the amount of their services
168.2 reduced as a result of this section.

168.3 Sec. 15. Minnesota Statutes 2008, section 256G.02, subdivision 6, is amended to read:

168.4 Subd. 6. **Excluded time.** "Excluded time" means:
168.5 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
168.6 other than an emergency shelter, halfway house, foster home, semi-independent living
168.7 domicile or services program, residential facility offering care, board and lodging facility
168.8 or other institution for the hospitalization or care of human beings, as defined in section
168.9 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
168.10 or correctional facility; or any facility based on an emergency hold under sections
168.11 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;
168.12 (b) any period an applicant spends on a placement basis in a training and habilitation
168.13 program, including a rehabilitation facility or work or employment program as defined
168.14 in section 268A.01; or receiving personal care assistant services pursuant to section
168.15 ~~256B.0655, subdivision 2~~ 256B.0659; semi-independent living services provided under
168.16 section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and
168.17 habilitation programs and assisted living services; and
168.18 (c) any placement for a person with an indeterminate commitment, including
168.19 independent living.

168.20 Sec. 16. Minnesota Statutes 2008, section 256I.05, subdivision 1a, is amended to read:

168.21 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section
168.22 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37
168.23 for other services necessary to provide room and board provided by the group residence
168.24 if the residence is licensed by or registered by the Department of Health, or licensed by
168.25 the Department of Human Services to provide services in addition to room and board,
168.26 and if the provider of services is not also concurrently receiving funding for services for
168.27 a recipient under a home and community-based waiver under title XIX of the Social
168.28 Security Act; or funding from the medical assistance program under section ~~256B.0655,~~
168.29 ~~subdivision 2~~ 256B.0659, for personal care services for residents in the setting; or residing
168.30 in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000.
168.31 If funding is available for other necessary services through a home and community-based
168.32 waiver, or personal care services under section ~~256B.0655, subdivision 2~~ 256B.0659,
168.33 then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided
168.34 in law, in no case may the supplementary service rate exceed $426.37. The registration

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

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

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

169.19 Sec. 17. Minnesota Statutes 2008, section 256J.45, subdivision 3, is amended to read:

169.20 Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county
169.21 agency shall not impose the sanction under section 256J.46 if it determines that the
169.22 participant has good cause for failing to attend orientation. Good cause exists when:

169.23 (1) appropriate child care is not available;

169.24 (2) the participant is ill or injured;

169.25 (3) a family member is ill and needs care by the participant that prevents the
169.26 participant from attending orientation. For a caregiver with a child or adult in the
169.27 household who meets the disability or medical criteria for home care services under
169.28 section ~~256B.0655, subdivision 1c~~ 256B.0659, or a home and community-based waiver
169.29 services program under chapter 256B, or meets the criteria for severe emotional
169.30 disturbance under section 245.4871, subdivision 6, or for serious and persistent mental
169.31 illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when
169.32 an interruption in the provision of those services occurs which prevents the participant
169.33 from attending orientation;

169.34 (4) the caregiver is unable to secure necessary transportation;

169.35 (5) the caregiver is in an emergency situation that prevents orientation attendance;

170.1 (6) the orientation conflicts with the caregiver's work, training, or school schedule; or
170.2 (7) the caregiver documents other verifiable impediments to orientation attendance
170.3 beyond the caregiver's control.
170.4 (b) Counties must work with clients to provide child care and transportation
170.5 necessary to ensure a caregiver has every opportunity to attend orientation.

170.6 Sec. 18. Minnesota Statutes 2008, section 604A.33, subdivision 1, is amended to read:

170.7 Subdivision 1. **Application.** This section applies to residential treatment programs
170.8 for children or group homes for children licensed under chapter 245A, residential
170.9 services and programs for juveniles licensed under section 241.021, providers licensed
170.10 pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care
170.11 provider organizations under section ~~256B.0655, subdivision 1g~~ 256B.0659, providers
170.12 of day training and habilitation services under sections 252.40 to 252.46, board and
170.13 lodging facilities licensed under chapter 157, intermediate care facilities for persons with
170.14 developmental disabilities, and other facilities licensed to provide residential services to
170.15 persons with developmental disabilities.

170.16 Sec. 19. Minnesota Statutes 2008, section 609.232, subdivision 11, is amended to read:

170.17 Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
170.18 age or older who:
170.19 (1) is a resident inpatient of a facility;
170.20 (2) receives services at or from a facility required to be licensed to serve adults
170.21 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
170.22 treatment of chemical dependency or mental illness, or one who is committed as a sexual
170.23 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
170.24 considered a vulnerable adult unless the person meets the requirements of clause (4);
170.25 (3) receives services from a home care provider required to be licensed under section
170.26 144A.46; or from a person or organization that exclusively offers, provides, or arranges
170.27 for personal care assistant services under the medical assistance program as authorized
170.28 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651~~, and~~
170.29 ~~256B.0653~~ to 256B.0656 and 256B.0659; or
170.30 (4) regardless of residence or whether any type of service is received, possesses a
170.31 physical or mental infirmity or other physical, mental, or emotional dysfunction:
170.32 (i) that impairs the individual's ability to provide adequately for the individual's
170.33 own care without assistance, including the provision of food, shelter, clothing, health
170.34 care, or supervision; and

171.1 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
171.2 has an impaired ability to protect the individual from maltreatment.

171.3 Sec. 20. Minnesota Statutes 2008, section 626.5572, subdivision 6, is amended to read:

171.4 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be
171.5 licensed under sections 144.50 to 144.58; a nursing home required to be licensed to
171.6 serve adults under section 144A.02; a residential or nonresidential facility required to
171.7 be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider
171.8 licensed or required to be licensed under section 144A.46; a hospice provider licensed
171.9 under sections 144A.75 to 144A.755; or a person or organization that exclusively offers,
171.10 provides, or arranges for personal care assistant services under the medical assistance
171.11 program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision
171.12 19a, 256B.0651~~, and 256B.0653~~ to 256B.0656, and 256B.0659.

171.13 (b) For home care providers and personal care attendants, the term "facility" refers
171.14 to the provider or person or organization that exclusively offers, provides, or arranges for
171.15 personal care services, and does not refer to the client's home or other location at which
171.16 services are rendered.

171.17 Sec. 21. Minnesota Statutes 2008, section 626.5572, subdivision 21, is amended to
171.18 read:

171.19 Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
171.20 age or older who:

171.21 (1) is a resident or inpatient of a facility;

171.22 (2) receives services at or from a facility required to be licensed to serve adults
171.23 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
171.24 treatment of chemical dependency or mental illness, or one who is served in the Minnesota
171.25 sex offender program on a court-hold order for commitment, or is committed as a sexual
171.26 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
171.27 considered a vulnerable adult unless the person meets the requirements of clause (4);

171.28 (3) receives services from a home care provider required to be licensed under section
171.29 144A.46; or from a person or organization that exclusively offers, provides, or arranges
171.30 for personal care assistant services under the medical assistance program as authorized
171.31 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
171.32 256B.0653 to 256B.0656, and 256B.0659; or

171.33 (4) regardless of residence or whether any type of service is received, possesses a
171.34 physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

ARTICLE 7
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2008, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:

(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or

(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; ~~or~~

173.1 (6) in licensed professional clinical counseling, the mental health professional
173.2 shall be a licensed professional clinical counselor under section 148B.5301 with at least
173.3 4,000 hours of postmaster's supervised experience in the delivery of clinical services in
173.4 the treatment of mental illness; or
173.5 (7) in allied fields: a person with a master's degree from an accredited college or
173.6 university in one of the behavioral sciences or related fields, with at least 4,000 hours of
173.7 post-master's supervised experience in the delivery of clinical services in the treatment of
173.8 mental illness.

173.9 Sec. 2. Minnesota Statutes 2008, section 245.470, subdivision 1, is amended to read:

173.10 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide
173.11 or contract for enough outpatient services within the county to meet the needs of adults
173.12 with mental illness residing in the county. Services may be provided directly by the
173.13 county through county-operated mental health centers or mental health clinics approved
173.14 by the commissioner under section 245.69, subdivision 2; by contract with privately
173.15 operated mental health centers or mental health clinics approved by the commissioner
173.16 under section 245.69, subdivision 2; by contract with hospital mental health outpatient
173.17 programs certified by the Joint Commission on Accreditation of Hospital Organizations;
173.18 or by contract with a licensed mental health professional as defined in section 245.462,
173.19 subdivision 18, clauses (1) to ~~(4)~~ (6). Clients may be required to pay a fee according to
173.20 section 245.481. Outpatient services include:
173.21 (1) conducting diagnostic assessments;
173.22 (2) conducting psychological testing;
173.23 (3) developing or modifying individual treatment plans;
173.24 (4) making referrals and recommending placements as appropriate;
173.25 (5) treating an adult's mental health needs through therapy;
173.26 (6) prescribing and managing medication and evaluating the effectiveness of
173.27 prescribed medication; and
173.28 (7) preventing placement in settings that are more intensive, costly, or restrictive
173.29 than necessary and appropriate to meet client needs.
173.30 (b) County boards may request a waiver allowing outpatient services to be provided
173.31 in a nearby trade area if it is determined that the client can best be served outside the
173.32 county.

173.33 Sec. 3. Minnesota Statutes 2008, section 245.4871, subdivision 27, is amended to read:

174.1 Subd. 27. **Mental health professional.** "Mental health professional" means a
174.2 person providing clinical services in the diagnosis and treatment of children's emotional
174.3 disorders. A mental health professional must have training and experience in working with
174.4 children consistent with the age group to which the mental health professional is assigned.
174.5 A mental health professional must be qualified in at least one of the following ways:

174.6 (1) in psychiatric nursing, the mental health professional must be a registered nurse
174.7 who is licensed under sections 148.171 to 148.285 and who is certified as a clinical
174.8 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
174.9 certification organization or who has a master's degree in nursing or one of the behavioral
174.10 sciences or related fields from an accredited college or university or its equivalent, with
174.11 at least 4,000 hours of post-master's supervised experience in the delivery of clinical
174.12 services in the treatment of mental illness;

174.13 (2) in clinical social work, the mental health professional must be a person licensed
174.14 as an independent clinical social worker under chapter 148D, or a person with a master's
174.15 degree in social work from an accredited college or university, with at least 4,000 hours of
174.16 post-master's supervised experience in the delivery of clinical services in the treatment
174.17 of mental disorders;

174.18 (3) in psychology, the mental health professional must be an individual licensed by
174.19 the board of psychology under sections 148.88 to 148.98 who has stated to the board of
174.20 psychology competencies in the diagnosis and treatment of mental disorders;

174.21 (4) in psychiatry, the mental health professional must be a physician licensed under
174.22 chapter 147 and certified by the American board of psychiatry and neurology or eligible
174.23 for board certification in psychiatry;

174.24 (5) in marriage and family therapy, the mental health professional must be a
174.25 marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least
174.26 two years of post-master's supervised experience in the delivery of clinical services in the
174.27 treatment of mental disorders or emotional disturbances; ~~or~~

174.28 (6) in licensed professional clinical counseling, the mental health professional shall
174.29 be a licensed professional clinical counselor under section 148B.5301 with at least 4,000
174.30 hours of postmaster's supervised experience in the delivery of clinical services in the
174.31 treatment of mental disorders or emotional disturbances; or

174.32 (7) in allied fields, the mental health professional must be a person with a master's
174.33 degree from an accredited college or university in one of the behavioral sciences or related
174.34 fields, with at least 4,000 hours of post-master's supervised experience in the delivery of
174.35 clinical services in the treatment of emotional disturbances.

175.1 Sec. 4. Minnesota Statutes 2008, section 245.488, subdivision 1, is amended to read:

175.2 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide
175.3 or contract for enough outpatient services within the county to meet the needs of each
175.4 child with emotional disturbance residing in the county and the child's family. Services
175.5 may be provided directly by the county through county-operated mental health centers or
175.6 mental health clinics approved by the commissioner under section 245.69, subdivision 2;
175.7 by contract with privately operated mental health centers or mental health clinics approved
175.8 by the commissioner under section 245.69, subdivision 2; by contract with hospital
175.9 mental health outpatient programs certified by the Joint Commission on Accreditation
175.10 of Hospital Organizations; or by contract with a licensed mental health professional as
175.11 defined in section 245.4871, subdivision 27, clauses (1) to ~~(4)~~ (6). A child or a child's
175.12 parent may be required to pay a fee based in accordance with section 245.481. Outpatient
175.13 services include:

175.14 (1) conducting diagnostic assessments;

175.15 (2) conducting psychological testing;

175.16 (3) developing or modifying individual treatment plans;

175.17 (4) making referrals and recommending placements as appropriate;

175.18 (5) treating the child's mental health needs through therapy; and

175.19 (6) prescribing and managing medication and evaluating the effectiveness of
175.20 prescribed medication.

175.21 (b) County boards may request a waiver allowing outpatient services to be provided
175.22 in a nearby trade area if it is determined that the child requires necessary and appropriate
175.23 services that are only available outside the county.

175.24 (c) Outpatient services offered by the county board to prevent placement must be at
175.25 the level of treatment appropriate to the child's diagnostic assessment.

175.26 Sec. 5. Minnesota Statutes 2008, section 254A.02, is amended by adding a subdivision
175.27 to read:

175.28 Subd. 8a. **Placing authority.** "Placing authority" means a county, prepaid health
175.29 plan, or tribal governing board governed by Minnesota Rules, parts 9530.6600 to
175.30 9530.6655.

175.31 Sec. 6. Minnesota Statutes 2008, section 254A.16, is amended by adding a subdivision
175.32 to read:

175.33 Subd. 6. **Monitoring.** The commissioner shall gather and placing authorities shall
175.34 provide information to measure compliance with Minnesota Rules, parts 9530.6600 to

176.1 9530.6655. The commissioner shall specify the format for data collection to facilitate
176.2 tracking, aggregating, and using the information.

176.3 Sec. 7. Minnesota Statutes 2008, section 254B.03, subdivision 1, is amended to read:

176.4 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
176.5 dependency services to persons residing within its jurisdiction who meet criteria
176.6 established by the commissioner for placement in a chemical dependency residential or
176.7 nonresidential treatment service. Chemical dependency money must be administered
176.8 by the local agencies according to law and rules adopted by the commissioner under
176.9 sections 14.001 to 14.69.

176.10 (b) In order to contain costs, ~~the county board shall, with the approval of~~ the
176.11 commissioner of human services~~,~~ shall select eligible vendors of chemical dependency
176.12 services who can provide economical and appropriate treatment. Unless the local agency
176.13 is a social services department directly administered by a county or human services board,
176.14 the local agency shall not be an eligible vendor under section 254B.05. The commissioner
176.15 may approve proposals from county boards to provide services in an economical manner
176.16 or to control utilization, with safeguards to ensure that necessary services are provided.
176.17 If a county implements a demonstration or experimental medical services funding plan,
176.18 the commissioner shall transfer the money as appropriate. ~~If a county selects a vendor~~
176.19 ~~located in another state, the county shall ensure that the vendor is in compliance with the~~
176.20 ~~rules governing licensure of programs located in the state.~~

176.21 (c) A culturally specific vendor that provides assessments under a variance under
176.22 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
176.23 persons not covered by the variance.

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

176.25 Sec. 8. Minnesota Statutes 2008, section 254B.03, subdivision 3, is amended to read:

176.26 Subd. 3. **Local agencies to pay state for county share.** Local agencies shall pay
176.27 the state for the county share of the services authorized by the local agency, except when
176.28 the payment is made according to section 254B.09, subdivision 8.

176.29 Sec. 9. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
176.30 to read:

176.31 Subd. 9. **Commissioner to select vendors and set rates.** (a) Effective July 1, 2011,
176.32 the commissioner shall:

176.33 (1) enter into agreements with eligible vendors that:

177.1 (i) meet the standards in section 254B.05, subdivision 1;
177.2 (ii) have good standing in all applicable licensure; and
177.3 (iii) have a current approved provider agreement as a Minnesota health care program
177.4 provider; and
177.5 (2) set rates for services reimbursed under this chapter.
177.6 (b) When setting rates, the commissioner shall consider the complexity and the
177.7 acuity of the problems presented by the client.
177.8 (c) When rates set under this section and rates set under section 254B.09, subdivision
177.9 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

177.10 Sec. 10. Minnesota Statutes 2008, section 254B.05, subdivision 1, is amended to read:

177.11 Subdivision 1. **Licensure required.** Programs licensed by the commissioner are
177.12 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
177.13 notwithstanding the provisions of section 245A.03. American Indian programs located on
177.14 federally recognized tribal lands that provide chemical dependency primary treatment,
177.15 extended care, transitional residence, or outpatient treatment services, and are licensed by
177.16 tribal government are eligible vendors. Detoxification programs are not eligible vendors.
177.17 Programs that are not licensed as a chemical dependency residential or nonresidential
177.18 treatment program by the commissioner or by tribal government are not eligible vendors.
177.19 To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund,
177.20 a vendor of a chemical dependency service must participate in the Drug and Alcohol
177.21 Abuse Normative Evaluation System and the treatment accountability plan.
177.22 Effective January 1, 2000, vendors of room and board are eligible for chemical
177.23 dependency fund payment if the vendor:
177.24 (1) ~~is certified by the county or tribal governing body as having~~ has rules prohibiting
177.25 residents bringing chemicals into the facility or using chemicals while residing in the
177.26 facility and provide consequences for infractions of those rules;
177.27 (2) has a current contract with a county or tribal governing body;
177.28 (3) is determined to meet applicable health and safety requirements;
177.29 (4) is not a jail or prison; and
177.30 (5) is not concurrently receiving funds under chapter 256I for the recipient.

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

177.32 Sec. 11. Minnesota Statutes 2008, section 254B.09, subdivision 2, is amended to read:

177.33 Subd. 2. **American Indian agreements.** The commissioner may enter into
177.34 agreements with federally recognized tribal units to pay for chemical dependency

178.1 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The
178.2 agreements must clarify how the governing body of the tribal unit fulfills local agency
178.3 responsibilities regarding:

178.4 ~~(1) selection of eligible vendors under section 254B.03, subdivision 1;~~

178.5 ~~(2) negotiation of agreements that establish vendor services and rates for programs~~
178.6 ~~located on the tribal governing body's reservation;~~

178.7 ~~(3)~~ <u>(1)</u> the form and manner of invoicing; and

178.8 ~~(4)~~ <u>(2)</u> provide that only invoices for eligible vendors according to section 254B.05
178.9 will be included in invoices sent to the commissioner for payment, to the extent that
178.10 money allocated under subdivisions 4 and 5 is used.

178.11 <u>**EFFECTIVE DATE.** This section is effective July 1, 2011.</u>

178.12 Sec. 12. <u>**[254B.11] MAXIMUM RATES.**</u>

178.13 <u>The commissioner shall publish maximum rates for vendors of the consolidated</u>
178.14 <u>chemical dependency treatment fund by July 1 of each year for implementation the</u>
178.15 <u>following January 1. Rates for calendar year 2010 must not exceed 185 percent of the</u>
178.16 <u>average rate on January 1, 2009, for each group of vendors with similar attributes. Unless</u>
178.17 <u>a new rate methodology is developed under section 254B.12, rates for services provided on</u>
178.18 <u>and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009,</u>
178.19 <u>for each group of vendors with similar attributes. Payment for services provided by Indian</u>
178.20 <u>Health Services or by agencies operated by Indian tribes for medical assistance-eligible</u>
178.21 <u>individuals must be governed by the applicable federal rate methodology.</u>

178.22 Sec. 13. <u>**[254B.12] RATE METHODOLOGY.**</u>

178.23 <u>The commissioner shall, with broad-based stakeholder input, develop a</u>
178.24 <u>recommendation and present a report to the 2011 legislature, including proposed</u>
178.25 <u>legislation for a new rate methodology for the consolidated chemical dependency</u>
178.26 <u>treatment fund. The new methodology must replace county-negotiated rates with a</u>
178.27 <u>uniform statewide methodology that must include a graduated reimbursement scale based</u>
178.28 <u>on the patients' level of acuity and complexity.</u>

178.29 Sec. 14. Minnesota Statutes 2008, section 256B.0622, subdivision 2, is amended to
178.30 read:

178.31 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
178.32 meanings given them.

179.1 (a) "Intensive nonresidential rehabilitative mental health services" means adult
179.2 rehabilitative mental health services as defined in section 256B.0623, subdivision 2,
179.3 paragraph (a), except that these services are provided by a multidisciplinary staff using
179.4 a total team approach consistent with assertive community treatment, the Fairweather
179.5 Lodge treatment model, as defined by the standards established by the National Coalition
179.6 for Community Living, and other evidence-based practices, and directed to recipients with
179.7 a serious mental illness who require intensive services.

179.8 (b) "Intensive residential rehabilitative mental health services" means short-term,
179.9 time-limited services provided in a residential setting to recipients who are in need of
179.10 more restrictive settings and are at risk of significant functional deterioration if they do
179.11 not receive these services. Services are designed to develop and enhance psychiatric
179.12 stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more
179.13 independent setting. Services must be directed toward a targeted discharge date with
179.14 specified client outcomes and must be consistent with the Fairweather Lodge treatment
179.15 model as defined in paragraph (a), and other evidence-based practices.

179.16 (c) "Evidence-based practices" are nationally recognized mental health services that
179.17 are proven by substantial research to be effective in helping individuals with serious
179.18 mental illness obtain specific treatment goals.

179.19 (d) "Overnight staff" means a member of the intensive residential rehabilitative
179.20 mental health treatment team who is responsible during hours when recipients are
179.21 typically asleep.

179.22 (e) "Treatment team" means all staff who provide services under this section to
179.23 recipients. At a minimum, this includes the clinical supervisor, mental health professionals
179.24 as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6); mental health
179.25 practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation
179.26 workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists
179.27 under section 256B.0615.

179.28 Sec. 15. Minnesota Statutes 2008, section 256B.0623, subdivision 5, is amended to
179.29 read:

179.30 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health
179.31 services must be provided by qualified individual provider staff of a certified provider
179.32 entity. Individual provider staff must be qualified under one of the following criteria:

179.33 (1) a mental health professional as defined in section 245.462, subdivision 18,
179.34 clauses (1) to ~~(5)~~ (6). If the recipient has a current diagnostic assessment by a licensed
179.35 mental health professional as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~

180.1 (6), recommending receipt of adult mental health rehabilitative services, the definition of
180.2 mental health professional for purposes of this section includes a person who is qualified
180.3 under section 245.462, subdivision 18, clause ~~(6)~~ (7), and who holds a current and valid
180.4 national certification as a certified rehabilitation counselor or certified psychosocial
180.5 rehabilitation practitioner;

180.6 (2) a mental health practitioner as defined in section 245.462, subdivision 17. The
180.7 mental health practitioner must work under the clinical supervision of a mental health
180.8 professional;

180.9 (3) a certified peer specialist under section 256B.0615. The certified peer specialist
180.10 must work under the clinical supervision of a mental health professional; or

180.11 (4) a mental health rehabilitation worker. A mental health rehabilitation worker
180.12 means a staff person working under the direction of a mental health practitioner or mental
180.13 health professional and under the clinical supervision of a mental health professional in
180.14 the implementation of rehabilitative mental health services as identified in the recipient's
180.15 individual treatment plan who:

180.16 (i) is at least 21 years of age;

180.17 (ii) has a high school diploma or equivalent;

180.18 (iii) has successfully completed 30 hours of training during the past two years in all
180.19 of the following areas: recipient rights, recipient-centered individual treatment planning,
180.20 behavioral terminology, mental illness, co-occurring mental illness and substance abuse,
180.21 psychotropic medications and side effects, functional assessment, local community
180.22 resources, adult vulnerability, recipient confidentiality; and

180.23 (iv) meets the qualifications in subitem (A) or (B):

180.24 (A) has an associate of arts degree in one of the behavioral sciences or human
180.25 services, or is a registered nurse without a bachelor's degree, or who within the previous
180.26 ten years has:

180.27 (1) three years of personal life experience with serious and persistent mental illness;

180.28 (2) three years of life experience as a primary caregiver to an adult with a serious
180.29 mental illness or traumatic brain injury; or

180.30 (3) 4,000 hours of supervised paid work experience in the delivery of mental health
180.31 services to adults with a serious mental illness or traumatic brain injury; or

180.32 (B)(1) is fluent in the non-English language or competent in the culture of the
180.33 ethnic group to which at least 20 percent of the mental health rehabilitation worker's
180.34 clients belong;

180.35 (2) receives during the first 2,000 hours of work, monthly documented individual
180.36 clinical supervision by a mental health professional;

181.1 (3) has 18 hours of documented field supervision by a mental health professional
181.2 or practitioner during the first 160 hours of contact work with recipients, and at least six
181.3 hours of field supervision quarterly during the following year;
181.4 (4) has review and cosignature of charting of recipient contacts during field
181.5 supervision by a mental health professional or practitioner; and
181.6 (5) has 40 hours of additional continuing education on mental health topics during
181.7 the first year of employment.

181.8 Sec. 16. Minnesota Statutes 2008, section 256B.0624, subdivision 5, is amended to
181.9 read:

181.10 Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult
181.11 mental health mobile crisis intervention services, a mobile crisis intervention team is
181.12 comprised of at least two mental health professionals as defined in section 245.462,
181.13 subdivision 18, clauses (1) to ~~(5)~~ (6), or a combination of at least one mental health
181.14 professional and one mental health practitioner as defined in section 245.462, subdivision
181.15 17, with the required mental health crisis training and under the clinical supervision of
181.16 a mental health professional on the team. The team must have at least two people with
181.17 at least one member providing on-site crisis intervention services when needed. Team
181.18 members must be experienced in mental health assessment, crisis intervention techniques,
181.19 and clinical decision-making under emergency conditions and have knowledge of local
181.20 services and resources. The team must recommend and coordinate the team's services
181.21 with appropriate local resources such as the county social services agency, mental health
181.22 services, and local law enforcement when necessary.

181.23 Sec. 17. Minnesota Statutes 2008, section 256B.0624, subdivision 8, is amended to
181.24 read:

181.25 Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health
181.26 crisis stabilization services must be provided by qualified individual staff of a qualified
181.27 provider entity. Individual provider staff must have the following qualifications:
181.28 (1) be a mental health professional as defined in section 245.462, subdivision 18,
181.29 clauses (1) to ~~(5)~~ (6);
181.30 (2) be a mental health practitioner as defined in section 245.462, subdivision 17.
181.31 The mental health practitioner must work under the clinical supervision of a mental health
181.32 professional; or
181.33 (3) be a mental health rehabilitation worker who meets the criteria in section
181.34 256B.0623, subdivision 5, clause (3); works under the direction of a mental health

practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Sec. 18. Minnesota Statutes 2008, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18, ~~clause~~ clauses (5) and (6); or 245.4871, subdivision 27, ~~clause~~ clauses (5) and (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 19. Minnesota Statutes 2008, section 256B.0943, subdivision 1, is amended to read:

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

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or

183.1 ethnic group as the client or the provider has developed the knowledge and skills through
183.2 training and experience to provide services to culturally diverse clients.
183.3 (f) "Day treatment program" for children means a site-based structured program
183.4 consisting of group psychotherapy for more than three individuals and other intensive
183.5 therapeutic services provided by a multidisciplinary team, under the clinical supervision
183.6 of a mental health professional.
183.7 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
183.8 11.
183.9 (h) "Direct service time" means the time that a mental health professional, mental
183.10 health practitioner, or mental health behavioral aide spends face-to-face with a client
183.11 and the client's family. Direct service time includes time in which the provider obtains
183.12 a client's history or provides service components of children's therapeutic services and
183.13 supports. Direct service time does not include time doing work before and after providing
183.14 direct services, including scheduling, maintaining clinical records, consulting with others
183.15 about the client's mental health status, preparing reports, receiving clinical supervision
183.16 directly related to the client's psychotherapy session, and revising the client's individual
183.17 treatment plan.
183.18 (i) "Direction of mental health behavioral aide" means the activities of a mental
183.19 health professional or mental health practitioner in guiding the mental health behavioral
183.20 aide in providing services to a client. The direction of a mental health behavioral aide
183.21 must be based on the client's individualized treatment plan and meet the requirements in
183.22 subdivision 6, paragraph (b), clause (5).
183.23 (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
183.24 15. For persons at least age 18 but under age 21, mental illness has the meaning given in
183.25 section 245.462, subdivision 20, paragraph (a).
183.26 (k) "Individual behavioral plan" means a plan of intervention, treatment, and
183.27 services for a child written by a mental health professional or mental health practitioner,
183.28 under the clinical supervision of a mental health professional, to guide the work of the
183.29 mental health behavioral aide.
183.30 (l) "Individual treatment plan" has the meaning given in section 245.4871,
183.31 subdivision 21.
183.32 (m) "Mental health professional" means an individual as defined in section 245.4871,
183.33 subdivision 27, clauses (1) to ~~(5)~~ (6), or tribal vendor as defined in section 256B.02,
183.34 subdivision 7, paragraph (b).
183.35 (n) "Preschool program" means a day program licensed under Minnesota Rules,
183.36 parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and

184.1 supports provider to provide a structured treatment program to a child who is at least 33
184.2 months old but who has not yet attended the first day of kindergarten.
184.3 (o) "Skills training" means individual, family, or group training designed to improve
184.4 the basic functioning of the child with emotional disturbance and the child's family in the
184.5 activities of daily living and community living, and to improve the social functioning of the
184.6 child and the child's family in areas important to the child's maintaining or reestablishing
184.7 residency in the community. Individual, family, and group skills training must:
184.8 (1) consist of activities designed to promote skill development of the child and the
184.9 child's family in the use of age-appropriate daily living skills, interpersonal and family
184.10 relationships, and leisure and recreational services;
184.11 (2) consist of activities that will assist the family's understanding of normal child
184.12 development and to use parenting skills that will help the child with emotional disturbance
184.13 achieve the goals outlined in the child's individual treatment plan; and
184.14 (3) promote family preservation and unification, promote the family's integration
184.15 with the community, and reduce the use of unnecessary out-of-home placement or
184.16 institutionalization of children with emotional disturbance.

184.17 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 47, is amended to
184.18 read:

184.19 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2007~~ 2011, and subject
184.20 to federal approval, medical assistance covers treatment foster care services according to
184.21 section 256B.0946.

184.22 Sec. 21. Minnesota Statutes 2008, section 256B.0943, subdivision 12, is amended to
184.23 read:

184.24 Subd. 12. **Excluded services.** The following services are not eligible for medical
184.25 assistance payment as children's therapeutic services and supports:
184.26 (1) service components of children's therapeutic services and supports
184.27 simultaneously provided by more than one provider entity unless prior authorization is
184.28 obtained;
184.29 (2) treatment by multiple providers within the same agency at the same clock time;
184.30 (3) children's therapeutic services and supports provided in violation of medical
184.31 assistance policy in Minnesota Rules, part 9505.0220;
184.32 ~~(3)~~ (4) mental health behavioral aide services provided by a personal care assistant
184.33 who is not qualified as a mental health behavioral aide and employed by a certified
184.34 children's therapeutic services and supports provider entity;

185.1 ~~(4)~~ <u>(5)</u> service components of CTSS that are the responsibility of a residential or
185.2 program license holder, including foster care providers under the terms of a service
185.3 agreement or administrative rules governing licensure;

185.4 ~~(5)~~ <u>(6)</u> adjunctive activities that may be offered by a provider entity but are not
185.5 otherwise covered by medical assistance, including:

185.6 (i) a service that is primarily recreation oriented or that is provided in a setting that
185.7 is not medically supervised. This includes sports activities, exercise groups, activities
185.8 such as craft hours, leisure time, social hours, meal or snack time, trips to community
185.9 activities, and tours;

185.10 (ii) a social or educational service that does not have or cannot reasonably be
185.11 expected to have a therapeutic outcome related to the client's emotional disturbance;

185.12 (iii) consultation with other providers or service agency staff about the care or
185.13 progress of a client;

185.14 (iv) prevention or education programs provided to the community; and

185.15 (v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and

185.16 ~~(6)~~ <u>(7)</u> activities that are not direct service time.

185.17 Sec. 22. Minnesota Statutes 2008, section 256B.0944, is amended by adding a
185.18 subdivision to read:

185.19 <u>Subd. 4a.</u> <u>**Alternative provider standards.**</u> <u>If a provider entity demonstrates that,</u>
185.20 <u>due to geographic or other barriers, it is not feasible to provide mobile crisis intervention</u>
185.21 <u>services 24 hours a day, seven days a week, according to the standards in subdivision 4,</u>
185.22 <u>paragraph (b), clause (1), the commissioner may approve a crisis response provider based</u>
185.23 <u>on an alternative plan proposed by a provider entity. The alternative plan must:</u>

185.24 <u>(1) result in increased access and a reduction in disparities in the availability of</u>
185.25 <u>crisis services; and</u>

185.26 <u>(2) provide mobile services outside of the usual nine-to-five office hours and on</u>
185.27 <u>weekends and holidays.</u>

185.28 Sec. 23. Minnesota Statutes 2008, section 256B.0947, subdivision 1, is amended to
185.29 read:

185.30 Subdivision 1. **Scope.** ~~Subject to federal approval~~ <u>Effective November 1, 2010, and</u>
185.31 <u>subject to federal approval</u>, medical assistance covers medically necessary, intensive
185.32 nonresidential rehabilitative mental health services as defined in subdivision 2, for
185.33 recipients as defined in subdivision 3, when the services are provided by an entity meeting
185.34 the standards in this section.

186.1 Sec. 24. Minnesota Statutes 2008, section 256J.08, subdivision 73a, is amended to read:

186.2 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity,
186.3 a "qualified professional" means a licensed physician, a physician's assistant, a nurse
186.4 practitioner, or a licensed chiropractor.

186.5 (b) For developmental disability and intelligence testing, a "qualified professional"
186.6 means an individual qualified by training and experience to administer the tests necessary
186.7 to make determinations, such as tests of intellectual functioning, assessments of adaptive
186.8 behavior, adaptive skills, and developmental functioning. These professionals include
186.9 licensed psychologists, certified school psychologists, or certified psychometrists working
186.10 under the supervision of a licensed psychologist.

186.11 (c) For learning disabilities, a "qualified professional" means a licensed psychologist
186.12 or school psychologist with experience determining learning disabilities.

186.13 (d) For mental health, a "qualified professional" means a licensed physician or a
186.14 qualified mental health professional. A "qualified mental health professional" means:

186.15 (1) for children, in psychiatric nursing, a registered nurse who is licensed under
186.16 sections 148.171 to 148.285, and who is certified as a clinical specialist in child
186.17 and adolescent psychiatric or mental health nursing by a national nurse certification
186.18 organization or who has a master's degree in nursing or one of the behavioral sciences
186.19 or related fields from an accredited college or university or its equivalent, with at least
186.20 4,000 hours of post-master's supervised experience in the delivery of clinical services in
186.21 the treatment of mental illness;

186.22 (2) for adults, in psychiatric nursing, a registered nurse who is licensed under
186.23 sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric
186.24 and mental health nursing by a national nurse certification organization or who has a
186.25 master's degree in nursing or one of the behavioral sciences or related fields from an
186.26 accredited college or university or its equivalent, with at least 4,000 hours of post-master's
186.27 supervised experience in the delivery of clinical services in the treatment of mental illness;

186.28 (3) in clinical social work, a person licensed as an independent clinical social worker
186.29 under chapter 148D, or a person with a master's degree in social work from an accredited
186.30 college or university, with at least 4,000 hours of post-master's supervised experience in
186.31 the delivery of clinical services in the treatment of mental illness;

186.32 (4) in psychology, an individual licensed by the Board of Psychology under sections
186.33 148.88 to 148.98, who has stated to the Board of Psychology competencies in the
186.34 diagnosis and treatment of mental illness;

187.1 (5) in psychiatry, a physician licensed under chapter 147 and certified by the
187.2 American Board of Psychiatry and Neurology or eligible for board certification in
187.3 psychiatry; ~~and~~
187.4 (6) in marriage and family therapy, the mental health professional must be a
187.5 marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least
187.6 two years of post-master's supervised experience in the delivery of clinical services in the
187.7 treatment of mental illness; and
187.8 (7) in licensed professional clinical counseling, the mental health professional
187.9 shall be a licensed professional clinical counselor under section 148B.5301 with at least
187.10 4,000 hours of postmaster's supervised experience in the delivery of clinical services in
187.11 the treatment of mental illness.

187.12 Sec. 25. **AUTISM SPECTRUM DISORDER TASK FORCE.**
187.13 (a) The Autism Spectrum Disorder Task Force is composed of 15 members,
187.14 appointed as follows:
187.15 (1) two members of the senate appointed by the Subcommittee on Committees of the
187.16 Committee on Rules and Administration, one of whom must be a member of the minority;
187.17 (2) two members of the house of representatives, one from the majority party,
187.18 appointed by the speaker of the house, and one from the minority party, appointed by
187.19 the minority leader;
187.20 (3) two members appointed by the legislature, with regard to geographic diversity in
187.21 the state, who are parents of children with autism spectrum disorder (ASD); one member
187.22 shall be appointed by the senate Subcommittee on Committees of the Committee on
187.23 Rules and Administration making appointments for the senate; and one member shall be
187.24 appointed by the speaker of the house making the appointments for the house;
187.25 (4) one member appointed by the Minnesota chapter of the American Academy of
187.26 Pediatrics who is a general primary care pediatrician;
187.27 (5) one member appointed by the Minnesota Academy of Family Physicians who is
187.28 a family practice physician;
187.29 (6) one member appointed by the Minnesota Psychological Association who is a
187.30 neuropsychologist;
187.31 (7) one member appointed by the directors of public school student support services;
187.32 (8) one member appointed by the Somali American Autism Foundation;
187.33 (9) one member appointed by the ARC of Minnesota;
187.34 (10) one member appointed by the Autism Society of Minnesota;

188.1 (11) one member appointed by the Parent Advocacy Coalition for Educational
188.2 Rights; and
188.3 (12) one member appointed by the Minnesota Council of Health Plans.
188.4 Appointments must be made by September 1, 2009. The Legislative Coordinating
188.5 Commission shall provide meeting space for the task force. The senate member appointed
188.6 by the minority leader of the senate shall convene the first meeting of the task force no
188.7 later than October 1, 2009. The task force shall elect a chair at the first meeting.
188.8 (b) If federal or state funding is available, the commissioners of education,
188.9 employment and economic development, health, and human services shall provide
188.10 assistance to the task force.
188.11 (c) The task force shall develop recommendations and report on the following topics:
188.12 (1) ways to improve services provided by all state and political subdivisions;
188.13 (2) sources of public and private funding available for treatment and ways to
188.14 improve efficiency in the use of these funds;
188.15 (3) methods to improve coordination in the delivery of service between public
188.16 and private agencies, health providers, and schools, and to address any geographic
188.17 discrepancies in the delivery of services;
188.18 (4) increasing the availability of and the training for medical providers and educators
188.19 who identify and provide services to individuals with ASD; and
188.20 (5) treatment options supported by peer-reviewed, established scientific research
188.21 for individuals with ASD.
188.22 (d) The task force shall coordinate with existing efforts at the Departments of
188.23 Education, Health, Human Services, and Employment and Economic Development
188.24 related to ASD.
188.25 (e) By January 15 of each year, the task force shall provide a report regarding its
188.26 findings and consideration of the topics listed under paragraph (c), and the action taken
188.27 under paragraph (d), including draft legislation if necessary, to the chairs and ranking
188.28 minority members of the legislative committees with jurisdiction over health and human
188.29 services.
188.30 (f) This section expires June 30, 2011.

188.31 Sec. 26. **STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT**
188.32 **PROJECT.**

188.33 Subdivision 1. **Establishment; purpose.** There is established a state-county
188.34 chemical health care home pilot project. The purpose of the pilot project is for the
188.35 Department of Human Services and counties to authentically and creatively work in

189.1 partnership to redesign the current chemical health service delivery system in a way
189.2 that promotes greater accountability, productivity, and results in the delivery of state
189.3 chemical dependency services. The pilot project or projects must look to provide
189.4 appropriate flexibility in a way that ensures timely access to needed services as well
189.5 as better aligning systems and services to offer the most appropriate level of chemical
189.6 health care services to the client. This may include, but is not limited to, looking into new
189.7 governance agreements, performance agreements, or service level agreements. Pilot
189.8 projects must maintain eligibility requirements for the consolidated chemical dependency
189.9 treatment fund, continue to meet the requirements of Minnesota Rules, parts 9530.6600 to
189.10 9530.6655 (also known as Rule 25) and Minnesota Rules, parts 9530.6405 to 9530.6505
189.11 (also known as Rule 31), and must not put at risk current and future federal funding toward
189.12 chemical health-related services in the state of Minnesota.

189.13 Subd. 2. **Workgroup; report.** A workgroup must be convened on or before July
189.14 15, 2009, consisting of representatives from the Department of Human Services and
189.15 potential participating counties to develop draft proposals for pilot projects meeting the
189.16 requirements of this section. The workgroup shall report back to the legislative committees
189.17 with jurisdiction over chemical health by January 15, 2010, for potential approval of one
189.18 metro and one nonmetro county pilot project to be implemented beginning July 10, 2010.

189.19 Subd. 3. **Report.** The Department of Human Services shall evaluate the efficacy and
189.20 feasibility of the pilot projects and report the results of that evaluation to the legislative
189.21 committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot
189.22 projects may occur only if the department's report finds the pilot projects effective.

189.23 Subd. 4. **Expiration.** This section expires June 30, 2012.

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

189.25 **ARTICLE 8**
189.26 **CONTINUING CARE**

189.27 Section 1. Minnesota Statutes 2008, section 144.0724, subdivision 2, is amended to
189.28 read:

189.29 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
189.30 meanings given.

189.31 (a) "Assessment reference date" means the last day of the minimum data set
189.32 observation period. The date sets the designated endpoint of the common observation
189.33 period, and all minimum data set items refer back in time from that point.

190.1 (b) "Case mix index" means the weighting factors assigned to the RUG-III
190.2 classifications.
190.3 (c) "Index maximization" means classifying a resident who could be assigned to
190.4 more than one category, to the category with the highest case mix index.
190.5 (d) "Minimum data set" means the assessment instrument specified by the Centers for
190.6 Medicare and Medicaid Services and designated by the Minnesota Department of Health.
190.7 (e) "Representative" means a person who is the resident's guardian or conservator,
190.8 the person authorized to pay the nursing home expenses of the resident, a representative
190.9 of the nursing home ombudsman's office whose assistance has been requested, or any
190.10 other individual designated by the resident.
190.11 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
190.12 facility's residents according to their clinical and functional status identified in data
190.13 supplied by the facility's minimum data set.
190.14 (g) "Activities of daily living" means grooming, dressing, bathing, transferring,
190.15 mobility, positioning, eating, and toileting.
190.16 (h) "Nursing facility level of care determination" means the assessment process
190.17 that results in a determination of a resident's or prospective resident's need for nursing
190.18 facility level of care as established in subdivision 11 for purposes of medical assistance
190.19 payment of long-term care services for:
190.20 (1) nursing facility services under section 256B.434 or 256B.441;
190.21 (2) elderly waiver services under section 256B.0915;
190.22 (3) CADI and TBI waiver services under section 256B.49; and
190.23 (4) state payment of alternative care services under section 256B.0913.

190.24 **EFFECTIVE DATE.** The section is effective January 1, 2011.

190.25 Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 4, is amended to read:

190.26 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
190.27 electronically submit to the commissioner of health case mix assessments that conform
190.28 with the assessment schedule defined by Code of Federal Regulations, title 42, section
190.29 483.20, and published by the United States Department of Health and Human Services,
190.30 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
190.31 Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made
190.32 in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0,
190.33 August 1996. The commissioner of health may substitute successor manuals or question
190.34 and answer documents published by the United States Department of Health and Human

191.1 Services, Centers for Medicare and Medicaid Services, to replace or supplement the
191.2 current version of the manual or document.

191.3 (b) The assessments used to determine a case mix classification for reimbursement
191.4 include the following:

191.5 (1) a new admission assessment must be completed by day 14 following admission;

191.6 (2) an annual assessment must be completed within 366 days of the last
191.7 comprehensive assessment;

191.8 (3) a significant change assessment must be completed within 14 days of the
191.9 identification of a significant change; and

191.10 (4) the second quarterly assessment following either a new admission assessment,
191.11 an annual assessment, or a significant change assessment, and all quarterly assessments
191.12 beginning October 1, 2006. Each quarterly assessment must be completed within 92
191.13 days of the previous assessment.

191.14 (c) In addition to the assessments listed in paragraph (b), the assessments used to
191.15 determine nursing facility level of care include the following:

191.16 (1) preadmission screening completed under section 256B.0911, subdivision 4a,
191.17 by a county, tribe, or managed care organization under contract with the Department
191.18 of Human Services; and

191.19 (2) a face-to-face long-term care consultation assessment completed under section
191.20 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization
191.21 under contract with the Department of Human Services.

191.22 **EFFECTIVE DATE.** The section is effective January 1, 2011.

191.23 Sec. 3. Minnesota Statutes 2008, section 144.0724, subdivision 8, is amended to read:

191.24 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident,
191.25 or resident's representative, or the nursing facility or boarding care home may request that
191.26 the commissioner of health reconsider the assigned reimbursement classification. The
191.27 request for reconsideration must be submitted in writing to the commissioner within
191.28 30 days of the day the resident or the resident's representative receives the resident
191.29 classification notice. The request for reconsideration must include the name of the
191.30 resident, the name and address of the facility in which the resident resides, the reasons for
191.31 the reconsideration, the requested classification changes, and documentation supporting
191.32 the requested classification. The documentation accompanying the reconsideration request
191.33 is limited to documentation which establishes that the needs of the resident at the time of
191.34 the assessment justify a classification which is different than the classification established
191.35 by the commissioner of health.

192.1 (b) Upon request, the nursing facility must give the resident or the resident's
192.2 representative a copy of the assessment form and the other documentation that was given
192.3 to the commissioner of health to support the assessment findings. The nursing facility
192.4 shall also provide access to and a copy of other information from the resident's record that
192.5 has been requested by or on behalf of the resident to support a resident's reconsideration
192.6 request. A copy of any requested material must be provided within three working days of
192.7 receipt of a written request for the information. If a facility fails to provide the material
192.8 within this time, it is subject to the issuance of a correction order and penalty assessment
192.9 under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order
192.10 issued under this subdivision must require that the nursing facility immediately comply
192.11 with the request for information and that as of the date of the issuance of the correction
192.12 order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and
192.13 an increase in the $100 fine by $50 increments for each day the noncompliance continues.
192.14 (c) In addition to the information required under paragraphs (a) and (b), a
192.15 reconsideration request from a nursing facility must contain the following information: (i)
192.16 the date the reimbursement classification notices were received by the facility; (ii) the date
192.17 the classification notices were distributed to the resident or the resident's representative;
192.18 and (iii) a copy of a notice sent to the resident or to the resident's representative. This
192.19 notice must inform the resident or the resident's representative that a reconsideration of the
192.20 resident's classification is being requested, the reason for the request, that the resident's
192.21 rate will change if the request is approved by the commissioner, the extent of the change,
192.22 that copies of the facility's request and supporting documentation are available for review,
192.23 and that the resident also has the right to request a reconsideration. If the facility fails to
192.24 provide the required information with the reconsideration request, the request must be
192.25 denied, and the facility may not make further reconsideration requests on that specific
192.26 reimbursement classification.
192.27 (d) Reconsideration by the commissioner must be made by individuals not involved
192.28 in reviewing the assessment, audit, or reconsideration that established the disputed
192.29 classification. The reconsideration must be based upon the initial assessment and upon the
192.30 information provided to the commissioner under paragraphs (a) and (b). If necessary for
192.31 evaluating the reconsideration request, the commissioner may conduct on-site reviews.
192.32 Within 15 working days of receiving the request for reconsideration, the commissioner
192.33 shall affirm or modify the original resident classification. The original classification
192.34 must be modified if the commissioner determines that the assessment resulting in the
192.35 classification did not accurately reflect the needs or assessment characteristics of the
192.36 resident at the time of the assessment. The resident and the nursing facility or boarding

193.1 care home shall be notified within five working days after the decision is made. A decision
193.2 by the commissioner under this subdivision is the final administrative decision of the
193.3 agency for the party requesting reconsideration.

193.4 (e) The resident classification established by the commissioner shall be the
193.5 classification that applies to the resident while the request for reconsideration is pending.
193.6 If a request for reconsideration applies to an assessment used to determine nursing facility
193.7 level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible
193.8 for nursing facility level of care while the request for reconsideration is pending.

193.9 (f) The commissioner may request additional documentation regarding a
193.10 reconsideration necessary to make an accurate reconsideration determination.

193.11 **EFFECTIVE DATE.** The section is effective January 1, 2011.

193.12 Sec. 4. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
193.13 to read:

193.14 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance
193.15 payment of long-term care services, a recipient must be determined, using assessments
193.16 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

193.17 (1) the person needs the assistance of another person or constant supervision to begin
193.18 and complete at least four of the following activities of living: bathing, bed mobility,
193.19 dressing, eating, grooming, toileting, transferring, and walking;

193.20 (2) the person needs the assistance of another person or constant supervision to begin
193.21 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

193.22 (3) the person has significant difficulty with memory, using information, daily
193.23 decision making, or behavioral needs that require intervention;

193.24 (4) the person has had a qualifying nursing facility stay of at least 90 days; or

193.25 (5) the person is determined to be at risk for nursing facility admission or
193.26 readmission through a face-to-face long-term care consultation assessment as specified
193.27 in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care
193.28 organization under contract with the Department of Human Services. The person is
193.29 considered at risk under this clause if the person currently lives alone or will live alone
193.30 upon discharge and also meets one of the following criteria:

193.31 (i) the person has experienced a fall resulting in a fracture;

193.32 (ii) the person has been determined to be at risk of maltreatment or neglect,
193.33 including self-neglect; or

193.34 (iii) the person has a sensory impairment that substantially impacts functional ability
193.35 and maintenance of a community residence.

194.1 (b) The assessment used to establish medical assistance payment for nursing facility
194.2 services must be the most recent assessment performed under subdivision 4, paragraph
194.3 (b), that occurred no more than 90 calendar days before the effective date of medical
194.4 assistance eligibility for payment of long-term care services. In no case shall medical
194.5 assistance payment for long-term care services occur prior to the date of the determination
194.6 of nursing facility level of care.

194.7 (c) The assessment used to establish medical assistance payment for long-term care
194.8 services provided under sections 256B.0915 and 256B.49 and alternative care payment
194.9 for services provided under section 256B.0913 must be the most recent face-to-face
194.10 assessment performed under section 256B.0911, subdivision 3a, that occurred no more
194.11 than 60 calendar days before the effective date of medical assistance eligibility for
194.12 payment of long-term care services.

194.13 **EFFECTIVE DATE.** The section is effective January 1, 2011.

194.14 Sec. 5. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
194.15 to read:

194.16 Subd. 12. **Appeal of nursing facility level of care determination.** A resident or
194.17 prospective resident whose level of care determination results in a denial of long-term care
194.18 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
194.19 paragraph (h), clause (7).

194.20 **EFFECTIVE DATE.** The section is effective January 1, 2011.

194.21 Sec. 6. Minnesota Statutes 2008, section 144A.073, is amended by adding a
194.22 subdivision to read:

194.23 Subd. 12. **Extension of approval of moratorium exception projects.**
194.24 Notwithstanding subdivision 3, the commissioner of health shall extend project approval
194.25 by an additional 18 months for an approved proposal for an exception to the nursing home
194.26 licensure and certification moratorium if the proposal was approved under this section
194.27 between July 1, 2007, and June 30, 2009.

194.28 Sec. 7. Minnesota Statutes 2008, section 144A.44, subdivision 2, is amended to read:

194.29 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
194.30 for the benefit of persons who receive home care services. "Home care services" means
194.31 home care services as defined in section 144A.43, subdivision 3, and unlicensed personal
194.32 care assistance services, including services covered by medical assistance under section
194.33 256B.0625, subdivision 19a. A home care provider may not require a person to surrender

195.1 these rights as a condition of receiving services. A guardian or conservator or, when there
195.2 is no guardian or conservator, a designated person, may seek to enforce these rights. This
195.3 statement of rights does not replace or diminish other rights and liberties that may exist
195.4 relative to persons receiving home care services, persons providing home care services, or
195.5 providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided
195.6 to an individual at the time home care services, including personal care assistance
195.7 services, are initiated. The copy shall also contain the address and phone number of the
195.8 Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care
195.9 and a brief statement describing how to file a complaint with these offices. Information
195.10 about how to contact the Office of Ombudsman for Long-Term Care shall be included in
195.11 notices of change in client fees and in notices where home care providers initiate transfer
195.12 or discontinuation of services.

195.13 Sec. 8. Minnesota Statutes 2008, section 245A.03, is amended by adding a subdivision
195.14 to read:

195.15 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
195.16 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
195.17 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
195.18 9555.6265, under this chapter for a physical location that will not be the primary residence
195.19 of the license holder for the entire period of licensure. If a license is issued during this
195.20 moratorium, and the license holder changes the license holder's primary residence away
195.21 from the physical location of the foster care license, the commissioner shall revoke the
195.22 license according to section 245A.07. Exceptions to the moratorium include:

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

195.24 (2) foster care licenses replacing foster care licenses in existence on the effective
195.25 date of this section and determined to be needed by the commissioner under paragraph (b);

195.26 (3) new foster care licenses determined to be needed by the commissioner under
195.27 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;

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

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

195.33 (b) The commissioner shall determine the need for newly licensed foster care homes
195.34 as defined under this subdivision. As part of the determination, the commissioner shall
195.35 consider the availability of foster care capacity in the area which the licensee seeks to

196.1 operate, and the recommendation of the local county board. The determination by the
196.2 commissioner must be final. A determination of need is not required for a change in
196.3 ownership at the same address.

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

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

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

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

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

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

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

196.22 (d) The commissioner shall study the effects of the license moratorium under this
196.23 subdivision and shall report back to the legislature by January 15, 2011.

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

196.25 Sec. 9. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
196.26 to read:

196.27 Subd. 8. **Community residential setting license.** (a) The commissioner shall
196.28 establish provider standards for residential support services that integrate service standards
196.29 and the residential setting under one license. The commissioner shall propose statutory
196.30 language and an implementation plan for licensing requirements for residential support
196.31 services to the legislature by January 15, 2011.

196.32 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
196.33 for services in settings licensed as adult foster care under Minnesota Rules, parts
196.34 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to

197.1 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
197.2 (b), must be required to obtain a community residential setting license.

197.3 Sec. 10. Minnesota Statutes 2008, section 252.46, is amended by adding a subdivision
197.4 to read:

197.5 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
197.6 a statewide rate-setting methodology for all day training and habilitation services. The
197.7 rate-setting methodology must abide by the principles of transparency and equitability
197.8 across the state. The methodology must involve a uniform process of structuring rates for
197.9 each service and must promote quality and participant choice.

197.10 Sec. 11. Minnesota Statutes 2008, section 252.50, subdivision 1, is amended to read:

197.11 Subdivision 1. **Community-based programs established.** The commissioner
197.12 shall establish a system of state-operated, community-based programs for persons with
197.13 developmental disabilities. For purposes of this section, "state-operated, community-based
197.14 program" means a program administered by the state to provide treatment and habilitation
197.15 in noninstitutional community settings to persons with developmental disabilities.
197.16 Employees of the programs, except clients who work within and benefit from these
197.17 treatment and habilitation programs, must be state employees under chapters 43A and
197.18 179A. Although any clients who work within and benefit from these treatment and
197.19 habilitation programs are not employees under chapters 43A and 179A, the Department
197.20 of Human Services may consider clients who work within and benefit from these
197.21 programs employees for federal tax purposes. The establishment of state-operated,
197.22 community-based programs must be within the context of a comprehensive definition of
197.23 the role of state-operated services in the state. The role of state-operated services must
197.24 be defined within the context of a comprehensive system of services for persons with
197.25 developmental disabilities. State-operated, community-based programs may include, but
197.26 are not limited to, community group homes, foster care, supportive living services, day
197.27 training and habilitation programs, and respite care arrangements. The commissioner
197.28 may operate the pilot projects established under Laws 1985, First Special Session
197.29 chapter 9, article 1, section 2, subdivision 6, and shall, within the limits of available
197.30 appropriations, establish additional state-operated, community-based programs for
197.31 persons with developmental disabilities. State-operated, community-based programs may
197.32 accept admissions from regional treatment centers, from the person's own home, or from
197.33 community programs. State-operated, community-based programs offering day program
197.34 services may be provided for persons with developmental disabilities who are living in

198.1 state-operated, community-based residential programs until July 1, 2000. No later than
198.2 1994, the commissioner, together with family members, counties, advocates, employee
198.3 representatives, and other interested parties, shall begin planning so that by July 1, 2000,
198.4 state-operated, community-based residential facilities will be in compliance with section
198.5 252.41, subdivision 9.

198.6 Sec. 12. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
198.7 to read:

198.8 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
198.9 determinations of disability by the commissioner's state medical review team under
198.10 sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, paragraph
198.11 (j), and 256B.055, subdivision 12, the commissioner shall review all medical evidence
198.12 submitted by county agencies with a referral and seek additional information from
198.13 providers, applicants, and enrollees to support the determination of disability where
198.14 necessary. Disability shall be determined according to the rules of title XVI and title
198.15 XIX of the Social Security Act and pertinent rules and policies of the Social Security
198.16 Administration.

198.17 (b) Prior to a denial or withdrawal of a requested determination of disability due
198.18 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
198.19 necessary and appropriate to a determination of disability, and (2) assist applicants and
198.20 enrollees to obtain the evidence, including, but not limited to, medical examinations
198.21 and electronic medical records.

198.22 (c) The commissioner shall provide the chairs of the legislative committees with
198.23 jurisdiction over health and human services finance and budget the following information
198.24 on the activities of the state medical review team by February 1, 2010, and annually
198.25 thereafter:

198.26 (1) the number of applications to the state medical review team that were denied,
198.27 approved, or withdrawn;

198.28 (2) the average length of time from receipt of the application to a decision;

198.29 (3) the number of appeals and appeal results;

198.30 (4) for applicants, their age, health coverage at the time of application, hospitalization
198.31 history within three months of application, and whether an application for Social Security
198.32 or Supplemental Security Income benefits is pending; and

198.33 (5) specific information on the medical certification, licensure, or other credentials
198.34 of the person or persons performing the medical review determinations and length of
198.35 time in that position.

199.1 Sec. 13. **[256.0281] INTERAGENCY DATA EXCHANGE.**

199.2 The Department of Human Services, the Department of Health, and the Office of the
199.3 Ombudsman for Mental Health and Developmental Disabilities may establish interagency
199.4 agreements governing the electronic exchange of data on providers and individuals
199.5 collected, maintained, or used by each agency when such exchange is outlined by each
199.6 agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

199.7 (1) to improve provider enrollment processes for home and community-based
199.8 services and state plan home care services;

199.9 (2) to improve quality management of providers between state agencies;

199.10 (3) to establish and maintain provider eligibility to participate as providers under
199.11 Minnesota health care programs; or

199.12 (4) to meet the quality assurance reporting requirements under federal law under
199.13 section 1915(c) of the Social Security Act related to home and community-based waiver
199.14 programs.

199.15 Each interagency agreement must include provisions to ensure anonymity of individuals,
199.16 including mandated reporters, and must outline the specific uses of and access to shared
199.17 data within each agency. Electronic interfaces between source data systems developed
199.18 under these interagency agreements must incorporate these provisions as well as other
199.19 HIPPA provisions related to individual data.

199.20 Sec. 14. Minnesota Statutes 2008, section 256.476, subdivision 5, is amended to read:

199.21 Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of
199.22 transferring persons to the consumer support grant program from the family support
199.23 program and personal care assistant services, home health aide services, or private duty
199.24 nursing services, the amount of funds transferred by the commissioner between the
199.25 family support program account, the medical assistance account, or the consumer support
199.26 grant account shall be based on each county's participation in transferring persons to the
199.27 consumer support grant program from those programs and services.

199.28 (b) At the beginning of each fiscal year, county allocations for consumer support
199.29 grants shall be based on:

199.30 (1) the number of persons to whom the county board expects to provide consumer
199.31 supports grants;

199.32 (2) their eligibility for current program and services;

199.33 (3) the ~~amount of nonfederal dollars~~ monthly grant levels allowed under subdivision
199.34 11; and

200.1 (4) projected dates when persons will start receiving grants. County allocations shall
200.2 be adjusted periodically by the commissioner based on the actual transfer of persons or
200.3 service openings, and the ~~nonfederal dollars~~ monthly grant levels associated with those
200.4 persons or service openings, to the consumer support grant program.

200.5 (c) The amount of funds transferred by the commissioner from the medical
200.6 assistance account for an individual may be changed if it is determined by the county or its
200.7 agent that the individual's need for support has changed.

200.8 (d) The authority to utilize funds transferred to the consumer support grant account
200.9 for the purposes of implementing and administering the consumer support grant program
200.10 will not be limited or constrained by the spending authority provided to the program
200.11 of origination.

200.12 (e) The commissioner may use up to five percent of each county's allocation, as
200.13 adjusted, for payments for administrative expenses, to be paid as a proportionate addition
200.14 to reported direct service expenditures.

200.15 (f) The county allocation for each person or the person's legal representative or other
200.16 authorized representative cannot exceed the amount allowed under subdivision 11.

200.17 (g) The commissioner may recover, suspend, or withhold payments if the county
200.18 board, local agency, or grantee does not comply with the requirements of this section.

200.19 (h) Grant funds unexpended by consumers shall return to the state once a year. The
200.20 annual return of unexpended grant funds shall occur in the quarter following the end of
200.21 the state fiscal year.

200.22 Sec. 15. Minnesota Statutes 2008, section 256.476, subdivision 11, is amended to read:

200.23 Subd. 11. **Consumer support grant program after July 1, 2001.** ~~(a)~~ Effective
200.24 July 1, 2001, the commissioner shall allocate consumer support grant resources to
200.25 serve additional individuals based on a review of Medicaid authorization and payment
200.26 information of persons eligible for a consumer support grant from the most recent fiscal
200.27 year. The commissioner shall use the following methodology to calculate maximum
200.28 allowable monthly consumer support grant levels:

200.29 (1) For individuals whose program of origination is medical assistance home care
200.30 under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly
200.31 grant levels are calculated by:

200.32 (i) determining ~~the nonfederal share~~ 50 percent of the average service authorization
200.33 for each home care rating;

200.34 (ii) calculating the overall ratio of actual payments to service authorizations by
200.35 program;

201.1 (iii) applying the overall ratio to the average service authorization level of each
201.2 home care rating;
201.3 (iv) adjusting the result for any authorized rate increases provided by the legislature;
201.4 and
201.5 (v) adjusting the result for the average monthly utilization per recipient.
201.6 (2) The commissioner may review and evaluate the methodology to reflect changes
201.7 in the home care ~~program's overall ratio of actual payments to service authorizations~~
201.8 programs.
201.9 ~~(b) Effective January 1, 2004, persons previously receiving exception grants will~~
201.10 ~~have their grants calculated using the methodology in paragraph (a), clause (1). If a person~~
201.11 ~~currently receiving an exception grant wishes to have their home care rating reevaluated,~~
201.12 ~~they may request an assessment as defined in section 256B.0651, subdivision 1, paragraph~~
201.13 ~~(b).~~

201.14 Sec. 16. Minnesota Statutes 2008, section 256.975, subdivision 7, is amended to read:

201.15 Subd. 7. **Consumer information and assistance and long-term care options**
201.16 **counseling; ~~senior linkage~~ Senior LinkAge Line.** (a) The Minnesota Board on Aging
201.17 shall operate a statewide ~~information and assistance~~ service to aid older Minnesotans and
201.18 their families in making informed choices about long-term care options and health care
201.19 benefits. Language services to persons with limited English language skills may be made
201.20 available. The service, known as Senior LinkAge Line, must be available during business
201.21 hours through a statewide toll-free number and must also be available through the Internet.
201.22 (b) The service must ~~assist~~ provide long-term care options counseling by assisting
201.23 older adults, caregivers, and providers in accessing information and options counseling
201.24 about choices in long-term care services that are purchased through private providers or
201.25 available through public options. The service must:
201.26 (1) develop a comprehensive database that includes detailed listings in both
201.27 consumer- and provider-oriented formats;
201.28 (2) make the database accessible on the Internet and through other telecommunication
201.29 and media-related tools;
201.30 (3) link callers to interactive long-term care screening tools and make these tools
201.31 available through the Internet by integrating the tools with the database;
201.32 (4) develop community education materials with a focus on planning for long-term
201.33 care and evaluating independent living, housing, and service options;
201.34 (5) conduct an outreach campaign to assist older adults and their caregivers in
201.35 finding information on the Internet and through other means of communication;

202.1 (6) implement a messaging system for overflow callers and respond to these callers
202.2 by the next business day;
202.3 (7) link callers with county human services and other providers to receive more
202.4 in-depth assistance and consultation related to long-term care options;
202.5 (8) link callers with quality profiles for nursing facilities and other providers
202.6 developed by the commissioner of health; ~~and~~
202.7 (9) incorporate information about housing with services and consumer rights
202.8 within the MinnesotaHelp.info network long-term care database to facilitate consumer
202.9 comparison of services and costs among housing with services establishments and with
202.10 other in-home services and to support financial self-sufficiency as long as possible.
202.11 Housing with services establishments and their arranged home care providers shall provide
202.12 information to the commissioner of human services that is consistent with information
202.13 required by the commissioner of health under section 144G.06, the Uniform Consumer
202.14 Information Guide. The commissioner of human services shall provide the data to the
202.15 Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term
202.16 care database~~.~~;
202.17 (10) provide long-term care options counseling. Long-term care options counselors
202.18 shall:
202.19 (i) for individuals not eligible for case management under a public program or public
202.20 funding source, provide interactive decision support under which consumers, family
202.21 members, or other helpers are supported in their deliberations to determine appropriate
202.22 long-term care choices in the context of the consumer's needs, preferences, values, and
202.23 individual circumstances, including implementing a community support plan;
202.24 (ii) provide Web-based educational information and collateral written materials to
202.25 familiarize consumers, family members, or other helpers with the long-term care basics,
202.26 issues to be considered, and the range of options available in the community;
202.27 (iii) provide long-term care futures planning, which means providing assistance to
202.28 individuals who anticipate having long-term care needs to develop a plan for the more
202.29 distant future; and
202.30 (iv) provide expertise in benefits and financing options for long-term care, including
202.31 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
202.32 private pay options, and ways to access low or no-cost services or benefits through
202.33 volunteer-based or charitable programs; and
202.34 (11) using risk management and support planning protocols, provide long-term care
202.35 options counseling to current residents of nursing homes deemed appropriate for discharge
202.36 by the commissioner. In order to meet this requirement, the commissioner shall provide

203.1 designated Senior LinkAge Line contact centers with a list of nursing home residents
203.2 appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall
203.3 provide these residents, if they indicate a preference to receive long-term care options
203.4 counseling, with initial assessment, review of risk factors, independent living support
203.5 consultation, or referral to:

203.6 (i) services under section 256B.0911, subdivision 3;

203.7 (ii) designated care coordinators of contracted entities under section 256B.035 for
203.8 persons who are enrolled in a managed care plan; or

203.9 (iii) the long-term care consultation team for those who are appropriate for relocation
203.10 service coordination due to high-risk factors or psychological or physical disability.

203.11 ~~(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness~~
203.12 ~~of the statewide information and assistance, and submit this evaluation to the legislature~~
203.13 ~~by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps~~
203.14 ~~in service delivery, continuity in information between the service and identified linkages,~~
203.15 ~~and potential use of private funding to enhance the service.~~

203.16 Sec. 17. Minnesota Statutes 2008, section 256B.055, subdivision 7, is amended to read:

203.17 Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for
203.18 a person who meets the categorical eligibility requirements of the supplemental security
203.19 income program or, who would meet those requirements except for excess income or
203.20 assets, and who meets the other eligibility requirements of this section.

203.21 (b) Following a determination that the applicant is not aged or blind and does not
203.22 meet any other category of eligibility for medical assistance and has not been determined
203.23 disabled by the Social Security Administration, applicants under this subdivision shall be
203.24 referred to the commissioner's state medical review team for a determination of disability.

203.25 Sec. 18. Minnesota Statutes 2008, section 256B.0625, subdivision 6a, is amended to
203.26 read:

203.27 Subd. 6a. **Home health services.** Home health services are those services specified
203.28 in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical
203.29 assistance covers home health services at a recipient's home residence. Medical assistance
203.30 does not cover home health services for residents of a hospital, nursing facility, or
203.31 intermediate care facility, unless the commissioner of human services has ~~prior~~ authorized
203.32 skilled nurse visits for less than 90 days for a resident at an intermediate care facility for
203.33 persons with developmental disabilities, to prevent an admission to a hospital or nursing
203.34 facility or unless a resident who is otherwise eligible is on leave from the facility and the

204.1 facility either pays for the home health services or forgoes the facility per diem for the
204.2 leave days that home health services are used. Home health services must be provided by
204.3 a Medicare certified home health agency. All nursing and home health aide services must
204.4 be provided according to sections 256B.0651 to ~~256B.0656~~ 256B.0653.

204.5 Sec. 19. Minnesota Statutes 2008, section 256B.0625, subdivision 7, is amended to
204.6 read:

204.7 Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing
204.8 services in a recipient's home. Recipients who are authorized to receive private duty
204.9 nursing services in their home may use approved hours outside of the home during hours
204.10 when normal life activities take them outside of their home. To use private duty nursing
204.11 services at school, the recipient or responsible party must provide written authorization in
204.12 the care plan identifying the chosen provider and the daily amount of services to be used at
204.13 school. Medical assistance does not cover private duty nursing services for residents of a
204.14 hospital, nursing facility, intermediate care facility, or a health care facility licensed by the
204.15 commissioner of health, except as authorized in section 256B.64 for ventilator-dependent
204.16 recipients in hospitals or unless a resident who is otherwise eligible is on leave from the
204.17 facility and the facility either pays for the private duty nursing services or forgoes the
204.18 facility per diem for the leave days that private duty nursing services are used. Total hours
204.19 of service and payment allowed for services outside the home cannot exceed that which is
204.20 otherwise allowed in an in-home setting according to sections 256B.0651 and ~~256B.0653~~
204.21 256B.0654 to 256B.0656. All private duty nursing services must be provided according to
204.22 the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private
204.23 duty nursing services may not be reimbursed if the nurse is the family foster care provider
204.24 of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

204.25 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to
204.26 read:

204.27 Subd. 19a. **Personal care ~~assistant~~ assistance services.** Medical assistance covers
204.28 personal care ~~assistant~~ assistance services in a recipient's home. Effective January 1,
204.29 2010, to qualify for personal care ~~assistant~~ assistance services, a recipient must require
204.30 assistance and be determined dependent in one activity of daily living as defined in section
204.31 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section
204.32 256B.0659, subdivision 1, paragraph (c). Beginning July 1, 2011, to qualify for personal
204.33 care assistance services, a recipient must require assistance and be determined dependent
204.34 in at least two activities of daily living as defined in section 256B.0659. Recipients or

205.1 responsible parties must be able to identify the recipient's needs, direct and evaluate task
205.2 accomplishment, and provide for health and safety. Approved hours may be used outside
205.3 the home when normal life activities take them outside the home. To use personal care
205.4 ~~assistant~~ assistance services at school, the recipient or responsible party must provide
205.5 written authorization in the care plan identifying the chosen provider and the daily amount
205.6 of services to be used at school. Total hours for services, whether actually performed
205.7 inside or outside the recipient's home, cannot exceed that which is otherwise allowed for
205.8 personal care ~~assistant~~ assistance services in an in-home setting according to sections
205.9 256B.0651 ~~and 256B.0653~~ to 256B.0656. Medical assistance does not cover personal care
205.10 ~~assistant~~ assistance services for residents of a hospital, nursing facility, intermediate care
205.11 facility, health care facility licensed by the commissioner of health, or unless a resident
205.12 who is otherwise eligible is on leave from the facility and the facility either pays for the
205.13 personal care ~~assistant~~ assistance services or forgoes the facility per diem for the leave
205.14 days that personal care ~~assistant~~ assistance services are used. All personal care ~~assistant~~
205.15 assistance services must be provided according to sections 256B.0651 ~~and 256B.0653~~
205.16 to 256B.0656. Personal care ~~assistant~~ assistance services may not be reimbursed if the
205.17 personal care assistant is the spouse or ~~legal~~ paid guardian of the recipient or the parent of
205.18 a recipient under age 18, or the responsible party or the family foster care provider of a
205.19 recipient who cannot direct the recipient's own care unless, in the case of a foster care
205.20 provider, a county or state case manager visits the recipient as needed, but not less than
205.21 every six months, to monitor the health and safety of the recipient and to ensure the goals
205.22 of the care plan are met. ~~Parents of adult recipients, adult children of the recipient or~~
205.23 ~~adult siblings of the recipient may be reimbursed for personal care assistant services,~~
205.24 ~~if they are granted a waiver under sections 256B.0651 and 256B.0653 to 256B.0656~~.
205.25 Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause~~
205.26 ~~(4)~~ 256B.0659, the ~~noncorporate legal~~ unpaid guardian or conservator of an adult, who is
205.27 not the responsible party and not the personal care provider organization, may be ~~granted a~~
205.28 ~~hardship waiver under sections 256B.0651 and 256B.0653 to 256B.0656, to be~~ reimbursed
205.29 to provide personal care ~~assistant~~ assistance services to the recipient if the guardian or
205.30 conservator meets all criteria for a personal care assistant according to section 256B.0659,
205.31 and shall not be considered to have a service provider interest for purposes of participation
205.32 on the screening team under section 256B.092, subdivision 7.

205.33 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 19c, is amended to
205.34 read:

Subd. 19c. **Personal care.** Medical assistance covers personal care ~~assistant~~ assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 ~~and 256B.0653~~ to 256B.0656, ~~where the services have a statement of need by a physician,~~ provided in accordance with a plan, and ~~are~~ supervised by ~~the recipient or~~ a qualified professional. ~~The physician's statement of need for personal care assistant services shall be documented on a form approved by the commissioner and include the diagnosis or condition of the person that results in a need for personal care assistant services and be updated when the person's medical condition requires a change, but at least annually if the need for personal care assistant services is ongoing.~~

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, ~~or~~ a licensed social worker as defined in section 148B.21, or a qualified developmental disabilities specialist undersection 245B.07, subdivision 4. ~~As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant.~~ The qualified professional shall perform the duties ~~described~~ required in ~~Minnesota Rules, part 9505.0335, subpart 4~~ section 256B.0659.

Sec. 22. Minnesota Statutes 2008, section 256B.0641, subdivision 3, is amended to read:

Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of ownership of a facility to a nonrelated organization while the facility to be sold, transferred or reorganized is in receivership under section 144A.14, 144A.15, 245A.12, or 245A.13, and the commissioner during the receivership has not determined the need to place residents of the facility into a newly constructed or newly established facility. Nothing in this subdivision limits the liability of a former owner.

Sec. 23. Minnesota Statutes 2008, section 256B.0651, is amended to read:

256B.0651 HOME CARE SERVICES.

Subdivision 1. **Definitions.** (a) ~~"Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning~~ For the purposes of sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g) have the meanings given.

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

207.1 (c) "Assessment" means a review and evaluation of a recipient's need for home care
207.2 services conducted in person. Assessments for home health agency services shall be
207.3 conducted by a home health agency nurse. Assessments for medical assistance home care
207.4 services for developmental disability and alternative care services for developmentally
207.5 disabled home and community-based waivered recipients may be conducted by the county
207.6 public health nurse to ensure coordination and avoid duplication. Assessments must be
207.7 completed on forms provided by the commissioner within 30 days of a request for home
207.8 care services by a recipient or responsible party.

207.9 (c) (d) "Home care services" means a health service, determined by the commissioner
207.10 as medically necessary, that is ordered by a physician and documented in a service plan
207.11 that is reviewed by the physician at least once every 60 days for the provision of home
207.12 health services, or private duty nursing, or at least once every 365 days for personal care.
207.13 Home care services are provided to the recipient at the recipient's residence that is a
207.14 place other than a hospital or long-term care facility or as specified in section 256B.0625
207.15 means medical assistance covered services that are home health agency services, including
207.16 skilled nurse visits; home health aide visits; physical therapy, occupational therapy,
207.17 respiratory therapy, and language-speech pathology therapy; private duty nursing; and
207.18 personal care assistance.

207.19 (e) "Home residence," effective January 1, 2010, means a residence owned or rented
207.20 by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid
207.21 responsible party or legal representative; or a family foster home where the license holder
207.22 lives with the recipient and is not paid to provide home care services for the recipient
207.23 except as allowed under sections 256B.0651, subdivision 9, and 256B.0654, subdivision 4.

207.24 (d) (f) "Medically necessary" has the meaning given in Minnesota Rules, parts
207.25 9505.0170 to 9505.0475.

207.26 (e) "Telehomecare" means the use of telecommunications technology by a home
207.27 health care professional to deliver home health care services, within the professional's
207.28 scope of practice, to a patient located at a site other than the site where the practitioner
207.29 is located.

207.30 (g) "Ventilator-dependent" means an individual who receives mechanical ventilation
207.31 for life support at least six hours per day and is expected to be or has been dependent on a
207.32 ventilator for at least 30 consecutive days.

207.33 Subd. 2. **Services covered.** Home care services covered under this section and
207.34 sections 256B.0653 256B.0652 to 256B.0656 and 256B.0659 include:

207.35 (1) nursing services under section sections 256B.0625, subdivision 6a, and
207.36 256B.0653;

208.1 (2) private duty nursing services under ~~section~~ sections 256B.0625, subdivision
208.2 7, and 256B.0654;
208.3 (3) home health services under ~~section~~ sections 256B.0625, subdivision 6a, and
208.4 256B.0653;
208.5 (4) personal care ~~assistant~~ assistance services under ~~section~~ sections 256B.0625,
208.6 subdivision 19a, and 256B.0659;
208.7 (5) supervision of personal care ~~assistant~~ assistance services provided by a qualified
208.8 professional under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659;
208.9 (6) ~~qualified professional of personal care assistant services under the fiscal~~
208.10 ~~intermediary option as specified in section 256B.0655, subdivision 7;~~
208.11 ~~(7)~~ face-to-face assessments by county public health nurses for services under
208.12 ~~section~~ sections 256B.0625, subdivision 19a, 256B.0655, and 256B.0659; and
208.13 ~~(8)~~ (7) service updates and review of temporary increases for personal care ~~assistant~~
208.14 assistance services by the county public health nurse for services under ~~section~~ sections
208.15 256B.0625, subdivision 19a, and 256B.0659.

208.16 Subd. 3. **Noncovered home care services.** The following home care services are
208.17 not eligible for payment under medical assistance:
208.18 ~~(1) skilled nurse visits for the sole purpose of supervision of the home health aide;~~
208.19 ~~(2) a skilled nursing visit:~~
208.20 ~~(i) only for the purpose of monitoring medication compliance with an established~~
208.21 ~~medication program for a recipient; or~~
208.22 ~~(ii) to administer or assist with medication administration, including injections,~~
208.23 ~~prefilling syringes for injections, or oral medication set-up of an adult recipient, when as~~
208.24 ~~determined and documented by the registered nurse, the need can be met by an available~~
208.25 ~~pharmacy or the recipient is physically and mentally able to self-administer or prefill~~
208.26 ~~a medication;~~
208.27 ~~(3) home care services to a recipient who is eligible for covered services under the~~
208.28 ~~Medicare program or any other insurance held by the recipient;~~
208.29 ~~(4) services to other members of the recipient's household;~~
208.30 ~~(5) a visit made by a skilled nurse solely to train other home health agency workers;~~
208.31 ~~(6) any home care service included in the daily rate of the community-based~~
208.32 ~~residential facility where the recipient is residing;~~
208.33 ~~(7) nursing and rehabilitation therapy services that are reasonably accessible to a~~
208.34 ~~recipient outside the recipient's place of residence, excluding the assessment, counseling~~
208.35 ~~and education, and personal assistant care;~~

~~(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and~~

~~(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.~~

(1) services provided in a nursing facility, hospital, or intermediate care facility with exceptions in section 256B.0653;

(2) services for the sole purpose of monitoring medication compliance with an established medication program for a recipient;

(3) home care services for covered services under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(6) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistance care; or

(7) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Subd. 4. **~~Prior~~ Authorization; exceptions.** All home care services above the limits in subdivision 11 must receive the commissioner's ~~prior~~ authorization before services begin, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) ~~the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;~~ a recipient's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for home care services is completed based on the date of a current assessment, eligibility, and request for authorization;

210.1 (3) a third-party payor for home care services has denied or adjusted a payment.
210.2 Authorization requests must be submitted by the provider within 20 working days of the
210.3 notice of denial or adjustment. A copy of the notice must be included with the request;
210.4 (4) the commissioner has determined that a county or state human services agency
210.5 has made an error; or
210.6 (5) ~~the professional nurse determines an immediate need for up to 40 skilled nursing~~
210.7 ~~or home health aide visits per calendar year and submits a request for authorization within~~
210.8 ~~20 working days of the initial service date, and medical assistance is determined to be~~
210.9 ~~the appropriate payer.~~ if a recipient enrolled in managed care experiences a temporary
210.10 disenrollment from a health plan, the commissioner shall accept the current health plan
210.11 authorization for personal care assistance services for up to 60 days. The request must
210.12 be received within the first 30 days of the disenrollment. If the recipient's reenrollment
210.13 in managed care is after the 60 days and before 90 days, the provider shall request an
210.14 additional 30-day extension of the current health plan authorization, for a total limit of
210.15 90 days from the time of disenrollment.

210.16 ~~Subd. 5.~~ ~~**Retroactive authorization.**~~ ~~A request for retroactive authorization will be~~
210.17 ~~evaluated according to the same criteria applied to prior authorization requests.~~

210.18 Subd. 6. ~~**Prior**~~ **Authorization.** (a) The commissioner, or the commissioner's
210.19 designee, shall review the assessment, ~~service update,~~ request for temporary services,
210.20 ~~request for flexible use option,~~ service plan, and any additional information that is
210.21 submitted. The commissioner shall, within 30 days after receiving a complete request,
210.22 assessment, and service plan, authorize home care services as ~~follows:~~ provided in this
210.23 section.
210.24 ~~(a)~~ ~~**Home health services.**~~ (b) ~~All~~ Home health services ~~provided by a home health~~
210.25 ~~aide~~ including skilled nurse visits and home health aide visits must be ~~prior~~ authorized
210.26 by the commissioner or the commissioner's designee. ~~Prior~~ Authorization must be based
210.27 on medical necessity and cost-effectiveness when compared with other care options.
210.28 The commissioner must receive the request for authorization of skilled nurse visits and
210.29 home health aide visits within 20 working days of the start of service. When home health
210.30 services are used in combination with personal care and private duty nursing, the cost of
210.31 all home care services shall be considered for cost-effectiveness. ~~The commissioner shall~~
210.32 ~~limit home health aide visits to no more than one visit each per day. The commissioner, or~~
210.33 ~~the commissioner's designee, may authorize up to two skilled nurse visits per day.~~
210.34 ~~(b)~~ ~~**Ventilator-dependent recipients.**~~ (c) If the recipient is ventilator-dependent, the
210.35 monthly medical assistance authorization for home care services shall not exceed what the
210.36 commissioner would pay for care at the highest cost hospital designated as a long-term

211.1 hospital under the Medicare program. For purposes of this paragraph, home care services
211.2 means all direct care services provided in the home that would be included in the payment
211.3 for care at the long-term hospital. ~~"Ventilator-dependent" means an individual who~~
211.4 ~~receives mechanical ventilation for life support at least six hours per day and is expected~~
211.5 ~~to be or has been dependent for at least 30 consecutive days.~~ Recipients who meet the
211.6 definition of ventilator dependent and the EN home care rating and utilize a combination
211.7 of home care services are limited up to a total of 24 hours of home care services per day.
211.8 Additional hours may be authorized when a recipient's assessment indicates a need for two
211.9 staff to perform activities. Additional time is limited to four hours per day.

211.10 Subd. 7. ~~**Prior**~~ **Authorization; time limits.** (a) The commissioner or the
211.11 commissioner's designee shall determine the time period for which ~~a prior~~ an authorization
211.12 shall be effective ~~and, if flexible use has been requested, whether to allow the flexible use~~
211.13 ~~option~~. If the recipient continues to require home care services beyond the duration of
211.14 the ~~prior~~ authorization, the home care provider must request a new ~~prior~~ authorization.
211.15 A personal care provider agency must request a new personal care ~~assistant~~ assistance
211.16 services assessment, or service update if allowed, at least 60 days prior to the end of
211.17 the current ~~prior~~ authorization time period. The request for the assessment must be
211.18 made on a form approved by the commissioner. ~~Under no circumstances, other than the~~
211.19 ~~exceptions in subdivision 4, shall a prior~~ An authorization must be valid ~~prior to the date~~
211.20 ~~the commissioner receives the request or~~ for no more than 12 months.

211.21 (b) The amount and type of personal care assistance services authorized based
211.22 upon the assessment and service plan must remain in effect for the recipient whether
211.23 the recipient chooses a different provider or enrolls or disenrolls from a managed care
211.24 plan under section 256B.0659, unless the service needs of the recipient change and new
211.25 assessment is warranted under section 256B.0655, subdivision 1b.

211.26 (c) A recipient who appeals a reduction in previously authorized home care
211.27 services may continue previously authorized services, other than temporary services
211.28 under subdivision 8, pending an appeal under section 256.045. The commissioner must
211.29 ~~provide~~ ensure that the recipient has a copy of the most recent service plan that contains
211.30 a detailed explanation of ~~why the authorized services~~ which areas of covered personal
211.31 care assistance tasks are reduced ~~in amount from those requested by the home care~~
211.32 ~~provider~~, and provide notice of the amount of time per day reduced, and the reasons for
211.33 the reduction in the recipient's notice of denial, termination, or reduction.

211.34 Subd. 8. ~~**Prior**~~ **Authorization requests; temporary services.** The agency nurse,
211.35 ~~the~~ independently enrolled private duty nurse, or county public health nurse may request
211.36 a temporary authorization for home care services ~~by telephone~~. The commissioner may

212.1 approve a temporary level of home care services based on the assessment, and service
212.2 or care plan information, and primary payer coverage determination information as
212.3 required. Authorization for a temporary level of home care services including nurse
212.4 supervision is limited to the time specified by the commissioner, but shall not exceed
212.5 45 days~~, unless extended because the county public health nurse has not completed the~~
212.6 ~~required assessment and service plan, or the commissioner's determination has not been~~
212.7 ~~made~~. The level of services authorized under this provision shall have no bearing on a
212.8 future ~~prior~~ authorization.

212.9 Subd. 9. **~~Prior~~ Authorization for foster care setting.** (a) Home care services
212.10 provided in an adult or child foster care setting must receive ~~prior~~ authorization by the
212.11 ~~department~~ commissioner according to the limits established in subdivision 11.

212.12 (b) The commissioner may not authorize:

212.13 (1) home care services that are the responsibility of the foster care provider under
212.14 the terms of the foster care placement agreement, difficulty of care rate as of January 1,
212.15 2010, and administrative rules;

212.16 (2) personal care ~~assistant~~ assistance services when the foster care license holder is
212.17 also the personal care provider or personal care assistant ~~unless the recipient can direct the~~
212.18 ~~recipient's own care, or case management is provided as required in section 256B.0625,~~
212.19 ~~subdivision 19a~~, unless the foster home is the licensed provider's primary residence as
212.20 defined in section 256B.0625, subdivision 19a; or

212.21 ~~(3) personal care assistant services when the responsible party is an employee of, or~~
212.22 ~~under contract with, or has any direct or indirect financial relationship with the personal~~
212.23 ~~care provider or personal care assistant, unless case management is provided as required~~
212.24 ~~in section 256B.0625, subdivision 19a; or~~

212.25 ~~(4)~~ (3) personal care assistant and private duty nursing services when the ~~number~~
212.26 ~~of foster care residents~~ licensed capacity is greater than four ~~unless the county responsible~~
212.27 ~~for the recipient's foster placement made the placement prior to April 1, 1992, requests~~
212.28 ~~that personal care assistant and private duty nursing services be provided, and case~~
212.29 ~~management is provided as required in section 256B.0625, subdivision 19a~~.

212.30 ~~Subd. 10.~~ **~~Limitation on payments.~~** ~~Medical assistance payments for home care~~
212.31 ~~services shall be limited according to subdivisions 4 to 12 and sections 256B.0654,~~
212.32 ~~subdivision 2, and 256B.0655, subdivisions 3 and 4.~~

212.33 Subd. 11. **Limits on services without ~~prior~~ authorization.** A recipient may receive
212.34 the following home care services during a calendar year:

213.1 (1) up to two face-to-face assessments to determine a recipient's need for personal
213.2 care ~~assistant~~ assistance services;
213.3 (2) one service update done to determine a recipient's need for personal care ~~assistant~~
213.4 assistance services; and
213.5 (3) up to nine face-to-face skilled nurse visits.

213.6 Subd. 12. **Approval of home care services.** The commissioner or the
213.7 commissioner's designee shall determine the medical necessity of home care services,
213.8 the level of caregiver according to subdivision 2, and the institutional comparison
213.9 according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, ~~and~~ 256B.0655,
213.10 subdivisions 3 and 4, and 256B.0659, the cost-effectiveness of services, and the amount,
213.11 scope, and duration of home care services reimbursable by medical assistance, based
213.12 on the assessment, primary payer coverage determination information as required, the
213.13 service plan, the recipient's age, the cost of services, the recipient's medical condition, and
213.14 diagnosis or disability. The commissioner may publish additional criteria for determining
213.15 medical necessity according to section 256B.04.

213.16 Subd. 13. **Recovery of excessive payments.** The commissioner shall seek
213.17 monetary recovery from providers of payments made for services which exceed the limits
213.18 established in this section and sections 256B.0653 to 256B.0656, and 256B.0659. This
213.19 subdivision does not apply to services provided to a recipient at the previously authorized
213.20 level pending an appeal under section 256.045, subdivision 10.

213.21 Subd. 14. **Referrals to Medicare providers required.** Home care providers that
213.22 do not participate in or accept Medicare assignment must refer and document the referral
213.23 of dual-eligible recipients to Medicare providers when Medicare is determined to be the
213.24 appropriate payer for services and supplies and equipment. Providers must be terminated
213.25 from participation in the medical assistance program for failure to make these referrals.

213.26 Subd. 15. **Quality assurance for program integrity.** The commissioner shall
213.27 establish an ongoing quality assurance process for home care services to monitor program
213.28 integrity, including provider standards and training, consumer surveys, and random
213.29 reviews of documentation.

213.30 Subd. 16. **Oversight of enrolled providers.** The commissioner has the authority to
213.31 request proof of documentation of meeting provider standards, quality standards of care,
213.32 correct billing practices, and other information. Failure to comply with or to provide access
213.33 and information to demonstrate compliance with laws, rules, or policies may result in
213.34 suspension, denial, or termination of the provider agency's enrollment with the department.

214.1 Sec. 24. Minnesota Statutes 2008, section 256B.0652, is amended to read:

214.2 **256B.0652 ~~PRIOR~~ AUTHORIZATION AND REVIEW OF HOME CARE**
214.3 **SERVICES.**

214.4 Subdivision 1. **State coordination.** The commissioner shall supervise the
214.5 coordination of the ~~prior~~ authorization and review of home care services that are
214.6 reimbursed by medical assistance.

214.7 Subd. 2. **Duties.** (a) The commissioner may contract with or employ ~~qualified~~
214.8 ~~registered nurses and~~ necessary ~~support~~ staff, or contract with qualified agencies, to
214.9 provide home care ~~prior~~ authorization and review services for medical assistance
214.10 recipients who are receiving home care services.

214.11 (b) Reimbursement for the ~~prior~~ authorization function shall be made through the
214.12 medical assistance administrative authority. The state shall pay the nonfederal share.
214.13 The functions will be to:

214.14 (1) assess the recipient's individual need for services required to be cared for safely
214.15 in the community;

214.16 (2) ensure that a ~~service~~ care plan that meets the recipient's needs is developed
214.17 by the appropriate agency or individual;

214.18 (3) ensure cost-effectiveness and nonduplication of medical assistance home care
214.19 services;

214.20 (4) recommend the approval or denial of the use of medical assistance funds to pay
214.21 for home care services;

214.22 (5) reassess the recipient's need for and level of home care services at a frequency
214.23 determined by the commissioner; ~~and~~

214.24 (6) conduct on-site assessments when determined necessary by the commissioner
214.25 and recommend changes to care plans that will provide more efficient and appropriate
214.26 home care; and

214.27 (7) on the department's Web site:

214.28 (i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies
214.29 with the following information: main office address, contact information for the agency,
214.30 counties in which services are provided, type of home care services provided, whether
214.31 the personal care assistance choice option is offered, types of qualified professionals
214.32 employed, number of personal care assistants employed, and data on staff turnover; and

214.33 (ii) post data on home care services including information from both fee-for-service
214.34 and managed care plans on recipients as available.

214.35 (c) In addition, the commissioner or the commissioner's designee may:

215.1 (1) review care plans, service plans, and reimbursement data for utilization of
215.2 services that exceed community-based standards for home care, inappropriate home care
215.3 services, medical necessity, home care services that do not meet quality of care standards,
215.4 or unauthorized services and make appropriate referrals within the department or to other
215.5 appropriate entities based on the findings;

215.6 (2) assist the recipient in obtaining services necessary to allow the recipient to
215.7 remain safely in or return to the community;

215.8 (3) coordinate home care services with other medical assistance services under
215.9 section 256B.0625;

215.10 (4) assist the recipient with problems related to the provision of home care services;

215.11 (5) assure the quality of home care services; and

215.12 (6) assure that all liable third-party payers including, but not limited to, Medicare
215.13 have been used prior to medical assistance for home care services~~, including but not~~
215.14 ~~limited to, home health agency, elected hospice benefit, waivered services, alternative care~~
215.15 ~~program services, and personal care services~~.

215.16 (d) For the purposes of this section, "home care services" means medical assistance
215.17 services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

215.18 Subd. 3. **Assessment and ~~prior~~ authorization process for persons receiving**
215.19 **personal care assistance and developmental disabilities services.** ~~Effective January 1,~~
215.20 ~~1996,~~ For purposes of providing informed choice, coordinating of local planning decisions,
215.21 and streamlining administrative requirements, the assessment and ~~prior~~ authorization
215.22 process for persons receiving both home care and home and community-based waivered
215.23 services for persons with developmental disabilities shall meet the requirements of
215.24 sections 256B.0651 and 256B.0653 to 256B.0656 with the following exceptions:

215.25 (a) Upon request for home care services and subsequent assessment by the public
215.26 health nurse under sections 256B.0651 and 256B.0653 to 256B.0656, the public health
215.27 nurse shall participate in the screening process, as appropriate, and, if home care
215.28 services are determined to be necessary, participate in the development of a service plan
215.29 coordinating the need for home care and home and community-based waivered services
215.30 with the assigned county case manager, the recipient of services, and the recipient's legal
215.31 representative, if any.

215.32 (b) The public health nurse shall give ~~prior~~ authorization for home care services
215.33 to the extent that home care services are:

215.34 (1) medically necessary;

215.35 (2) chosen by the recipient and their legal representative, if any, from the array of
215.36 home care and home and community-based waivered services available;

216.1 (3) coordinated with other services to be received by the recipient as described
216.2 in the service plan; and
216.3 (4) provided within the county's reimbursement limits for home care and home and
216.4 community-based waivered services for persons with developmental disabilities.
216.5 (c) If the public health agency is or may be the provider of home care services to the
216.6 recipient, the public health agency shall provide the commissioner of human services with
216.7 a written plan that specifies how the assessment and ~~prior~~ authorization process will be
216.8 held separate and distinct from the provision of services.

216.9 Sec. 25. Minnesota Statutes 2008, section 256B.0653, is amended to read:

216.10 **256B.0653 HOME HEALTH AGENCY ~~COVERED~~ SERVICES.**

216.11 Subdivision 1. **~~Homecare; skilled nurse visits~~ Scope.** ~~"Skilled nurse visits" are~~
216.12 ~~provided in a recipient's residence under a plan of care or service plan that specifies a level~~
216.13 ~~of care which the nurse is qualified to provide. These services are:~~
216.14 ~~(1) nursing services according to the written plan of care or service plan and accepted~~
216.15 ~~standards of medical and nursing practice in accordance with chapter 148;~~
216.16 ~~(2) services which due to the recipient's medical condition may only be safely and~~
216.17 ~~effectively provided by a registered nurse or a licensed practical nurse;~~
216.18 ~~(3) assessments performed only by a registered nurse; and~~
216.19 ~~(4) teaching and training the recipient, the recipient's family, or other caregivers~~
216.20 ~~requiring the skills of a registered nurse or licensed practical nurse.~~ This section applies to
216.21 home health agency services including, home health aide, skilled nursing visits, physical
216.22 therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.

216.23 Subd. 2. **~~Telehomecare; skilled nurse visits~~ Definitions.** ~~Medical assistance~~
216.24 ~~covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via~~
216.25 ~~telehomecare, for services which do not require hands-on care between the home care~~
216.26 ~~nurse and recipient. The provision of telehomecare must be made via live, two-way~~
216.27 ~~interactive audiovisual technology and may be augmented by utilizing store-and-forward~~
216.28 ~~technologies. Store-and-forward technology includes telehomecare services that do not~~
216.29 ~~occur in real time via synchronous transmissions, and that do not require a face-to-face~~
216.30 ~~encounter with the recipient for all or any part of any such telehomecare visit. Individually~~
216.31 ~~identifiable patient data obtained through real-time or store-and-forward technology must~~
216.32 ~~be maintained as health records according to sections 144.291 to 144.298. If the video~~
216.33 ~~is used for research, training, or other purposes unrelated to the care of the patient, the~~
216.34 ~~identity of the patient must be concealed. A communication between the home care nurse~~
216.35 ~~and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or~~

217.1 ~~a consultation between two health care practitioners, is not to be considered a telehomecare~~
217.2 ~~visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage~~
217.3 ~~of telehomecare is limited to two visits per day. All skilled nurse visits provided via~~
217.4 ~~telehomecare must be prior authorized by the commissioner or the commissioner's~~
217.5 ~~designee and will be covered at the same allowable rate as skilled nurse visits provided~~
217.6 ~~in-person.~~ For the purposes of this section, the following terms have the meanings given.
217.7 (a) "Assessment" means an evaluation of the recipient's medical need for home
217.8 health agency services by a registered nurse or appropriate therapist that is conducted
217.9 within 30 days of a request.
217.10 (b) "Home care therapies" means occupational, physical, and respiratory therapy
217.11 and speech-language pathology services provided in the home by a Medicare certified
217.12 home health agency.
217.13 (c) "Home health agency services" means services delivered in the recipient's home
217.14 residence, except as specified in section 256B.0625, by a home health agency to a recipient
217.15 with medical needs due to illness, disability, or physical conditions.
217.16 (d) "Home health aide" means an employee of a home health agency who completes
217.17 medically oriented tasks written in the plan of care for a recipient.
217.18 (e) "Home health agency" means a home care provider agency that is
217.19 Medicare-certified.
217.20 (f) "Occupational therapy services" mean the services defined in Minnesota Rules,
217.21 part 9505.0390.
217.22 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
217.23 9505.0390.
217.24 (h) "Respiratory therapy services" mean the services defined in chapter 147C and
217.25 Minnesota Rules, part 4668.0003, subpart 37.
217.26 (i) "Speech-language pathology services" mean the services defined in Minnesota
217.27 Rules, part 9505.0390.
217.28 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
217.29 required due to a recipient's medical condition that can only be safely provided by a
217.30 professional nurse to restore and maintain optimal health.
217.31 (k) "Store-and-forward technology" means telehomecare services that do not occur
217.32 in real time via synchronous transmissions such as diabetic and vital sign monitoring.
217.33 (l) "Telehomecare" means the use of telecommunications technology via
217.34 live, two-way interactive audiovisual technology which may be augmented by
217.35 store-and-forward technology.

218.1 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to
218.2 deliver a skilled nurse visit to a recipient located at a site other than the site where the
218.3 nurse is located and is used in combination with face-to-face skilled nurse visits to
218.4 adequately meet the recipient's needs.

218.5 Subd. 3. ~~**Therapies through home health agencies**~~ **Home health aide visits.**
218.6 ~~(a) Medical assistance covers physical therapy and related services, including specialized~~
218.7 ~~maintenance therapy. Services provided by a physical therapy assistant shall be~~
218.8 ~~reimbursed at the same rate as services performed by a physical therapist when the~~
218.9 ~~services of the physical therapy assistant are provided under the direction of a physical~~
218.10 ~~therapist who is on the premises. Services provided by a physical therapy assistant that are~~
218.11 ~~provided under the direction of a physical therapist who is not on the premises shall be~~
218.12 ~~reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy~~
218.13 ~~assistant must be provided by the physical therapist as described in Minnesota Rules, part~~
218.14 ~~9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may~~
218.15 ~~not both bill for services provided to a recipient on the same day.~~
218.16 ~~(b) Medical assistance covers occupational therapy and related services, including~~
218.17 ~~specialized maintenance therapy. Services provided by an occupational therapy assistant~~
218.18 ~~shall be reimbursed at the same rate as services performed by an occupational therapist~~
218.19 ~~when the services of the occupational therapy assistant are provided under the direction of~~
218.20 ~~the occupational therapist who is on the premises. Services provided by an occupational~~
218.21 ~~therapy assistant under the direction of an occupational therapist who is not on the~~
218.22 ~~premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction~~
218.23 ~~of the occupational therapy assistant must be provided by the occupational therapist as~~
218.24 ~~described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational~~
218.25 ~~therapist and occupational therapist assistant may not both bill for services provided~~
218.26 ~~to a recipient on the same day.~~
218.27 (a) Home health aide visits must be provided by a certified home health aide
218.28 using a written plan of care that is updated in compliance with Medicare regulations.
218.29 A home health aide shall provide hands-on personal care, perform simple procedures
218.30 as an extension of therapy or nursing services, and assist in instrumental activities of
218.31 daily living as defined in section 256B.0659. Home health aide visits must be provided
218.32 in the recipient's home.
218.33 (b) All home health aide visits must have authorization under section 256B.0652.
218.34 The commissioner shall limit home health aide visits to no more than one visit per day
218.35 per recipient.

219.1 (c) Home health aides must be supervised by a registered nurse or an appropriate
219.2 therapist when providing services that are an extension of therapy.

219.3 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be
219.4 provided by a registered nurse or a licensed practical nurse under the supervision of a
219.5 registered nurse, according to the written plan of care and accepted standards of medical
219.6 and nursing practice according to chapter 148. Skilled nurse visit services must be ordered
219.7 by a physician and documented in a plan of care that is reviewed and approved by the
219.8 ordering physician at least once every 60 days. All skilled nurse visits must be medically
219.9 necessary and provided in the recipient's home residence except as allowed under section
219.10 256B.0625, subdivision 6a.

219.11 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of
219.12 up to two visits per day per recipient. All visits must be based on assessed needs.

219.13 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status
219.14 can be accurately measured and assessed without a need for a face-to-face, hands-on
219.15 encounter. All telehomecare skilled nurse visits must have authorization and are paid at
219.16 the same allowable rates as face-to-face skilled nurse visits.

219.17 (d) The provision of telehomecare must be made via live, two-way interactive
219.18 audiovisual technology and may be augmented by utilizing store-and-forward
219.19 technologies. Individually identifiable patient data obtained through real-time or
219.20 store-and-forward technology must be maintained as health records according to sections
219.21 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated
219.22 to the care of the patient, the identity of the patient must be concealed.

219.23 (e) Authorization for skilled nurse visits must be completed under section
219.24 256B.0652. A total of nine face-to-face skilled nurses visits per calendar year do not
219.25 require authorization. All telehomecare skilled nurse visits require authorization.

219.26 Subd. 5. **Home care therapies.** (a) Home care therapies include the following:
219.27 physical therapy, occupational therapy, respiratory therapy, and speech and language
219.28 pathology therapy services.

219.29 (b) Home care therapies must be:

219.30 (1) provided in the recipient's residence after it has been determined the recipient is
219.31 unable to access outpatient therapy;

219.32 (2) prescribed, ordered, or referred by a physician and documented in a plan of care
219.33 and reviewed, according to Minnesota Rules, part 9505.0390;

219.34 (3) assessed by an appropriate therapist; and

219.35 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid
219.36 provider agency.

220.1 (c) Restorative and specialized maintenance therapies must be provided according to
220.2 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be
220.3 used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.
220.4 (d) For both physical and occupational therapies, the therapist and the therapist's
220.5 assistant may not both bill for services provided to a recipient on the same day.

220.6 Subd. 6. **Noncovered home health agency services.** The following are not eligible
220.7 for payment under medical assistance as a home health agency service:
220.8 (1) telehomecare skilled nurses services that is communication between the home
220.9 care nurse and recipient that consists solely of a telephone conversation, facsimile,
220.10 electronic mail, or a consultation between two health care practitioners;
220.11 (2) the following skilled nurse visits:
220.12 (i) for the purpose of monitoring medication compliance with an established
220.13 medication program for a recipient;
220.14 (ii) administering or assisting with medication administration, including injections,
220.15 prefilling syringes for injections, or oral medication setup of an adult recipient, when,
220.16 as determined and documented by the registered nurse, the need can be met by an
220.17 available pharmacy or the recipient or a family member is physically and mentally able
220.18 to self-administer or prefill a medication;
220.19 (iii) services done for the sole purpose of supervision of the home health aide or
220.20 personal care assistant;
220.21 (iv) services done for the sole purpose to train other home health agency workers;
220.22 (v) services done for the sole purpose of blood samples or lab draw when the
220.23 recipient is able to access these services outside the home; and
220.24 (vi) Medicare evaluation or administrative nursing visits required by Medicare;
220.25 (3) home health aide visits when the following activities are the sole purpose for the
220.26 visit: companionship, socialization, household tasks, transportation, and education; and
220.27 (4) home care therapies provided in other settings such as a clinic, day program, or as
220.28 an inpatient or when the recipient can access therapy outside of the recipient's residence.

220.29 Sec. 26. Minnesota Statutes 2008, section 256B.0654, is amended to read:

220.30 **256B.0654 PRIVATE DUTY NURSING.**

220.31 Subdivision 1. **Definitions.** ~~(a) "Assessment" means a review and evaluation of a~~
220.32 ~~recipient's need for home care services conducted in person. Assessments for private duty~~
220.33 ~~nursing shall be conducted by a registered private duty nurse. Assessments for medical~~
220.34 ~~assistance home care services for developmental disabilities and alternative care services~~

221.1 ~~for developmentally disabled home and community-based waivered recipients may be~~
221.2 ~~conducted by the county public health nurse to ensure coordination and avoid duplication.~~
221.3 ~~(b)~~ (a) "Complex ~~and regular~~ private duty nursing care" means~~:~~
221.4 ~~(1) complex care is private duty~~ nursing services provided to recipients who are
221.5 ventilator dependent or for whom a physician has certified that ~~were it not for private duty~~
221.6 ~~nursing~~ the recipient would meet the criteria for inpatient hospital intensive care unit
221.7 (ICU) level of care~~; and~~
221.8 ~~(2) regular care is private duty nursing provided to all other recipients~~.
221.9 (b) "Private duty nursing" means ongoing professional nursing services by a
221.10 registered or licensed practical nurse including assessment, professional nursing tasks, and
221.11 education, based on an assessment and physician orders to maintain or restore optimal
221.12 health of the recipient.
221.13 (c) "Private duty nursing agency" means a medical assistance enrolled provider
221.14 licensed under chapter 144A to provide private duty nursing services.
221.15 (d) "Regular private duty nursing" means nursing services provided to a recipient
221.16 who is considered stable and not at an inpatient hospital intensive care unit level of care,
221.17 but may have episodes of instability that are not life threatening.
221.18 (e) "Shared private duty nursing" means the provision of nursing services by a
221.19 private duty nurse to two recipients at the same time and in the same setting.

221.20 Subd. 2. **Authorization; private duty nursing services.** (a) All private duty
221.21 nursing services shall be ~~prior~~ authorized by the commissioner or the commissioner's
221.22 designee. ~~Prior~~ Authorization for private duty nursing services shall be based on
221.23 medical necessity and cost-effectiveness when compared with alternative care options.
221.24 The commissioner may authorize medically necessary private duty nursing services in
221.25 quarter-hour units when:
221.26 (1) the recipient requires more individual and continuous care than can be provided
221.27 during a skilled nurse visit; or
221.28 (2) the cares are outside of the scope of services that can be provided by a home
221.29 health aide or personal care assistant.
221.30 (b) The commissioner may authorize:
221.31 (1) up to two times the average amount of direct care hours provided in nursing
221.32 facilities statewide for case mix classification "K" as established by the annual cost report
221.33 submitted to the department by nursing facilities in May 1992;
221.34 (2) private duty nursing in combination with other home care services up to the total
221.35 cost allowed under section 256B.0655, subdivision 4;

222.1 (3) up to 16 hours per day if the recipient requires more nursing than the maximum
222.2 number of direct care hours as established in clause (1) and the recipient meets the hospital
222.3 admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

222.4 (c) The commissioner may authorize up to 16 hours per day of medically necessary
222.5 private duty nursing services or up to 24 hours per day of medically necessary private duty
222.6 nursing services until such time as the commissioner is able to make a determination of
222.7 eligibility for recipients who are cooperatively applying for home care services under
222.8 the community alternative care program developed under section 256B.49, or until it is
222.9 determined by the appropriate regulatory agency that a health benefit plan is or is not
222.10 required to pay for appropriate medically necessary health care services. Recipients
222.11 or their representatives must cooperatively assist the commissioner in obtaining this
222.12 determination. Recipients who are eligible for the community alternative care program
222.13 may not receive more hours of nursing under this section and sections 256B.0651,
222.14 256B.0653, ~~256B.0655, and~~ 256B.0656, and 256B.0659 than would otherwise be
222.15 authorized under section 256B.49.

222.16 Subd. 2a. **Private duty nursing services.** (a) Private duty nursing services must
222.17 be used:

222.18 (1) in the recipient's home or outside the home when normal life activities require;

222.19 (2) when the recipient requires more individual and continuous care than can be
222.20 provided during a skilled nurse visit; and

222.21 (3) when the care required is outside of the scope of services that can be provided by
222.22 a home health aide or personal care assistant.

222.23 (b) Private duty nursing services must be:

222.24 (1) assessed by a registered nurse on a form approved by the commissioner;

222.25 (2) ordered by a physician and documented in a plan of care that is reviewed by the
222.26 physician at least once every 60 days; and

222.27 (3) authorized by the commissioner under section 256B.0652.

222.28 Subd. 2b. **Noncovered private duty nursing services.** Private duty nursing
222.29 services do not cover the following:

222.30 (1) nursing services by a nurse who is the family foster care provider of a person
222.31 who has not reached 18 years of age unless allowed under subdivision 4;

222.32 (2) nursing services to more than two persons receiving shared private duty nursing
222.33 services from a private duty nurse in a single setting; and

222.34 (3) nursing services provided by a registered nurse or licensed practical nurse who is
222.35 the recipient's legal guardian or related to the recipient as spouse, parent, or family foster

223.1 parent whether by blood, marriage, or adoption except as specified in section 256B.0652,
223.2 subdivision 4.

223.3 Subd. 3. **Shared private duty nursing care option.** (a) Medical assistance
223.4 payments for shared private duty nursing services by a private duty nurse shall be limited
223.5 according to this subdivision. For the purposes of this section and sections 256B.0651,
223.6 256B.0653, 256B.0655, and 256B.0656, "private duty nursing agency" means an agency
223.7 licensed under chapter 144A to provide private duty nursing services. Unless otherwise
223.8 provided in this subdivision, all other statutory and regulatory provisions relating to
223.9 private duty nursing services apply to shared private duty nursing services. Nothing in
223.10 this subdivision shall be construed to reduce the total number of private duty nursing
223.11 hours authorized for an individual recipient.

223.12 (b) Recipients of private duty nursing services may share nursing staff and the
223.13 commissioner shall provide a rate methodology for shared private duty nursing. For two
223.14 persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the
223.15 regular private duty nursing rates paid for serving a single individual by a registered nurse
223.16 or licensed practical nurse. These rates apply only to situations in which both recipients
223.17 are present and receive shared private duty nursing care on the date for which the service
223.18 is billed. No more than two persons may receive shared private duty nursing services
223.19 from a private duty nurse in a single setting.

223.20 (c) (b) Shared private duty nursing care is the provision of nursing services by a
223.21 private duty nurse to two medical assistance eligible recipients at the same time and in
223.22 the same setting. This subdivision does not apply when a private duty nurse is caring for
223.23 multiple recipients in more than one setting.

223.24 (c) For the purposes of this subdivision, "setting" means:

223.25 (1) the home residence or foster care home of one of the individual recipients as
223.26 defined in section 256B.0651; or

223.27 (2) a child care program licensed under chapter 245A or operated by a local school
223.28 district or private school; or

223.29 (3) an adult day care service licensed under chapter 245A; or

223.30 (4) outside the home residence or foster care home of one of the recipients when
223.31 normal life activities take the recipients outside the home.

223.32 This subdivision does not apply when a private duty nurse is caring for multiple
223.33 recipients in more than one setting.

223.34 (d) The private duty nursing agency must offer the recipient the option of shared or
223.35 one-on-one private duty nursing services. The recipient may withdraw from participating
223.36 in a shared service arrangement at any time.

~~(d)~~ (e) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the ~~home health care~~ private duty nursing agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

~~(e)~~ (f) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

~~(f)~~ (g) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

~~(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.~~

(h) ~~The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care~~ The documentation for shared private duty nursing must be on a form approved by the commissioner for each individual recipient sharing private duty nursing. The documentation must be part of the recipient's health service record and include:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing ~~care~~ hours per week chosen by the recipient and

225.1 permission for shared private duty nursing services provided in and outside the recipient's
225.2 home residence;
225.3 (2) permission by the recipient or the recipient's legal representative for shared
225.4 private duty nursing services provided outside the recipient's residence;
225.5 (3) permission by the recipient or the recipient's legal representative for others to
225.6 receive shared private duty nursing services in the recipient's residence;
225.7 (4) revocation by the recipient or the recipient's legal representative of for the shared
225.8 private duty nursing care authorization, or the shared care to be provided to others in the
225.9 recipient's residence, or the shared private duty nursing services to be provided outside
225.10 permission, or services provided to others in and outside the recipient's residence; and
225.11 (5) (3) daily documentation of the shared private duty nursing services provided by
225.12 each identified private duty nurse, including:
225.13 (i) the names of each recipient receiving shared private duty nursing services
225.14 together;
225.15 (ii) the setting for the shared services, including the starting and ending times that
225.16 the recipient received shared private duty nursing care; and
225.17 (iii) notes by the private duty nurse regarding changes in the recipient's condition,
225.18 problems that may arise from the sharing of private duty nursing services, and scheduling
225.19 and care issues.
225.20 (i) Unless otherwise provided in this subdivision, all other statutory and regulatory
225.21 provisions relating to private duty nursing services apply to shared private duty nursing
225.22 services.
225.23 Nothing in this subdivision shall be construed to reduce the total number of private
225.24 duty nursing hours authorized for an individual recipient under subdivision 2.
225.25 (i) The commissioner shall provide a rate methodology for shared private duty
225.26 nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed
225.27 1.5 times the regular private duty nursing rates paid for serving a single individual by a
225.28 registered nurse or licensed practical nurse. These rates apply only to situations in which
225.29 both recipients are present and receive shared private duty nursing care on the date for
225.30 which the service is billed.
225.31 Subd. 4. **Hardship criteria; private duty nursing.** (a) Payment is allowed for
225.32 extraordinary services that require specialized nursing skills and are provided by parents
225.33 of minor children, family foster parents, spouses, and legal guardians who are providing
225.34 private duty nursing care under the following conditions:
225.35 (1) the provision of these services is not legally required of the parents, spouses,
225.36 or legal guardians;

226.1 (2) the services are necessary to prevent hospitalization of the recipient; and
226.2 (3) the recipient is eligible for state plan home care or a home and community-based
226.3 waiver and one of the following hardship criteria are met:
226.4 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
226.5 provide nursing care for the recipient; ~~or~~
226.6 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
226.7 less compensation to provide nursing care for the recipient; ~~or~~
226.8 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to
226.9 provide nursing care for the recipient; or
226.10 (iv) because of labor conditions, special language needs, or intermittent hours of
226.11 care needed, the parent, spouse, or legal guardian is needed in order to provide adequate
226.12 private duty nursing services to meet the medical needs of the recipient.
226.13 (b) Private duty nursing may be provided by a parent, spouse, family foster parent,
226.14 or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services
226.15 provided by a parent, spouse, family foster parent, or legal guardian cannot be used in
226.16 lieu of nursing services covered and available under liable third-party payors, including
226.17 Medicare. The private duty nursing provided by a parent, spouse, family foster parent, or
226.18 legal guardian must be included in the service ~~plan~~ agreement. Authorized ~~skilled~~ nursing
226.19 services for a single recipient or recipients with the same residence and provided by the
226.20 parent, spouse, family foster parent, or legal guardian may not exceed 50 percent of the
226.21 total approved nursing hours, or eight hours per day, whichever is less, up to a maximum
226.22 of 40 hours per week. A parent or parents, spouse, family foster parent, or legal guardian
226.23 shall not provide more than 40 hours of services in a seven-day period. For parents, family
226.24 foster parents, and legal guardians, 40 hours is the total amount allowed regardless of the
226.25 number of children or adults who receive services. Nothing in this subdivision precludes
226.26 the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family
226.27 responsibilities of emergency backup caregiver and primary caregiver.
226.28 (c) A parent, family foster parent, or a spouse may not be paid to provide private
226.29 duty nursing care if:
226.30 (1) the parent or spouse fails to pass a criminal background check according to
226.31 chapter 245C~~, or if~~;
226.32 (2) it has been determined by the ~~home health~~ private duty nursing agency, the
226.33 case manager, or the physician that the private duty nursing ~~care~~ provided by the parent,
226.34 family foster parent, spouse, or legal guardian is unsafe; or
226.35 (3) the parent, family foster parent, spouse, or legal guardian do not follow physician
226.36 orders.

227.1 (d) For purposes of this section, "assessment" means a review and evaluation of a
227.2 recipient's need for home care services conducted in person. Assessments for private duty
227.3 nursing must be conducted by a registered nurse.

227.4 Sec. 27. Minnesota Statutes 2008, section 256B.0655, subdivision 1b, is amended to
227.5 read:

227.6 Subd. 1b. **Assessment.** "Assessment" means a review and evaluation of a recipient's
227.7 need for home care services conducted in person. Assessments for personal care assistant
227.8 services shall be conducted by the county public health nurse or a certified public
227.9 health nurse under contract with the county. ~~A face-to-face~~ An in-person assessment
227.10 must include: documentation of health status, determination of need, evaluation of
227.11 service effectiveness, identification of appropriate services, service plan development
227.12 or modification, coordination of services, referrals and follow-up to appropriate payers
227.13 and community resources, completion of required reports, recommendation of service
227.14 authorization, and consumer education. Once the need for personal care assistant
227.15 services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654,
227.16 and 256B.0656, the county public health nurse or certified public health nurse under
227.17 contract with the county is responsible for communicating this recommendation to the
227.18 commissioner and the recipient. ~~A face-to-face assessment for personal care assistant~~
227.19 ~~services is conducted on those recipients who have never had a county public health~~
227.20 ~~nurse assessment. A face-to-face~~ An in-person assessment must occur at least annually or
227.21 when there is a significant change in the recipient's condition or when there is a change
227.22 in the need for personal care assistant services. A service update may substitute for
227.23 the annual face-to-face assessment when there is not a significant change in recipient
227.24 condition or a change in the need for personal care assistant service. A service update
227.25 may be completed by telephone, used when there is no need for an increase in personal
227.26 care assistant services, and used for two consecutive assessments if followed by a
227.27 face-to-face assessment. A service update must be completed on a form approved by the
227.28 commissioner. A service update or review for temporary increase includes a review of
227.29 initial baseline data, evaluation of service effectiveness, redetermination of service need,
227.30 modification of service plan and appropriate referrals, update of initial forms, obtaining
227.31 service authorization, and on going consumer education. Assessments must be completed
227.32 on forms provided by the commissioner within 30 days of a request for home care services
227.33 by a recipient or responsible party or personal care provider agency.

228.1 Sec. 28. Minnesota Statutes 2008, section 256B.0655, subdivision 4, is amended to
228.2 read:

228.3 Subd. 4. **~~Prior~~ Authorization; personal care assistance and qualified**
228.4 **professional.** ~~The commissioner, or the commissioner's designee, shall review the~~
228.5 ~~assessment, service update, request for temporary services, request for flexible use option,~~
228.6 ~~service plan, and any additional information that is submitted. The commissioner shall,~~
228.7 ~~within 30 days after receiving a complete request, assessment, and service plan, authorize~~
228.8 ~~home care services as follows:~~

228.9 ~~(1)~~ (a) All personal care ~~assistant~~ assistance services ~~and~~, supervision by a
228.10 qualified professional, ~~if requested by the recipient,~~ and additional services beyond the
228.11 limits established in section 256B.0651, subdivision 11, must be ~~prior~~ authorized by
228.12 the commissioner or the commissioner's designee before services begin except for the
228.13 assessments established in ~~section~~ sections 256B.0651, subdivision 11, and 256B.0911.
228.14 The authorization for personal care assistance and qualified professional services under
228.15 section 256B.0659 must be completed within 30 days after receiving a complete request.

228.16 (b) The amount of personal care ~~assistant~~ assistance services authorized must be
228.17 based on the recipient's home care rating. The home care rating shall be determined by
228.18 the commissioner or the commissioner's designee based on information submitted to the
228.19 commissioner identifying the following:

228.20 (1) total number of dependencies of activities of daily living as defined in section
228.21 256B.0659;

228.22 (2) number of complex health-related functions as defined in section 256B.0659; and

228.23 (3) number of behavior descriptions as defined in section 256B.0659.

228.24 (c) The methodology to determine total time for personal care assistance services for
228.25 each home care rating is based on the median paid units per day for each home care rating
228.26 from fiscal year 2007 data for the personal care assistance program. Each home care rating
228.27 has a base level of hours assigned. Additional time is added through the assessment and
228.28 identification of the following:

228.29 (1) 30 additional minutes per day for a dependency in each critical activity of daily
228.30 living as defined in section 256B.0659;

228.31 (2) 30 additional minutes per day for each complex health-related function as
228.32 defined in section 256B.0659; and

228.33 (3) 30 additional minutes per day for each behavior issue as defined in section
228.34 256B.0659.

228.35 (d) A limit of 96 units of qualified professional supervision may be authorized for
228.36 each recipient receiving personal care assistance services. A request to the commissioner

229.1 to exceed this total in a calendar year must be requested by the personal care provider
229.2 agency on a form approved by the commissioner.

229.3 A child may not be found to be dependent in an activity of daily living if because
229.4 of the child's age an adult would either perform the activity for the child or assist the
229.5 child with the activity and the amount of assistance needed is similar to the assistance
229.6 appropriate for a typical child of the same age. Based on medical necessity, the
229.7 commissioner may authorize:

229.8 (A) up to two times the average number of direct care hours provided in nursing
229.9 facilities for the recipient's comparable case mix level; or

229.10 (B) up to three times the average number of direct care hours provided in nursing
229.11 facilities for recipients who have complex medical needs or are dependent in at least seven
229.12 activities of daily living and need physical assistance with eating or have a neurological
229.13 diagnosis; or

229.14 (C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care
229.15 provided in a regional treatment center for recipients who have Level I behavior, plus any
229.16 inflation adjustment as provided by the legislature for personal care service; or

229.17 (D) up to the amount the commissioner would pay, as of July 1, 1991, plus any
229.18 inflation adjustment provided for home care services, for care provided in a regional
229.19 treatment center for recipients referred to the commissioner by a regional treatment center
229.20 preadmission evaluation team. For purposes of this clause, home care services means
229.21 all services provided in the home or community that would be included in the payment
229.22 to a regional treatment center; or

229.23 (E) up to the amount medical assistance would reimburse for facility care for
229.24 recipients referred to the commissioner by a preadmission screening team established
229.25 under section 256B.0911 or 256B.092; and

229.26 (F) a reasonable amount of time for the provision of supervision by a qualified
229.27 professional of personal care assistant services, if a qualified professional is requested by
229.28 the recipient or responsible party.

229.29 (2) The number of direct care hours shall be determined according to the annual cost
229.30 report submitted to the department by nursing facilities. The average number of direct care
229.31 hours, as established by May 1, 1992, shall be calculated and incorporated into the home
229.32 care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

229.33 (3) The home care rating shall be determined by the commissioner or the
229.34 commissioner's designee based on information submitted to the commissioner by the
229.35 county public health nurse on forms specified by the commissioner. The home care rating
229.36 shall be a combination of current assessment tools developed under sections 256B.0911

230.1 ~~and 256B.501 with an addition for seizure activity that will assess the frequency and~~
230.2 ~~severity of seizure activity and with adjustments, additions, and clarifications that are~~
230.3 ~~necessary to reflect the needs and conditions of recipients who need home care including~~
230.4 ~~children and adults under 65 years of age. The commissioner shall establish these forms~~
230.5 ~~and protocols under this section and sections 256B.0651, 256B.0653, 256B.0654, and~~
230.6 ~~256B.0656 and shall use an advisory group, including representatives of recipients,~~
230.7 ~~providers, and counties, for consultation in establishing and revising the forms and~~
230.8 ~~protocols.~~

230.9 ~~(4) A recipient shall qualify as having complex medical needs if the care required is~~
230.10 ~~difficult to perform and because of recipient's medical condition requires more time than~~
230.11 ~~community-based standards allow or requires more skill than would ordinarily be required~~
230.12 ~~and the recipient needs or has one or more of the following:~~

230.13 ~~(A) daily tube feedings;~~

230.14 ~~(B) daily parenteral therapy;~~

230.15 ~~(C) wound or decubiti care;~~

230.16 ~~(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy~~
230.17 ~~care, oxygen, mechanical ventilation;~~

230.18 ~~(E) catheterization;~~

230.19 ~~(F) ostomy care;~~

230.20 ~~(G) quadriplegia; or~~

230.21 ~~(H) other comparable medical conditions or treatments the commissioner determines~~
230.22 ~~would otherwise require institutional care.~~

230.23 ~~(5) A recipient shall qualify as having Level I behavior if there is reasonable~~
230.24 ~~supporting evidence that the recipient exhibits, or that without supervision, observation, or~~
230.25 ~~redirection would exhibit, one or more of the following behaviors that cause, or have the~~
230.26 ~~potential to cause:~~

230.27 ~~(A) injury to the recipient's own body;~~

230.28 ~~(B) physical injury to other people; or~~

230.29 ~~(C) destruction of property.~~

230.30 ~~(6) Time authorized for personal care relating to Level I behavior in paragraph~~
230.31 ~~(5), clauses (A) to (C), shall be based on the predictability, frequency, and amount of~~
230.32 ~~intervention required.~~

230.33 ~~(7) A recipient shall qualify as having Level II behavior if the recipient exhibits on a~~
230.34 ~~daily basis one or more of the following behaviors that interfere with the completion of~~
230.35 ~~personal care assistant services under subdivision 2, paragraph (a):~~

230.36 ~~(A) unusual or repetitive habits;~~

~~(B) withdrawn behavior; or~~

~~(C) offensive behavior.~~

~~(8) A recipient with a home care rating of Level II behavior in paragraph (7), clauses (A) to (C), shall be rated as comparable to a recipient with complex medical needs under paragraph (4). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under paragraph (1), clause (B).~~

EFFECTIVE DATE. The amendments to paragraphs (a) and (b) are effective January 1, 2010.

Sec. 29. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to read:

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be ~~equal to the greater of either~~ established based on:

(1) ~~the annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12-month period~~ assessed personal care assistance units, not to exceed the maximum number of personal care assistance units available, as determined by section 256B.0655; ~~or~~ and

(2) ~~the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.~~ the personal care assistance unit rate:

(i) with a reduction to the unit rate to pay for a program administrator as defined in subdivision 10; and

(ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for the state.

Sec. 30. Minnesota Statutes 2008, section 256B.0657, is amended by adding a subdivision to read:

Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports option is available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of 1,000 people in the first fiscal year of implementation and an additional 1,000 people in the second fiscal year. The commissioner shall evaluate the self-directed supports option during the first two years of implementation and make any necessary changes prior to the option becoming available statewide.

232.1 Sec. 31. [256B.0659] PERSONAL CARE ASSISTANCE PROGRAM.

232.2 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
232.3 paragraphs (b) to (p) have the meanings given unless otherwise provided in text.

232.4 (b) "Activities of daily living" means grooming, dressing, bathing, transferring,
232.5 mobility, positioning, eating, and toileting.

232.6 (c) "Behavior," effective January 1, 2010, means a category to determine the home
232.7 care rating and is based on the criteria found in this section. "Level I behavior" means
232.8 physical aggression towards self, others, or destruction of property that requires the
232.9 immediate response of another person.

232.10 (d) "Complex health-related needs," effective January 1, 2010, means a category to
232.11 determine the home care rating and is based on the criteria found in this section.

232.12 (e) "Critical activities of daily living," effective January 1, 2010, means transferring,
232.13 mobility, eating, and toileting.

232.14 (f) "Dependency in activities of daily living" means a person requires assistance to
232.15 begin and complete one or more of the activities of daily living.

232.16 (g) "Health-related procedures and tasks" means procedures and tasks that can
232.17 be delegated or assigned by a licensed health care professional under state law to be
232.18 performed by a personal care assistant.

232.19 (h) "Instrumental activities of daily living" means activities to include meal planning
232.20 and preparation; basic assistance with paying bills; shopping for food, clothing, and
232.21 other essential items; performing household tasks integral to the personal care assistance
232.22 services; communication by telephone and other media; and traveling, including to
232.23 medical appointments and to participate in the community.

232.24 (i) "Managing employee" has the same definition as Code of Federal Regulations,
232.25 title 42, section 455.

232.26 (j) "Qualified professional" means a professional providing supervision of personal
232.27 care assistance services and staff as defined in section 256B.0625, subdivision 19c.

232.28 (k) "Personal care assistance provider agency" means a medical assistance enrolled
232.29 provider that provides or assists with providing personal care assistance services and
232.30 includes personal care assistance provider organizations, personal care assistance choice
232.31 agency, class A licensed nursing agency, and Medicare-certified home health agency.

232.32 (l) "Personal care assistant" or "PCA" means an individual employed by a personal
232.33 care assistance agency who provides personal care assistance services.

232.34 (m) "Personal care assistance care plan" means a written description of personal
232.35 care assistance services developed by the personal care assistance provider according
232.36 to the service plan.

233.1 (n) "Responsible party" means an individual who is capable of providing the support
233.2 necessary to assist the recipient to live in the community.
233.3 (o) "Self-administered medication" means medication taken orally, by injection or
233.4 insertion, or applied topically without the need for assistance.
233.5 (p) "Service plan" means a written summary of the assessment and description of the
233.6 services needed by the recipient.

233.7 Subd. 2. **Personal care assistance services; covered services.** (a) The personal
233.8 care assistance services eligible for payment include services and supports furnished
233.9 to an individual, as needed, to assist in:
233.10 (1) activities of daily living;
233.11 (2) health-related procedures and tasks;
233.12 (3) observation and redirection of behaviors; and
233.13 (4) instrumental activities of daily living.
233.14 (b) Activities of daily living include the following covered services:
233.15 (1) dressing, including assistance with choosing, application, and changing of
233.16 clothing and application of special appliances, wraps, or clothing;
233.17 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
233.18 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
233.19 except for recipients who are diabetic or have poor circulation;
233.20 (3) bathing, including assistance with basic personal hygiene and skin care;
233.21 (4) eating, including assistance with hand washing and application of orthotics
233.22 required for eating, transfers, and feeding;
233.23 (5) transfers, including assistance with transferring the recipient from one seating or
233.24 reclining area to another;
233.25 (6) mobility, including assistance with ambulation, including use of a wheelchair.
233.26 Mobility does not include providing transportation for a recipient;
233.27 (7) positioning, including assistance with positioning or turning a recipient for
233.28 necessary care and comfort; and
233.29 (8) toileting, including assistance with helping recipient with bowel or bladder
233.30 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
233.31 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
233.32 adjusting clothing.
233.33 (c) Health-related procedures and tasks include the following covered services:
233.34 (1) range of motion and passive exercise to maintain a recipient's strength and
233.35 muscle functioning;

234.1 (2) assistance with self-administered medication as defined by this section, including
234.2 reminders to take medication, bringing medication to the recipient, and assistance with
234.3 opening medication under the direction of the recipient or responsible party;

234.4 (3) interventions for seizure disorders, including monitoring and observation; and

234.5 (4) other activities considered within the scope of the personal care service and
234.6 meeting the definition of health-related procedures and tasks under this section.

234.7 (d) A personal care assistant may provide health-related procedures and tasks
234.8 associated with the complex health-related needs of a recipient if the procedures and
234.9 tasks meet the definition of health-related procedures and tasks under this section and the
234.10 personal care assistant is trained by a qualified professional and demonstrates competency
234.11 to safely complete the procedures and tasks. Delegation of health-related procedures and
234.12 tasks and all training must be documented in the personal care assistance care plan and the
234.13 recipient's and personal care assistant's files.

234.14 (e) Effective January 1, 2010, for a personal care assistant to provide the
234.15 health-related procedures and tasks of tracheostomy suctioning and services to recipients
234.16 on ventilator support there must be:

234.17 (1) delegation and training by a registered nurse, certified or licensed respiratory
234.18 therapist, or a physician;

234.19 (2) utilization of clean rather than sterile procedure;

234.20 (3) specialized training about the health-related procedures and tasks and equipment,
234.21 including ventilator operation and maintenance;

234.22 (4) individualized training regarding the needs of the recipient; and

234.23 (5) supervision by a qualified professional who is a registered nurse.

234.24 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
234.25 recipient for episodes where there is a need for redirection due to behaviors. Training of
234.26 the personal care assistant must occur based on the needs of the recipient, the personal
234.27 care assistance care plan, and any other support services provided.

234.28 (g) Instrumental activities of daily living under subdivision 1, paragraph (h).

234.29 Subd. 3. **Noncovered personal care assistance services.** (a) Personal care
234.30 assistance services are not eligible for medical assistance payment under this section
234.31 when provided:

234.32 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
234.33 guardian, licensed foster provider, except as allowed under section 256B.0651, subdivision
234.34 9a, or responsible party;

234.35 (2) in lieu of other staffing options in a residential or child care setting;

234.36 (3) solely as a child care or babysitting service; or

235.1 (4) without authorization by the commissioner or the commissioner's designee.

235.2 (b) The following personal care services are not eligible for medical assistance
235.3 payment under this section when provided in residential settings:

235.4 (1) effective January 1, 2010, when the provider of home care services who is not
235.5 related by blood, marriage, or adoption owns or otherwise controls the living arrangement,
235.6 including licensed or unlicensed services; or

235.7 (2) when personal care assistance services are the responsibility of a residential or
235.8 program license holder under the terms of a service agreement and administrative rules.

235.9 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible
235.10 for medical assistance reimbursement for personal care assistance services under this
235.11 section include:

235.12 (1) sterile procedures;

235.13 (2) injections of fluids and medications into veins, muscles, or skin;

235.14 (3) home maintenance or chore services;

235.15 (4) homemaker services not an integral part of assessed personal care assistance
235.16 services needed by a recipient;

235.17 (5) application of restraints or implementation of procedures under section 245.825;

235.18 (6) instrumental activities of daily living for children under the age of 18; and

235.19 (7) assessments for personal care assistance services by personal care assistance
235.20 provider agencies or by independently enrolled registered nurses.

235.21 Subd. 4. **Assessment for personal care assistance services.** (a) An assessment
235.22 as defined in section 256B.0655, subdivision 1b, must be completed for personal care
235.23 assistance services.

235.24 (b) The following limitations apply to the assessment:

235.25 (1) a person must be assessed as dependent in an activity of daily living based
235.26 on the person's need, on a daily basis, for:

235.27 (i) cueing and constant supervision to complete the task; or

235.28 (ii) hands-on assistance to complete the task; and

235.29 (2) a child may not be found to be dependent in an activity of daily living if because
235.30 of the child's age an adult would either perform the activity for the child or assist the child
235.31 with the activity. Assistance needed is the assistance appropriate for a typical child of
235.32 the same age.

235.33 (c) Assessment for complex health-related needs must meet the criteria in this
235.34 paragraph. During the assessment process, a recipient qualifies as having complex
235.35 health-related needs if the recipient has one or more of the interventions that are ordered by
235.36 a physician, specified in a personal care assistance care plan, and found in the following:

236.1 (1) tube feedings requiring:
236.2 (i) a gastro/jejunostomy tube; or
236.3 (ii) continuous tube feeding lasting longer than 12 hours per day;
236.4 (2) wounds described as:
236.5 (i) stage III or stage IV;
236.6 (ii) multiple wounds;
236.7 (iii) requiring sterile or clean dressing changes or a wound vac; or
236.8 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
236.9 specialized care;
236.10 (3) parenteral therapy described as:
236.11 (i) IV therapy more than two times per week lasting longer than four hours for
236.12 each treatment; or
236.13 (ii) total parenteral nutrition (TPN) daily;
236.14 (4) respiratory interventions including:
236.15 (i) oxygen required more than eight hours per day;
236.16 (ii) respiratory vest more than one time per day;
236.17 (iii) bronchial drainage treatments more than two times per day;
236.18 (iv) sterile or clean suctioning more than six times per day;
236.19 (v) dependence on another to apply respiratory ventilation augmentation devises
236.20 such as BiPAP and CPAP; and
236.21 (vi) ventilator dependence under section 256B.0652;
236.22 (5) insertion and maintenance of catheter including:
236.23 (i) sterile catheter changes more than one time per month;
236.24 (ii) clean self-catheterization more than six times per day; or
236.25 (iii) bladder irrigations;
236.26 (6) bowel program more than two times per week requiring more than 30 minutes to
236.27 perform each time;
236.28 (7) neurological intervention including:
236.29 (i) seizures more than two times per week and requiring significant physical
236.30 assistance to maintain safety; or
236.31 (ii) swallowing disorders diagnosed by a physician and requiring specialized
236.32 assistance from another on a daily basis; and
236.33 (8) other congenital or acquired diseases creating a need for significantly increased
236.34 direct hands-on assistance and interventions in six to eight activities of daily living.

237.1 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
237.2 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
237.3 assistance at least four times per week and shows one or more of the following behaviors:
237.4 (1) physical aggression towards self or others, or destruction of property that requires
237.5 the immediate response of another person;
237.6 (2) increased vulnerability due to cognitive deficits or socially inappropriate
237.7 behavior; or
237.8 (3) verbally aggressive and resistive to care.

237.9 Subd. 5. **Service, support planning, and referral.** (a) The assessor, with the
237.10 recipient or responsible party, shall review the assessment information and determine
237.11 referrals for other payers, services, and community supports as appropriate.
237.12 (b) The recipient must be referred for evaluation, services, or supports that are
237.13 appropriate to help meet the recipient's needs including, but not limited to, the following
237.14 circumstances:
237.15 (1) when there is another payer who is responsible to provide the service to meet
237.16 the recipient's needs;
237.17 (2) when the recipient qualifies for assistance due to mental illness or behaviors
237.18 under this section, a referral for a mental health diagnostic and functional assessment
237.19 must be completed, or referral must be made for other specific mental health services or
237.20 other community services;
237.21 (3) when the recipient is eligible for medical assistance and meets medical assistance
237.22 eligibility for a home health aide or skilled nurse visit;
237.23 (4) when the recipient would benefit from an evaluation for another service; and
237.24 (5) when there is a more appropriate service to meet the assessed needs.
237.25 (c) The reimbursement rates for public health nurse visits that relate to the provision
237.26 of personal care assistance services under this section and section 256B.0625, subdivision
237.27 19a, are:
237.28 (1) $210.50 for a face-to-face assessment visit;
237.29 (2) $105.25 for each service update; and
237.30 (3) $105.25 for each request for a temporary service increase.
237.31 (d) The rates specified in paragraph (c) must be adjusted to reflect provider rate
237.32 increases for personal care assistance services that are approved by the legislature for the
237.33 fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied
237.34 by the legislature to provider rate increases for personal care assistance services also
237.35 apply to adjustments under this paragraph.

238.1 (e) Effective July 1, 2008, the payment rate for an assessment under this section and
238.2 section 256B.0651 shall be reduced by 25 percent when the assessment is not completed
238.3 on time and the service agreement documentation is not submitted in time to continue
238.4 services. The commissioner shall reduce the amount of the claim for those assessments
238.5 that are not submitted on time.

238.6 Subd. 6. **Service plan.** The service plan must be completed by the assessor with the
238.7 recipient and responsible party on a form determined by the commissioner and include
238.8 a summary of the assessment with a description of the need, authorized amount, and
238.9 expected outcomes and goals of personal care assistance services. The recipient and
238.10 the provider chosen by the recipient or responsible party must be given a copy of the
238.11 completed service plan within ten working days of the assessment. The recipient or
238.12 responsible party must be given information by the assessor about the options in the
238.13 personal care assistance program to allow for review and decision making.

238.14 Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a
238.15 current personal care assistance care plan based on the service plan in subdivision 6 that is
238.16 developed by the qualified professional with the recipient and responsible party. A copy of
238.17 the most current personal care assistance care plan is required to be in the recipient's home
238.18 and in the recipient's file at the provider agency.

238.19 (b) The personal care assistance care plan must have the following components:

238.20 (1) start and end date of the care plan;

238.21 (2) recipient demographic information, including name and telephone number;

238.22 (3) emergency numbers, procedures, and a description of measures to address
238.23 identified safety and vulnerability issues, including a backup staffing plan;

238.24 (4) name of responsible party and instructions for contact;

238.25 (5) description of the recipient's individualized needs for assistance with activities of
238.26 daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

238.27 (6) dated signatures of recipient or responsible party and qualified professional.

238.28 (c) The personal care assistance care plan must have instructions and comments
238.29 about the recipient's needs for assistance and any special instructions or procedures
238.30 required. The month-to-month plan for the use of personal care assistance services is part
238.31 of the personal care assistance care plan. The personal care assistance care plan must
238.32 be completed within the first week after start of services with a personal care provider
238.33 agency and must be updated as needed when there is a change in need for personal care
238.34 assistance services. A new personal care assistance care plan is required annually at the
238.35 time of the reassessment.

239.1 Subd. 8. **Communication with recipient's physician.** The personal care assistance
239.2 program requires communication with the recipient's physician about a recipient's assessed
239.3 needs for personal care assistance services. The commissioner shall work with the state
239.4 medical director to develop options for communication with the recipient's physician.

239.5 Subd. 9. **Responsible party; generally.** (a) "Responsible party," effective January
239.6 1, 2010, means an individual who is capable of providing the support necessary to assist
239.7 the recipient to live in the community.

239.8 (b) A responsible party must be 18 years of age, actively participate in planning and
239.9 directing of personal care assistance services, and attend all assessments for the recipient.

239.10 (c) A responsible party must not be the:

239.11 (1) personal care assistant;

239.12 (2) home care provider agency owner or staff; or

239.13 (3) county staff acting as part of employment.

239.14 (d) A licensed family foster parent who lives with the recipient may be the
239.15 responsible party as long as the family foster parent meets the other responsible party
239.16 requirements.

239.17 (e) A responsible party is required when:

239.18 (1) the person is a minor according to section 524.5-102, subdivision 10;

239.19 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
239.20 6, resulting in a court-appointed guardian; or

239.21 (3) the assessment according to section 256B.0655, subdivision 1b, determines that
239.22 the recipient is in need of a responsible party to direct the recipient's care.

239.23 (f) There may be two persons designated as the responsible party for reasons such
239.24 as divided households and court-ordered custodies. Each person named as responsible
239.25 party must meet the program criteria and responsibilities.

239.26 (g) The recipient or the recipient's legal representative shall appoint a responsible
239.27 party if necessary to direct and supervise the care provided to the recipient. The
239.28 responsible party must be identified at the time of assessment and listed on the recipient's
239.29 service agreement and personal care assistance care plan.

239.30 Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall
239.31 enter into a written agreement with a personal care assistance provider agency, on a form
239.32 determined by the commissioner, to perform the following duties:

239.33 (1) be available while care is provided in a method agreed upon by the individual
239.34 or the individual's legal representative and documented in the recipient's personal care
239.35 assistance care plan;

240.1 (2) monitor personal care assistance services to ensure the recipient's personal care
240.2 assistance care plan is being followed; and
240.3 (3) review and sign personal care assistance time sheets after services are provided
240.4 to provide verification of the personal care assistance services.
240.5 Failure to provide the support required by the recipient must result in a referral to the
240.6 county common entry point.
240.7 (b) Responsible parties who are parents of minors or guardians of minors or
240.8 incapacitated persons may delegate the responsibility to another adult who is not the
240.9 personal care assistant during a temporary absence of at least 24 hours but not more
240.10 than six months. The person delegated as a responsible party must be able to meet the
240.11 definition of the responsible party, except that the delegated responsible party is required
240.12 to reside with the recipient only while serving as the responsible party. The responsible
240.13 party must ensure that the delegate performs the functions of the responsible party, is
240.14 identified at the time of the assessment, and is listed on the personal care assistance
240.15 care plan. The responsible party must communicate to the personal care assistance
240.16 provider agency about the need for a delegate responsible party, including the name of the
240.17 delegated responsible party, dates the delegated responsible party will be living with the
240.18 recipient, and contact numbers.
240.19 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
240.20 must meet the following requirements:
240.21 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
240.22 of age with these additional requirements:
240.23 (i) supervision by a qualified professional every 60 days; and
240.24 (ii) employment by only one personal care assistance provider agency responsible
240.25 for compliance with current labor laws;
240.26 (2) be employed by a personal care assistance provider agency;
240.27 (3) enroll with the department as a personal care assistant after clearing a background
240.28 study. Before a personal care assistant provides services, the personal care assistance
240.29 provider agency must initiate a background study on the personal care assistant under
240.30 chapter 245C, and the personal care assistance provider agency must have received a
240.31 notice from the commissioner that the personal care assistant is:
240.32 (i) not disqualified under section 245C.14; or
240.33 (ii) is disqualified, but the personal care assistant has received a set aside of the
240.34 disqualification under section 245C.22;
240.35 (4) be able to effectively communicate with the recipient and personal care
240.36 assistance provider agency;

241.1 (5) be able to provide covered personal care assistance services according to the
241.2 recipient's personal care assistance care plan, respond appropriately to recipient needs,
241.3 and report changes in the recipient's condition to the supervising qualified professional
241.4 or physician;
241.5 (6) not be a consumer of personal care assistance services;
241.6 (7) maintain daily written records including, but not limited to, time sheets under
241.7 subdivision 12;
241.8 (8) effective January 1, 2010, complete standardized training as determined by the
241.9 commissioner before completing enrollment. Personal care assistant training must include
241.10 successful completion of the following training components: basic first aid, vulnerable
241.11 adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of
241.12 personal care assistants including information about assistance with lifting and transfers
241.13 for recipients, emergency preparedness, orientation to positive behavioral practices, fraud
241.14 issues, and completion of time sheets. Upon completion of the training components,
241.15 the personal care assistant must demonstrate the competency to provide assistance to
241.16 recipients;
241.17 (9) complete training and orientation on the needs of the recipient within the first
241.18 seven days after the services begin; and
241.19 (10) be limited to providing and being paid for up to 310 hours per month of personal
241.20 care assistance services regardless of the number of recipients being served or the number
241.21 of personal care assistance provider agencies enrolled with.
241.22 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
241.23 for the guardian services and meets the criteria for personal care assistants in paragraph (a).
241.24 (c) Effective January 1, 2010, persons who do not qualify as a personal care assistant
241.25 include parents and stepparents of minors, spouses, paid legal guardians, family foster
241.26 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or
241.27 staff of a residential setting.

241.28 Subd. 12. **Documentation of personal care assistance services provided.** (a)
241.29 Personal care assistance services for a recipient must be documented daily by each personal
241.30 care assistant, on a time sheet form approved by the commissioner. All documentation
241.31 may be Web-based, electronic, or paper documentation. The completed form must be
241.32 submitted on a monthly basis to the provider and kept in the recipient's health record.
241.33 (b) The activity documentation must correspond to the personal care assistance care
241.34 plan and be reviewed by the qualified professional.

242.1 (c) The personal care assistant time sheet must be on a form approved by the
242.2 commissioner documenting time the personal care assistant provides services in the home.
242.3 The following criteria must be included in the time sheet:

242.4 (1) full name of personal care assistant and individual provider number;

242.5 (2) provider name and telephone numbers;

242.6 (3) full name of recipient;

242.7 (4) consecutive dates, including month, day, and year, and arrival and departure
242.8 time with a.m. or p.m. notations;

242.9 (5) signatures of recipient or the responsible party;

242.10 (6) personal signature of the personal care assistant;

242.11 (7) any shared care provided, if applicable;

242.12 (8) a statement that it is a federal crime to provide false information on personal
242.13 care service billings for medical assistance payments; and

242.14 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

242.15 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional
242.16 must be employed by a personal care assistance provider agency and meet the definition
242.17 under section 256B.0625, subdivision 19c. Before a qualified professional provides
242.18 services, the personal care assistance provider agency must initiate a background study on
242.19 the qualified professional under chapter 245C, and the personal care assistance provider
242.20 agency must have received a notice from the commissioner that the qualified professional:

242.21 (1) is not disqualified under section 245C.14; or

242.22 (2) is disqualified, but the qualified professional has received a set aside of the
242.23 disqualification under section 245C.22.

242.24 (b) The qualified professional shall perform the duties of training, supervision, and
242.25 evaluation of the personal care assistance staff and evaluation of the effectiveness of
242.26 personal care assistance services. The qualified professional shall:

242.27 (1) develop and monitor with the recipient a personal care assistance care plan based
242.28 on the service plan and individualized needs of the recipient;

242.29 (2) develop and monitor with the recipient a monthly plan for the use of personal
242.30 care assistance services;

242.31 (3) review documentation of personal care assistance services provided;

242.32 (4) provide training and ensure competency for the personal care assistant in the
242.33 individual needs of the recipient; and

242.34 (5) document all training, communication, evaluations, and needed actions to
242.35 improve performance of the personal care assistants.

243.1 (c) The qualified professional shall complete the provider training with basic
243.2 information about the personal care assistance program approved by the commissioner
243.3 within six months of the date hired by a personal care assistance provider agency.
243.4 Qualified professionals who have completed the required trainings as an employee with a
243.5 personal care assistance provider agency do not need to repeat the required trainings if they
243.6 are hired by another agency, if they have completed the training within the last three years.

243.7 Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal
243.8 care assistants must be supervised by a qualified professional.
243.9 (b) Through direct training, observation, return demonstrations, and consultation
243.10 with the staff and the recipient, the qualified professional must ensure and document
243.11 that the personal care assistant is:
243.12 (1) capable of providing the required personal care assistance services;
243.13 (2) knowledgeable about the plan of personal care assistance services before services
243.14 are performed; and
243.15 (3) able to identify conditions that should be immediately brought to the attention of
243.16 the qualified professional.
243.17 (c) The qualified professional shall evaluate the personal care assistant within the
243.18 first 14 days of starting to provide services for a recipient except for the personal care
243.19 assistance choice option under subdivision 19, paragraph (a), clause (4). The qualified
243.20 professional shall evaluate the personal care assistance services for a recipient through
243.21 direct observation of a personal care assistant's work:
243.22 (1) at least every 90 days thereafter for the first year of a recipient's services; and
243.23 (2) every 120 days after the first year of a recipient's service or whenever needed for
243.24 response to a recipient's request for increased supervision of the personal care assistance
243.25 staff.
243.26 (d) Communication with the recipient is a part of the evaluation process of the
243.27 personal care assistance staff.
243.28 (e) At each supervisory visit, the qualified professional shall evaluate personal care
243.29 assistance services including the following information:
243.30 (1) satisfaction level of the recipient with personal care assistance services;
243.31 (2) review of the month-to-month plan for use of personal care assistance services;
243.32 (3) review of documentation of personal care assistance services provided;
243.33 (4) whether the personal care assistance services are meeting the goals of the service
243.34 as stated in the personal care assistance care plan and service plan;
243.35 (5) a written record of the results of the evaluation and actions taken to correct any
243.36 deficiencies in the work of a personal care assistant; and

244.1 (6) revision of the personal care assistance care plan as necessary in consultation
244.2 with the recipient or responsible party, to meet the needs of the recipient.
244.3 (f) The qualified professional shall complete the required documentation in the
244.4 agency recipient and employee files and the recipient's home, including the following
244.5 documentation:
244.6 (1) the personal care assistance care plan based on the service plan and individualized
244.7 needs of the recipient;
244.8 (2) a month-to-month plan for use of personal care assistance services;
244.9 (3) changes in need of the recipient requiring a change to the level of service and the
244.10 personal care assistance care plan;
244.11 (4) evaluation results of supervision visits and identified issues with personal care
244.12 assistance staff with actions taken;
244.13 (5) all communication with the recipient and personal care assistance staff; and
244.14 (6) hands-on training or individualized training for the care of the recipient.
244.15 (g) The documentation in paragraph (f) must be done on agency forms.
244.16 (h) The services that are not eligible for payment as qualified professional services
244.17 include:
244.18 (1) direct professional nursing tasks that could be assessed and authorized as skilled
244.19 nursing tasks;
244.20 (2) supervision of personal care assistance completed by telephone;
244.21 (3) agency administrative activities;
244.22 (4) training other than the individualized training required to provide care for a
244.23 recipient; and
244.24 (5) any other activity that is not described in this section.
244.25 Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized
244.26 hours of personal care assistance services, which vary within a service authorization
244.27 period covering no more than six months, in order to more effectively meet the needs and
244.28 schedule of the recipient. Each 12-month service agreement is divided into two six-month
244.29 authorization date spans. No more than 75 percent of the total authorized units for a
244.30 12-month service agreement may be used in a six-month date span.
244.31 (b) Authorization of flexible use occurs during the authorization process under
244.32 section 256B.0652. The flexible use of authorized hours does not increase the total
244.33 amount of authorized hours available to a recipient. The commissioner shall not authorize
244.34 additional personal care assistance services to supplement a service authorization that
244.35 is exhausted before the end date under a flexible service use plan, unless the assessor
244.36 determines a change in condition and a need for increased services is established.

245.1 Authorized hours not used within the six-month period must not be carried over to another
245.2 time period.

245.3 (c) A recipient who has terminated personal care assistance services before the end
245.4 of the 12-month authorization period must not receive additional hours upon reapplying
245.5 during the same 12-month authorization period, except if a change in condition is
245.6 documented. Services must be prorated for the remainder of the 12-month authorization
245.7 period based on the first six-month assessment.

245.8 (d) The recipient, responsible party, and qualified professional must develop a
245.9 written month-to-month plan of the projected use of personal care assistance services that
245.10 is part of the personal care assistance care plan and ensures:

245.11 (1) that the health and safety needs of the recipient are met throughout both date
245.12 spans of the authorization period; and

245.13 (2) that the total authorized amount of personal care assistance services for each date
245.14 span must not be used before the end of each date span in the authorization period.

245.15 (e) The personal care assistance provider agency shall monitor the use of personal
245.16 care assistance services to ensure health and safety needs of the recipient are met
245.17 throughout both date spans of the authorization period. The commissioner or the
245.18 commissioner's designee shall provide written notice to the provider and the recipient or
245.19 responsible party when a recipient is at risk of exceeding the personal care assistance
245.20 services prior to the end of the six-month period.

245.21 (f) Misuse and abuse of the flexible use of personal care assistance services resulting
245.22 in the overuse of units in a manner where the recipient will not have enough units to meet
245.23 their needs for assistance and ensure health and safety for the entire six-month date span
245.24 may lead to an action by the commissioner. The commissioner may take action including,
245.25 but not limited to: (1) restricting recipients to service authorizations of no more than one
245.26 month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring
245.27 a qualified professional to monitor and report services on a monthly basis.

245.28 Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal
245.29 care assistance services are limited according to this subdivision.

245.30 (b) Shared service is the provision of personal care assistance services by a personal
245.31 care assistant to two or three recipients, eligible for medical assistance, who voluntarily
245.32 enter into an agreement to receive services at the same time and in the same setting.

245.33 (c) For the purposes of this subdivision, "setting" means:

245.34 (1) the home residence or family foster care home of one or more of the individual
245.35 recipients; or

246.1 (2) a child care program licensed under chapter 245A or operated by a local school
246.2 district or private school.
246.3 (d) Shared personal care assistance services follow the same criteria for covered
246.4 services as subdivision 2.
246.5 (e) Noncovered shared personal care assistance services include the following:
246.6 (1) services for more than three recipients by one personal care assistant at one time;
246.7 (2) staff requirements for child care programs under chapter 245C;
246.8 (3) caring for multiple recipients in more than one setting;
246.9 (4) additional units of personal care assistance based on the selection of the option;
246.10 and
246.11 (5) use of more than one personal care assistance provider agency for the shared
246.12 care services.
246.13 (f) The option of shared personal care assistance is elected by the recipient or the
246.14 responsible party with the assistance of the assessor. The option must be determined
246.15 appropriate based on the ages of the recipients, compatibility, and coordination of their
246.16 assessed care needs. The recipient or the responsible party, in conjunction with the
246.17 qualified professional, shall arrange the setting and grouping of shared services based
246.18 on the individual needs and preferences of the recipients. The personal care assistance
246.19 provider agency shall offer the recipient or the responsible party the option of shared or
246.20 one-on-one personal care assistance services or a combination of both. The recipient or
246.21 the responsible party may withdraw from participating in a shared services arrangement at
246.22 any time.
246.23 (g) Authorization for the shared service option must be determined by the
246.24 commissioner based on the criteria that the shared service is appropriate to meet all of the
246.25 recipients' needs and their health and safety is maintained. The authorization of shared
246.26 services is part of the overall authorization of personal care assistance services. Nothing
246.27 in this subdivision must be construed to reduce the total number of hours authorized for
246.28 an individual recipient.
246.29 (h) A personal care assistant providing shared personal care assistance services must:
246.30 (1) receive training specific for each recipient served; and
246.31 (2) follow all required documentation requirements for time and services provided.
246.32 (i) A qualified professional shall:
246.33 (1) evaluate the ability of the personal care assistant to provide services for all of
246.34 the recipients in a shared setting;

247.1 (2) visit the shared setting as services are being provided at least once every six
247.2 months or whenever needed for response to a recipient's request for increased supervision
247.3 of the personal care assistance staff;
247.4 (3) provide ongoing monitoring and evaluation of the effectiveness and
247.5 appropriateness of the shared services;
247.6 (4) develop a contingency plan with each of the recipients which accounts for
247.7 absence of the recipient in a share services setting due to illness or other circumstances;
247.8 (5) obtain permission from each of the recipients who are sharing a personal care
247.9 assistant for number of shared hours for services provided inside and outside the home
247.10 residence; and
247.11 (6) document the training completed by the personal care assistants specific to the
247.12 shared setting and recipients sharing services.

247.13 Subd. 17. **Shared services; rates.** The commissioner shall provide a rate system for
247.14 shared personal care assistance services. For two persons sharing services, the rate paid
247.15 to a provider must not exceed one and one-half times the rate paid for serving a single
247.16 individual, and for three persons sharing services, the rate paid to a provider must not
247.17 exceed twice the rate paid for serving a single individual. These rates apply only when all
247.18 of the criteria for the shared care personal care assistance service have been met.

247.19 Subd. 18. **Personal care assistance choice option; generally.** (a) The
247.20 commissioner may allow a recipient of personal care assistance services to use a fiscal
247.21 intermediary to assist the recipient in paying and accounting for medically necessary
247.22 covered personal care assistance services. Unless otherwise provided in this section, all
247.23 other statutory and regulatory provisions relating to personal care assistance services apply
247.24 to a recipient using the personal care assistance choice option.
247.25 (b) Personal care assistance choice is an option of the personal care assistance
247.26 program that allows the recipient who receives personal care assistance services to be
247.27 responsible for the hiring, training, scheduling, and firing of personal care assistants. This
247.28 program offers greater control and choice for the recipient in who provides the personal
247.29 care assistance service and when the service is scheduled. The recipient or the recipient's
247.30 responsible party must choose a personal care assistance choice provider agency as
247.31 a fiscal intermediary. This personal care assistance choice provider agency manages
247.32 payroll, invoices the state, is responsible for all payroll related taxes and insurance, and is
247.33 responsible for providing the consumer training and support in managing the recipient's
247.34 personal care assistance services.

248.1 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)
248.2 Under personal care assistance choice, the recipient or responsible party shall:
248.3 (1) recruit, hire, schedule, and terminate personal care assistants and a qualified
248.4 professional;
248.5 (2) develop a personal care assistance care plan based on the assessed needs
248.6 and addressing the health and safety of the recipient with the assistance of a qualified
248.7 professional as needed;
248.8 (3) orient and train the personal care assistant with assistance as needed from the
248.9 qualified professional;
248.10 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with
248.11 the qualified professional, who is required to visit the recipient at least every 180 days;
248.12 (5) monitor and verify in writing and report to the personal care assistance choice
248.13 agency the number of hours worked by the personal care assistant and the qualified
248.14 professional;
248.15 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
248.16 and service authorization; and
248.17 (7) use the same personal care assistance choice provider agency if shared personal
248.18 assistance care is being used.
248.19 (b) The personal care assistance choice provider agency shall:
248.20 (1) meet all personal care assistance provider agency standards;
248.21 (2) enter into a written agreement with the recipient, responsible party, and personal
248.22 care assistants;
248.23 (3) not be related as a parent, child, sibling, or spouse to the recipient, qualified
248.24 professional, or the personal care assistant; and
248.25 (4) ensure arm's-length transactions without undue influence or coercion with the
248.26 recipient and personal care assistant.
248.27 (c) The duties of the personal care assistance choice provider agency are to:
248.28 (1) be the employer of the personal care assistant and the qualified professional for
248.29 employment law and related regulations including, but not limited to, purchasing and
248.30 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
248.31 and liability insurance, and submit any or all necessary documentation including, but not
248.32 limited to, workers' compensation and unemployment insurance;
248.33 (2) bill the medical assistance program for personal care assistance services and
248.34 qualified professional services;
248.35 (3) request and complete background studies that comply with the requirements for
248.36 personal care assistants and qualified professionals;

249.1 (4) pay the personal care assistant and qualified professional based on actual hours
249.2 of services provided;
249.3 (5) withhold and pay all applicable federal and state taxes;
249.4 (6) verify and keep records of hours worked by the personal care assistant and
249.5 qualified professional;
249.6 (7) make the arrangements and pay taxes and other benefits, if any; and comply with
249.7 any legal requirements for a Minnesota employer;
249.8 (8) enroll in the medical assistance program as a personal care assistance choice
249.9 agency; and
249.10 (9) enter into a written agreement as specified in subdivision 20 before services
249.11 are provided.

249.12 Subd. 20. **Personal care assistance choice option; administration.** (a) Before
249.13 services commence under the personal care assistance choice option, and annually
249.14 thereafter, the personal care assistance choice provider agency, recipient, or responsible
249.15 party, each personal care assistant, and the qualified professional shall enter into a written
249.16 agreement. The agreement must include at a minimum:
249.17 (1) duties of the recipient, qualified professional, personal care assistant, and
249.18 personal care assistance choice provider agency;
249.19 (2) salary and benefits for the personal care assistant and the qualified professional;
249.20 (3) administrative fee of the personal care assistance choice provider agency and
249.21 services paid for with that fee, including background study fees;
249.22 (4) grievance procedures to respond to complaints;
249.23 (5) procedures for hiring and terminating the personal care assistant; and
249.24 (6) documentation requirements including, but not limited to, time sheets, activity
249.25 records, and the personal care assistance care plan.
249.26 (b) Effective January 1, 2010, except for the administrative fee of the personal care
249.27 assistance choice provider agency as reported on the written agreement, the remainder
249.28 of the rates paid to the personal care assistance choice provider agency must be used to
249.29 pay for the salary and benefits for the personal care assistant or the qualified professional.
249.30 The provider agency must use a minimum of 72.5 percent of the revenue generated by
249.31 the medical assistance rate for personal care assistance services for employee personal
249.32 care assistant wages and benefits.
249.33 (c) The commissioner shall deny, revoke, or suspend the authorization to use the
249.34 personal care assistance choice option if:
249.35 (1) it has been determined by the qualified professional or public health nurse that
249.36 the use of this option jeopardizes the recipient's health and safety;

250.1 (2) the parties have failed to comply with the written agreement specified in this
250.2 subdivision;
250.3 (3) the use of the option has led to abusive or fraudulent billing for personal care
250.4 assistance services; or
250.5 (4) the department terminates the personal care assistance choice option.
250.6 (d) The recipient or responsible party may appeal the commissioner's decision in
250.7 paragraph (c) according to section 256.045. The denial, revocation, or suspension to
250.8 use the personal care assistance choice option must not affect the recipient's authorized
250.9 level of personal care assistance services.

250.10 Subd. 21. **Requirements for initial enrollment of personal care assistance**
250.11 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
250.12 time of enrollment as a personal care assistance provider agency in a format determined
250.13 by the commissioner, information and documentation that includes, but is not limited to,
250.14 the following:
250.15 (1) the personal care assistance provider agency's current contact information
250.16 including address, telephone number, and e-mail address;
250.17 (2) proof of surety bond coverage in the amount of $50,000 or ten percent of the
250.18 provider's payments from Medicaid in the previous year, whichever is less;
250.19 (3) proof of fidelity bond coverage in the amount of $20,000;
250.20 (4) proof of workers' compensation insurance coverage;
250.21 (5) a description of the personal care assistance provider agency's organization
250.22 identifying the names of all owners, managing employees, staff, board of directors, and
250.23 the affiliations of the directors, owners, or staff to other service providers;
250.24 (6) a copy of the personal care assistance provider agency's written policies and
250.25 procedures including: hiring of employees; training requirements; service delivery;
250.26 and employee and consumer safety including process for notification and resolution
250.27 of consumer grievances, identification and prevention of communicable diseases, and
250.28 employee misconduct;
250.29 (7) copies of all other forms the personal care assistance provider agency uses in
250.30 the course of daily business including, but not limited to:
250.31 (i) a copy of the personal care assistance provider agency's time sheet if the time
250.32 sheet varies from the standard time sheet for personal care assistance services approved
250.33 by the commissioner, and a letter requesting approval of the personal care assistance
250.34 provider agency's nonstandard time sheet;
250.35 (ii) the personal care assistance provider agency's template for the personal care
250.36 assistance care plan; and

251.1 (iii) the personal care assistance provider agency's template and the written
251.2 agreement in subdivision 20 for recipients using the personal care assistance choice
251.3 option, if applicable;
251.4 (8) a list of all trainings and classes that the personal care assistance provider agency
251.5 requires of its staff providing personal care assistance services;
251.6 (9) documentation that the personal care assistance provider agency and staff have
251.7 successfully completed all the training required by this section;
251.8 (10) documentation of the agency's marketing practices;
251.9 (11) disclosure of ownership, leasing, or management of all residential properties
251.10 that is used or could be used for providing home care services; and
251.11 (12) documentation that the agency will use the following percentages of revenue
251.12 generated from the medical assistance rate paid for personal care assistance services
251.13 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
251.14 personal care assistance choice option and 72.5 percent of revenue from other personal
251.15 care assistance providers.
251.16 (b) Personal care assistance provider agencies shall provide the information specified
251.17 in paragraph (a) to the commissioner at the time the personal care assistance provider
251.18 agency enrolls as a vendor or upon request from the commissioner. The commissioner
251.19 shall collect the information specified in paragraph (a) from all personal care assistance
251.20 providers beginning upon enactment of this section.
251.21 (c) All personal care assistance provider agencies shall complete mandatory training
251.22 as determined by the commissioner before enrollment as a provider. Personal care
251.23 assistance provider agencies are required to send all owners, qualified professionals
251.24 employed by the agency, and all other managing employees to the initial and subsequent
251.25 trainings. Personal care assistance provider agency billing staff shall complete training
251.26 about personal care assistance program financial management. This training is effective
251.27 upon enactment of this section. Any personal care assistance provider agency enrolled
251.28 before that date shall, if it has not already, complete the provider training within 18 months
251.29 of the effective date of this section. Any new owners, new qualified professionals, and new
251.30 managing employees are required to complete mandatory training as a requisite of hiring.
251.31 Subd. 22. **Annual review for personal care providers.** (a) All personal care
251.32 assistance provider agencies shall resubmit, on an annual basis, the information specified
251.33 in subdivision 21, in a format determined by the commissioner, and provide a copy of the
251.34 personal care assistance provider agency's most current version of its grievance policies
251.35 and procedures along with a written record of grievances and resolutions of the grievances

252.1 that the personal care assistance provider agency has received in the previous year and any
252.2 other information requested by the commissioner.

252.3 (b) The commissioner shall send annual review notification to personal care
252.4 assistance provider agencies 30 days prior to renewal. The notification must:

252.5 (1) list the materials and information the personal care assistance provider agency is
252.6 required to submit;

252.7 (2) provide instructions on submitting information to the commissioner; and

252.8 (3) provide a due date by which the commissioner must receive the requested
252.9 information.

252.10 Personal care assistance provider agencies shall submit required documentation for
252.11 annual review within 30 days of notification from the commissioner. If no documentation
252.12 is submitted, the personal care assistance provider agency enrollment number must be
252.13 terminated or suspended.

252.14 (c) Personal care assistance provider agencies also currently licensed under
252.15 Minnesota Rules, part 4668.0012, as a class A provider or currently certified for
252.16 participation in Medicare as a home health agency are deemed in compliance with
252.17 the personal care assistance requirements for enrollment, annual review process, and
252.18 documentation.

252.19 Subd. 23. **Enrollment requirements following termination.** (a) A terminated
252.20 personal care assistance provider agency, including all named individuals on the current
252.21 enrollment disclosure form and known or discovered affiliates of the personal care
252.22 assistance provider agency, is not eligible to enroll as a personal care assistance provider
252.23 agency for two years following the termination.

252.24 (b) After the two-year period in paragraph (a), if the provider seeks to reenroll
252.25 as a personal care assistance provider agency, the personal care assistance provider
252.26 agency must be placed on a one-year probation period, beginning after completion of
252.27 the following:

252.28 (1) the department's provider trainings under this section; and

252.29 (2) initial enrollment requirements under subdivision 21.

252.30 (c) During the probationary period the commissioner shall complete site visits and
252.31 request submission of documentation to review compliance with program policy.

252.32 Subd. 24. **Personal care assistance provider agency; general duties.** A personal
252.33 care assistance provider agency shall:

252.34 (1) enroll as a Medicaid provider meeting all provider standards, including
252.35 completion of the required provider training;

252.36 (2) comply with general medical assistance coverage requirements;

253.1 (3) demonstrate compliance with law and policies of the personal care assistance
253.2 program to be determined by the commissioner;
253.3 (4) comply with background study requirements;
253.4 (5) verify and keep records of hours worked by the personal care assistant and
253.5 qualified professional;
253.6 (6) market agency services only through printed information in brochures and on
253.7 Web sites and not engage in any agency-initiated direct contact or marketing in person, by
253.8 phone, or other electronic means to potential recipients, guardians, or family members;
253.9 (7) pay the personal care assistant and qualified professional based on actual hours
253.10 of services provided;
253.11 (8) withhold and pay all applicable federal and state taxes;
253.12 (9) effective January 1, 2010, document that the agency uses a minimum of 72.5
253.13 percent of the revenue generated by the medical assistance rate for personal care assistance
253.14 services for employee personal care assistant wages and benefits;
253.15 (10) make the arrangements and pay unemployment insurance, taxes, workers'
253.16 compensation, liability insurance, and other benefits, if any;
253.17 (11) enter into a written agreement under subdivision 20 before services are provided;
253.18 (12) report suspected neglect and abuse to the common entry point according to
253.19 section 256B.0651;
253.20 (13) provide the recipient with a copy of the home care bill of rights at start of
253.21 service; and
253.22 (14) request reassessments at least 60 days prior to the end of the current
253.23 authorization for personal care assistance services, on forms provided by the commissioner.

253.24 Subd. 25. **Personal care assistance provider agency; background studies.**
253.25 Personal care assistance provider agencies enrolled to provide personal care assistance
253.26 services under the medical assistance program shall comply with the following:
253.27 (1) owners who have a five percent interest or more and all managing employees
253.28 are subject to a background study as provided in chapter 245C. This applies to currently
253.29 enrolled personal care assistance provider agencies and those agencies seeking enrollment
253.30 as a personal care assistance provider agency. Managing employee has the same meaning
253.31 as Code of Federal Regulations, title 42, section 455. An organization is barred from
253.32 enrollment if:
253.33 (i) the organization has not initiated background studies on owners and managing
253.34 employees; or
253.35 (ii) the organization has initiated background studies on owners and managing
253.36 employees, but the commissioner has sent the organization a notice that an owner or

254.1 managing employee of the organization has been disqualified under section 245C.14,
254.2 and the owner or managing employee has not received a set aside of the disqualification
254.3 under section 245C.22;

254.4 (2) a background study must be initiated and completed for all qualified
254.5 professionals; and

254.6 (3) a background study must be initiated and completed for all personal care
254.7 assistants.

254.8 Subd. 26. **Personal care assistance provider agency; communicable disease**
254.9 **prevention.** A personal care assistance provider agency shall establish and implement
254.10 policies and procedures for prevention, control, and investigation of infections and
254.11 communicable diseases according to current nationally recognized infection control
254.12 practices or guidelines established by the United States Centers for Disease Control and
254.13 Prevention, as well as applicable regulations of other federal or state agencies.

254.14 Subd. 27. **Personal care assistance provider agency; ventilator training.** The
254.15 personal care assistance provider agency is required to provide training for the personal
254.16 care assistant responsible for working with a recipient who is ventilator dependent. All
254.17 training must be administered by a respiratory therapist, nurse, or physician. Qualified
254.18 professional supervision by a nurse must be completed and documented on file in the
254.19 personal care assistant's employment record and the recipient's health record. If offering
254.20 personal care services to a ventilator-dependent recipient, the personal care assistance
254.21 provider agency shall demonstrate the ability to:

254.22 (1) train the personal care assistant;

254.23 (2) supervise the personal care assistant in ventilator operation and maintenance; and

254.24 (3) supervise the recipient and responsible party in ventilator operation and
254.25 maintenance.

254.26 Subd. 28. **Personal care assistance provider agency; required documentation.**
254.27 Required documentation must be completed and kept in the personal care assistance
254.28 provider agency file or the recipient's home residence. The required documentation
254.29 consists of:

254.30 (1) employee files, including:

254.31 (i) applications for employment;

254.32 (ii) background study requests and results;

254.33 (iii) orientation records about the agency policies;

254.34 (iv) trainings completed with demonstration of competence;

254.35 (v) supervisory visits;

255.1 (vi) evaluations of employment; and

255.2 (vii) signature on fraud statement;

255.3 (2) recipient files, including:

255.4 (i) demographics;

255.5 (ii) emergency contact information and emergency backup plan;

255.6 (iii) personal care assistance service plan;

255.7 (iv) personal care assistance care plan;

255.8 (v) month-to-month service use plan;

255.9 (vi) all communication records;

255.10 (vii) start of service information, including the written agreement with recipient; and

255.11 (viii) date the home care bill of rights was given to the recipient;

255.12 (3) agency policy manual, including:

255.13 (i) policies for employment and termination;

255.14 (ii) grievance policies with resolution of consumer grievances;

255.15 (iii) staff and consumer safety;

255.16 (iv) staff misconduct; and

255.17 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
255.18 resolution of consumer grievances;

255.19 (4) time sheets for each personal care assistant along with completed activity sheets
255.20 for each recipient served; and

255.21 (5) agency marketing and advertising materials and documentation of marketing
255.22 activities and costs.

255.23 Subd. 29. **Transitional assistance.** The commissioner, counties, health plans,
255.24 tribes, and personal care assistance providers shall work together to provide transitional
255.25 assistance for recipients and families to come into compliance with the new requirements
255.26 of this section and ensure the personal care assistance services are not provided by the
255.27 housing provider.

255.28 Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

255.29 (1) by October 31, 2009, information to recipients likely to be affected that (i)
255.30 describes the changes to the personal care assistance program that may result in the
255.31 loss of access to personal care assistance services, and (ii) includes resources to obtain
255.32 further information; and

255.33 (2) notice of changes in medical assistance home care services to each affected
255.34 recipient at least 30 days before the effective date of the change.

255.35 The notice shall include how to get further information on the changes, how to get help to
255.36 obtain other services, a list of community resources, and appeal rights. Notwithstanding

256.1 section 256.045, a recipient may request continued services pending appeal within the
256.2 time period allowed to request an appeal.

256.3 **EFFECTIVE DATE.** Subdivisions 4, 22, and 27 are effective January 1, 2010.

256.4 Sec. 32. Minnesota Statutes 2008, section 256B.0911, subdivision 1, is amended to
256.5 read:

256.6 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation
256.7 services is to assist persons with long-term or chronic care needs in making long-term
256.8 care decisions and selecting options that meet their needs and reflect their preferences.
256.9 The availability of, and access to, information and other types of assistance, including
256.10 assessment and support planning, is also intended to prevent or delay certified nursing
256.11 facility placements and to provide transition assistance after admission. Further, the goal
256.12 of these services is to contain costs associated with unnecessary certified nursing facility
256.13 admissions. Long-term consultation services must be available to any person regardless
256.14 of public program eligibility. The ~~commissioners~~ commissioner of human services ~~and~~
256.15 ~~health~~ shall seek to maximize use of available federal and state funds and establish the
256.16 broadest program possible within the funding available.

256.17 (b) These services must be coordinated with ~~services~~ long-term care options
256.18 counseling provided under section 256.975, subdivision 7, and ~~with services provided by~~
256.19 ~~other public and private agencies in the community~~ section 256.01, subdivision 24, for
256.20 telephone assistance and follow up and to offer a variety of cost-effective alternatives to
256.21 persons with disabilities and elderly persons. The county or tribal agency or managed
256.22 care plan providing long-term care consultation services shall encourage the use of
256.23 volunteers from families, religious organizations, social clubs, and similar civic and
256.24 service organizations to provide community-based services.

256.25 Sec. 33. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, is amended to
256.26 read:

256.27 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
256.28 (a) "Long-term care consultation services" means:
256.29 (1) ~~providing information and education to the general public regarding availability~~
256.30 ~~of the services authorized under this section;~~
256.31 ~~(2) an intake process that provides access to the services described in this section;~~
256.32 ~~(3) assessment of the health, psychological, and social needs of referred individuals;~~
256.33 ~~(4)~~ assistance in identifying services needed to maintain an individual in the ~~least~~
256.34 ~~restrictive~~ most inclusive environment;

257.1 (5) (2) providing recommendations on cost-effective community services that are
257.2 available to the individual;

257.3 (6) (3) development of an individual's person-centered community support plan;

257.4 (7) (4) providing information regarding eligibility for Minnesota health care
257.5 programs;

257.6 (5) face-to-face long-term care consultation assessments, which may be completed
257.7 in a hospital, nursing facility, intermediate care facility for persons with developmental
257.8 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
257.9 residence;

257.10 (8) preadmission (6) federally mandated screening to determine the need for
257.11 a nursing facility institutional level of care under section 256B.0911, subdivision 4,
257.12 paragraph (a);

257.13 (9) preliminary (7) determination of Minnesota health care programs home and
257.14 community-based waiver service eligibility including level of care determination for
257.15 individuals who need a nursing facility an institutional level of care as defined under
257.16 section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan
257.17 home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs
257.18 (a) and (c), based on assessment and support plan development with appropriate referrals
257.19 for final determination;

257.20 (10) (8) providing recommendations for nursing facility placement when there are
257.21 no cost-effective community services available; and

257.22 (11) (9) assistance to transition people back to community settings after facility
257.23 admission.

257.24 (b) "Long-term options counseling" means the services provided by the linkage
257.25 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
257.26 telephone assistance and follow up once a long-term care consultation assessment has
257.27 been completed.

257.28 (b) (c) "Minnesota health care programs" means the medical assistance program
257.29 under chapter 256B and the alternative care program under section 256B.0913.

257.30 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
257.31 plans administering long-term care consultation assessment and support planning services.

257.32 **EFFECTIVE DATE.** This section is effective January 1, 2011.

257.33 Sec. 34. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
257.34 subdivision to read:

258.1 Subd. 2b. **Certified assessors.** (a) Beginning January 1, 2011, each lead agency
258.2 shall use certified assessors who have completed training and certification process
258.3 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
258.4 best practices in assessment and support planning including person-centered planning
258.5 principals and have a common set of skills that must ensure consistency and equitable
258.6 access to services statewide. Assessors must be part of a multidisciplinary team of
258.7 professionals that includes public health nurses, social workers, and other professionals
258.8 as defined in paragraph (b). For persons with complex health care needs, a public health
258.9 nurse or registered nurse from a multidisciplinary team must be consulted.

258.10 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
258.11 work, nursing with a public health nursing certificate, or other closely related field with at
258.12 least one year of home and community-based experience or a two-year registered nursing
258.13 degree with at least three years of home and community-based experience that have
258.14 received training and certification specific to assessment and consultation for long-term
258.15 care services in the state.

258.16 Sec. 35. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
258.17 subdivision to read:

258.18 Subd. 2c. **Assessor training and certification.** The commissioner shall develop a
258.19 curriculum and an assessor certification process to begin no later than January 1, 2010.
258.20 All existing lead agency staff designated to provide the services defined in subdivision
258.21 1a must be certified by December 30, 2010. Each lead agency is required to ensure that
258.22 they have sufficient numbers of certified assessors to provide long-term consultation
258.23 assessment and support planning within the timelines and parameters of the service by
258.24 January 1, 2011. Certified assessors are required to be recertified every three years.

258.25 Sec. 36. Minnesota Statutes 2008, section 256B.0911, subdivision 3, is amended to
258.26 read:

258.27 Subd. 3. **Long-term care consultation team.** (a) Until January 1, 2011, a long-term
258.28 care consultation team shall be established by the county board of commissioners. Each
258.29 local consultation team shall consist of at least one social worker and at least one public
258.30 health nurse from their respective county agencies. The board may designate public
258.31 health or social services as the lead agency for long-term care consultation services. If a
258.32 county does not have a public health nurse available, it may request approval from the
258.33 commissioner to assign a county registered nurse with at least one year experience in

home care to participate on the team. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

Sec. 37. Minnesota Statutes 2008, 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 ~~ten working~~ 15 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 ~~long-term care consultation team must assess the health and social needs of the person~~ 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 ~~team must conduct the~~ assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, ~~if applicable~~ 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

260.1 person necessary to develop a support plan that ensures the person's health and safety, but
260.2 who is not a provider of service or has any financial interest in the provision of services.
260.3 (e) The ~~team must provide the~~ person, or the person's legal representative, must
260.4 be provided with written recommendations for ~~facility- or~~ community-based services~~.~~
260.5 ~~The team must document~~ or institutional care that include documentation that the most
260.6 cost-effective alternatives available were offered to the individual. For purposes of
260.7 this requirement, "cost-effective alternatives" means community services and living
260.8 arrangements that cost the same as or less than ~~nursing facility~~ institutional care.
260.9 (f) If the person chooses to use community-based services, the ~~team must provide~~
260.10 ~~the~~ person or the person's legal representative must be provided with a written community
260.11 support plan, regardless of whether the individual is eligible for Minnesota health care
260.12 programs. ~~The~~ A person may request assistance in ~~developing a community support plan~~
260.13 identifying community supports without participating in a complete assessment. Upon
260.14 a request for assistance identifying community support, the person must be transferred
260.15 or referred to the services available under sections 256.975, subdivision 7, and 256.01,
260.16 subdivision 24, for telephone assistance and follow up.
260.17 (g) The person has the right to make the final decision between ~~nursing~~
260.18 ~~facility~~ institutional placement and community placement after the ~~screening team's~~
260.19 ~~recommendation~~ recommendations have been provided, except as provided in subdivision
260.20 4a, paragraph (c).
260.21 (h) The team must give the person receiving assessment or support planning, or
260.22 the person's legal representative, materials, and forms supplied by the commissioner
260.23 containing the following information:
260.24 (1) the need for and purpose of preadmission screening if the person selects nursing
260.25 facility placement;
260.26 (2) the role of the long-term care consultation assessment and support planning in
260.27 waiver and alternative care program eligibility determination;
260.28 (3) information about Minnesota health care programs;
260.29 (4) the person's freedom to accept or reject the recommendations of the team;
260.30 (5) the person's right to confidentiality under the Minnesota Government Data
260.31 Practices Act, chapter 13;
260.32 (6) the long-term care consultant's decision regarding the person's need for ~~nursing~~
260.33 ~~facility~~ institutional level of care as determined under criteria established in section
260.34 144.0724, subdivision 11, or 256B.092; and

261.1 (7) the person's right to appeal the decision regarding the need for nursing facility
261.2 level of care or the county's final decisions regarding public programs eligibility according
261.3 to section 256.045, subdivision 3.

261.4 (i) Face-to-face assessment completed as part of eligibility determination for
261.5 the alternative care, elderly waiver, community alternatives for disabled individuals,
261.6 community alternative care, and traumatic brain injury waiver programs under sections
261.7 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
261.8 than 60 calendar days after the date of assessment. The effective eligibility start date
261.9 for these programs can never be prior to the date of assessment. If an assessment was
261.10 completed more than 60 days before the effective waiver or alternative care program
261.11 eligibility start date, assessment and support plan information must be updated in a
261.12 face-to-face visit and documented in the department's Medicaid Management Information
261.13 System (MMIS). The effective date of program eligibility in this case cannot be prior to
261.14 the date the updated assessment is completed.

261.15 Sec. 38. Minnesota Statutes 2008, section 256B.0911, subdivision 3b, is amended to
261.16 read:

261.17 Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall
261.18 provide assistance to persons residing in a nursing facility, hospital, regional treatment
261.19 center, or intermediate care facility for persons with developmental disabilities who
261.20 request or are referred for assistance. Transition assistance must include assessment,
261.21 community support plan development, referrals to long-term care options counseling
261.22 under section 256B.975, subdivision 10, for community support plan implementation and
261.23 to Minnesota health care programs, and referrals to programs that provide assistance
261.24 with housing. Transition assistance must also include information about the Centers for
261.25 Independent Living and the Senior LinkAge Line, and about other organizations that
261.26 can provide assistance with relocation efforts, and information about contacting these
261.27 organizations to obtain their assistance and support.

261.28 (b) The county shall develop transition processes with institutional social workers
261.29 and discharge planners to ensure that:

261.30 (1) persons admitted to facilities receive information about transition assistance
261.31 that is available;

261.32 (2) the assessment is completed for persons within ten working days of the date of
261.33 request or recommendation for assessment; and

261.34 (3) there is a plan for transition and follow-up for the individual's return to the
261.35 community. The plan must require notification of other local agencies when a person

262.1 who may require assistance is screened by one county for admission to a facility located
262.2 in another county.

262.3 (c) If a person who is eligible for a Minnesota health care program is admitted to a
262.4 nursing facility, the nursing facility must include a consultation team member or the case
262.5 manager in the discharge planning process.

262.6 Sec. 39. Minnesota Statutes 2008, section 256B.0911, subdivision 3c, is amended to
262.7 read:

262.8 Subd. 3c. **Transition to housing with services.** (a) Housing with services
262.9 establishments offering or providing assisted living under chapter 144G shall inform
262.10 all prospective residents of the availability of and contact information for transitional
262.11 consultation services under this subdivision prior to executing a lease or contract with the
262.12 prospective resident. The purpose of transitional long-term care consultation is to support
262.13 persons with current or anticipated long-term care needs in making informed choices
262.14 among options that include the most cost-effective and least restrictive settings, and to
262.15 delay spenddown to eligibility for publicly funded programs by connecting people to
262.16 alternative services in their homes before transition to housing with services. Regardless
262.17 of the consultation, prospective residents maintain the right to choose housing with
262.18 services or assisted living if that option is their preference.

262.19 (b) Transitional consultation services are provided as determined by the
262.20 commissioner of human services in partnership with county long-term care consultation
262.21 units, and the Area Agencies on Aging, and are a combination of telephone-based
262.22 and in-person assistance provided under models developed by the commissioner. The
262.23 consultation shall be performed in a manner that provides objective and complete
262.24 information. Transitional consultation must be provided within five working days of the
262.25 request of the prospective resident as follows:

262.26 (1) the consultation must be provided by a qualified professional as determined by
262.27 the commissioner;

262.28 (2) the consultation must include a review of the prospective resident's reasons for
262.29 considering assisted living, the prospective resident's personal goals, a discussion of the
262.30 prospective resident's immediate and projected long-term care needs, and alternative
262.31 community services or assisted living settings that may meet the prospective resident's
262.32 needs; and

262.33 (3) the prospective resident shall be informed of the availability of long-term care
262.34 consultation services described in subdivision 3a that are available at no charge to the
262.35 prospective resident to assist the prospective resident in assessment and planning to meet

263.1 the prospective resident's long-term care needs. The Senior LinkAge Line and long-term
263.2 care consultation team shall give the highest priority to referrals who are at highest risk of
263.3 nursing facility placement or as needed for determining eligibility.

263.4 Sec. 40. Minnesota Statutes 2008, section 256B.0911, subdivision 4a, is amended to
263.5 read:

263.6 Subd. 4a. **Preadmission screening activities related to nursing facility**
263.7 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
263.8 boarding care facilities, must be screened prior to admission regardless of income, assets,
263.9 or funding sources for nursing facility care, except as described in subdivision 4b. The
263.10 purpose of the screening is to determine the need for nursing facility level of care as
263.11 described in paragraph (d) and to complete activities required under federal law related to
263.12 mental illness and developmental disability as outlined in paragraph (b).

263.13 (b) A person who has a diagnosis or possible diagnosis of mental illness or
263.14 developmental disability must receive a preadmission screening before admission
263.15 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need
263.16 for further evaluation and specialized services, unless the admission prior to screening is
263.17 authorized by the local mental health authority or the local developmental disabilities case
263.18 manager, or unless authorized by the county agency according to Public Law 101-508.

263.19 The following criteria apply to the preadmission screening:

263.20 (1) the county must use forms and criteria developed by the commissioner to identify
263.21 persons who require referral for further evaluation and determination of the need for
263.22 specialized services; and

263.23 (2) the evaluation and determination of the need for specialized services must be
263.24 done by:

263.25 (i) a qualified independent mental health professional, for persons with a primary or
263.26 secondary diagnosis of a serious mental illness; or

263.27 (ii) a qualified developmental disability professional, for persons with a primary or
263.28 secondary diagnosis of developmental disability. For purposes of this requirement, a
263.29 qualified developmental disability professional must meet the standards for a qualified
263.30 developmental disability professional under Code of Federal Regulations, title 42, section
263.31 483.430.

263.32 (c) The local county mental health authority or the state developmental disability
263.33 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
263.34 nursing facility if the individual does not meet the nursing facility level of care criteria or
263.35 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For

264.1 purposes of this section, "specialized services" for a person with developmental disability
264.2 means active treatment as that term is defined under Code of Federal Regulations, title
264.3 42, section 483.440 (a)(1).

264.4 (d) The determination of the need for nursing facility level of care must be made
264.5 according to criteria <u>established in section 144.0724, subdivision 11, and 256B.092,</u>
264.6 <u>using forms</u> developed by the commissioner. In assessing a person's needs, consultation
264.7 team members shall have a physician available for consultation and shall consider the
264.8 assessment of the individual's attending physician, if any. The individual's physician must
264.9 be included if the physician chooses to participate. Other personnel may be included on
264.10 the team as deemed appropriate by the county.

264.11 <u>**EFFECTIVE DATE.**</u> <u>The section is effective January 1, 2011.</u>

264.12 Sec. 41. Minnesota Statutes 2008, section 256B.0911, subdivision 5, is amended to
264.13 read:

264.14 Subd. 5. **Administrative activity.** The commissioner shall ~~minimize the number~~
264.15 ~~of forms required in the provision of long-term care consultation services and shall~~
264.16 ~~limit the screening document to items necessary for community support plan approval,~~
264.17 ~~reimbursement, program planning, evaluation, and policy development~~ <u>streamline the</u>
264.18 <u>processes, including timelines for when assessments need to be completed, required to</u>
264.19 <u>provide the services in this section and shall implement integrated solutions to automate</u>
264.20 <u>the business processes to the extent necessary for community support plan approval,</u>
264.21 <u>reimbursement, program planning, evaluation, and policy development</u>.

264.22 Sec. 42. Minnesota Statutes 2008, section 256B.0911, subdivision 6, is amended to
264.23 read:

264.24 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
264.25 for each county must be paid monthly by certified nursing facilities in the county. The
264.26 monthly amount to be paid by each nursing facility for each fiscal year must be determined
264.27 by dividing the county's annual allocation for long-term care consultation services by 12
264.28 to determine the monthly payment and allocating the monthly payment to each nursing
264.29 facility based on the number of licensed beds in the nursing facility. Payments to counties
264.30 in which there is no certified nursing facility must be made by increasing the payment
264.31 rate of the two facilities located nearest to the county seat.

264.32 (b) The commissioner shall include the total annual payment determined under
264.33 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
264.34 according to section 256B.431, subdivision 2b, paragraph (g).

265.1 (c) In the event of the layaway, delicensure and decertification, or removal from
265.2 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
265.3 the per diem payment amount in paragraph (b) and may adjust the monthly payment
265.4 amount in paragraph (a). The effective date of an adjustment made under this paragraph
265.5 shall be on or after the first day of the month following the effective date of the layaway,
265.6 delicensure and decertification, or removal from layaway.

265.7 (d) Payments for long-term care consultation services are available to the county
265.8 or counties to cover staff salaries and expenses to provide the services described in
265.9 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
265.10 the limits of available funding, sufficient personnel to provide long-term care consultation
265.11 services while meeting the state's long-term care outcomes and objectives as defined in
265.12 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
265.13 objectives as approved by the commissioner in the biennial home and community-based
265.14 services quality assurance plan on a form provided by the commissioner.

265.15 (e) Notwithstanding section 256B.0641, overpayments attributable to payment of the
265.16 screening costs under the medical assistance program may not be recovered from a facility.

265.17 (f) The commissioner of human services shall amend the Minnesota medical
265.18 assistance plan to include reimbursement for the local consultation teams.

265.19 (g) The county may bill, as case management services, assessments, support
265.20 planning, and follow-along provided to persons determined to be eligible for case
265.21 management under Minnesota health care programs. No individual or family member
265.22 shall be charged for an initial assessment or initial support plan development provided
265.23 under subdivision 3a or 3b.

265.24 (h) The commissioner shall develop an alternative payment methodology for
265.25 long-term care consultation services that includes the funding available under this
265.26 subdivision, and sections 256B.092 and 256B.0659. In developing the new payment
265.27 methodology, the commissioner shall consider the maximization of federal funding for
265.28 this activity.

265.29 Sec. 43. Minnesota Statutes 2008, section 256B.0911, subdivision 7, is amended to
265.30 read:

265.31 Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance
265.32 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
265.33 only if a preadmission screening has been conducted prior to admission or the county has
265.34 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
265.35 not be provided for any recipient who the local screener has determined does not meet the

266.1 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,
266.2 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
266.3 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
266.4 mental illness is approved by the local mental health authority or an admission for a
266.5 recipient with developmental disability is approved by the state developmental disability
266.6 authority.

266.7 (b) The nursing facility must not bill a person who is not a medical assistance
266.8 recipient for resident days that preceded the date of completion of screening activities as
266.9 required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed
266.10 resident days in the nursing facility resident day totals reported to the commissioner.

266.11 **EFFECTIVE DATE.** The section is effective January 1, 2011.

266.12 Sec. 44. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to
266.13 read:

266.14 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**
266.15 (a) Funding for services under the alternative care program is available to persons who
266.16 meet the following criteria:

266.17 (1) the person has been determined by a community assessment under section
266.18 256B.0911 to be a person who would require the level of care provided in a nursing
266.19 facility, but for the provision of services under the alternative care program. Effective
266.20 January 1, 2011, this determination must be made according to the criteria established in
266.21 section 144.0724, subdivision 11;

266.22 (2) the person is age 65 or older;

266.23 (3) the person would be eligible for medical assistance within 135 days of admission
266.24 to a nursing facility;

266.25 (4) the person is not ineligible for the payment of long-term care services by the
266.26 medical assistance program due to an asset transfer penalty under section 256B.0595 or
266.27 equity interest in the home exceeding $500,000 as stated in section 256B.056;

266.28 (5) the person needs long-term care services that are not funded through other state
266.29 or federal funding;

266.30 (6) except for individuals described in clause (7), the monthly cost of the alternative
266.31 care services funded by the program for this person does not exceed 75 percent of the
266.32 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
266.33 does not prohibit the alternative care client from payment for additional services, but in no
266.34 case may the cost of additional services purchased under this section exceed the difference
266.35 between the client's monthly service limit defined under section 256B.0915, subdivision

267.1 3, and the alternative care program monthly service limit defined in this paragraph. If
267.2 care-related supplies and equipment or environmental modifications and adaptations are or
267.3 will be purchased for an alternative care services recipient, the costs may be prorated on a
267.4 monthly basis for up to 12 consecutive months beginning with the month of purchase.
267.5 If the monthly cost of a recipient's other alternative care services exceeds the monthly
267.6 limit established in this paragraph, the annual cost of the alternative care services shall be
267.7 determined. In this event, the annual cost of alternative care services shall not exceed 12
267.8 times the monthly limit described in this paragraph; ~~and~~

267.9 (7) for individuals assigned a case mix classification A as described under section
267.10 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
267.11 living, (ii) only one dependency in bathing, dressing, grooming, or walking, or (iii) a
267.12 dependency score of less than three if eating is the only dependency as determined by an
267.13 assessment performed under section 256B.0911, the monthly cost of alternative care
267.14 services funded by the program cannot exceed $600 per month for all new participants
267.15 enrolled in the program on or after July 1, 2009. This monthly limit shall be applied to
267.16 all other participants who meet this criteria at reassessment. This monthly limit shall be
267.17 increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This
267.18 monthly limit does not prohibit the alternative care client from payment for additional
267.19 services, but in no case may the cost of additional services purchased exceed the difference
267.20 between the client's monthly service limit defined in this clause and the limit described in
267.21 clause (6) for case mix classification A; and

267.22 (8) the person is making timely payments of the assessed monthly fee.
267.23 A person is ineligible if payment of the fee is over 60 days past due, unless the person
267.24 agrees to:

267.25 (i) the appointment of a representative payee;

267.26 (ii) automatic payment from a financial account;

267.27 (iii) the establishment of greater family involvement in the financial management of
267.28 payments; or

267.29 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

267.30 The lead agency may extend the client's eligibility as necessary while making
267.31 arrangements to facilitate payment of past-due amounts and future premium payments.
267.32 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
267.33 reinstated for a period of 30 days.

267.34 (b) Alternative care funding under this subdivision is not available for a person
267.35 who is a medical assistance recipient or who would be eligible for medical assistance
267.36 without a spenddown or waiver obligation. A person whose initial application for medical

268.1 assistance and the elderly waiver program is being processed may be served under the
268.2 alternative care program for a period up to 60 days. If the individual is found to be eligible
268.3 for medical assistance, medical assistance must be billed for services payable under the
268.4 federally approved elderly waiver plan and delivered from the date the individual was
268.5 found eligible for the federally approved elderly waiver plan. Notwithstanding this
268.6 provision, alternative care funds may not be used to pay for any service the cost of which:
268.7 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
268.8 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
268.9 to participate in the federally approved elderly waiver program under the special income
268.10 standard provision.

268.11 (c) Alternative care funding is not available for a person who resides in a licensed
268.12 nursing home, certified boarding care home, hospital, or intermediate care facility, except
268.13 for case management services which are provided in support of the discharge planning
268.14 process for a nursing home resident or certified boarding care home resident to assist with
268.15 a relocation process to a community-based setting.

268.16 (d) Alternative care funding is not available for a person whose income is greater
268.17 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
268.18 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
268.19 year for which alternative care eligibility is determined, who would be eligible for the
268.20 elderly waiver with a waiver obligation.

268.21 Sec. 45. Minnesota Statutes 2008, section 256B.0915, subdivision 3a, is amended to
268.22 read:

268.23 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
268.24 waivered services to an individual elderly waiver client except for individuals described
268.25 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
268.26 mix resident class to which the elderly waiver client would be assigned under Minnesota
268.27 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
268.28 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
268.29 which the resident assessment system as described in section 256B.438 for nursing home
268.30 rate determination is implemented. Effective on the first day of the state fiscal year in
268.31 which the resident assessment system as described in section 256B.438 for nursing home
268.32 rate determination is implemented and the first day of each subsequent state fiscal year, the
268.33 monthly limit for the cost of waivered services to an individual elderly waiver client shall
268.34 be the rate of the case mix resident class to which the waiver client would be assigned
268.35 under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the

269.1 previous state fiscal year, adjusted by the greater of any legislatively adopted home and
269.2 community-based services percentage rate increase or the average statewide percentage
269.3 increase in nursing facility payment rates.

269.4 (b) The monthly limit for the cost of waivered services to an individual elderly
269.5 waiver client assigned to a case mix classification A under paragraph (a) with (1) no
269.6 dependencies in activities of daily living, (2) only one dependency in bathing, dressing,
269.7 grooming, or walking, or (3) a dependency score of less than three if eating is the only
269.8 dependency, shall be the lower of the case mix classification amount for case mix A as
269.9 determined under paragraph (a) or the case mix classification amount for case mix A
269.10 effective on October 1, 2008, per month for all new participants enrolled in the program
269.11 on or after July 1, 2009. This monthly limit shall be applied to all other participants who
269.12 meet this criteria at reassessment.

269.13 (c) If extended medical supplies and equipment or environmental modifications are
269.14 or will be purchased for an elderly waiver client, the costs may be prorated for up to
269.15 12 consecutive months beginning with the month of purchase. If the monthly cost of a
269.16 recipient's waivered services exceeds the monthly limit established in paragraph (a) or (b),
269.17 the annual cost of all waivered services shall be determined. In this event, the annual cost
269.18 of all waivered services shall not exceed 12 times the monthly limit of waivered services
269.19 as described in paragraph (a) or (b).

269.20 Sec. 46. Minnesota Statutes 2008, section 256B.0915, subdivision 3e, is amended to
269.21 read:

269.22 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
269.23 services shall be a monthly rate ~~negotiated and~~ authorized by the lead agency within the
269.24 parameters established by the commissioner. The payment agreement must delineate the
269.25 ~~services that have been customized for each recipient and specify the~~ amount of each
269.26 component service included in the recipient's customized living service ~~to be provided~~
269.27 plan. The lead agency shall ensure that there is a documented need ~~for all~~ within the
269.28 parameters established by the commissioner for all component customized living services
269.29 authorized. ~~Customized living services must not include rent or raw food costs.~~

269.30 (b) The ~~negotiated~~ payment rate must be based on the amount of component services
269.31 to be provided utilizing component rates established by the commissioner. Counties and
269.32 tribes shall use tools issued by the commissioner to develop and document customized
269.33 living service plans and rates.

270.1 ~~Negotiated~~ (c) Component service rates must not exceed payment rates for
270.2 comparable elderly waiver or medical assistance services and must reflect economies of
270.3 scale. Customized living services must not include rent or raw food costs.

270.4 ~~(b)~~ (d) The individualized monthly ~~negotiated~~ authorized payment for the
270.5 customized living ~~services~~ service plan shall not exceed ~~the nonfederal share, in effect~~
270.6 ~~on July 1 of the state fiscal year for which the rate limit is being calculated,~~ 50 percent
270.7 of the greater of either the statewide or any of the geographic groups' weighted average
270.8 monthly nursing facility rate of the case mix resident class to which the elderly waiver
270.9 eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
270.10 less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until
270.11 the July 1 of the state fiscal year in which the resident assessment system as described
270.12 in section 256B.438 for nursing home rate determination is implemented. Effective on
270.13 July 1 of the state fiscal year in which the resident assessment system as described in
270.14 section 256B.438 for nursing home rate determination is implemented and July 1 of each
270.15 subsequent state fiscal year, the individualized monthly ~~negotiated~~ authorized payment
270.16 for the services described in this clause shall not exceed the limit ~~described in this clause~~
270.17 which was in effect on June 30 of the previous state fiscal year ~~and which has been~~
270.18 ~~adjusted by the greater of any legislatively adopted home and community-based services~~
270.19 ~~cost-of-living percentage increase or any legislatively adopted statewide percent rate~~
270.20 ~~increase for nursing facilities~~ updated annually based on legislatively adopted changes to
270.21 all service rate maximums for home and community-based service providers.

270.22 ~~(c)~~ (e) Customized living services are delivered by a provider licensed by the
270.23 Department of Health as a class A or class F home care provider and provided in a
270.24 building that is registered as a housing with services establishment under chapter 144D.

270.25 Sec. 47. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to
270.26 read:

270.27 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
270.28 payment ~~rates~~ rate for 24-hour customized living services is a monthly rate ~~negotiated~~
270.29 ~~and~~ authorized by the lead agency within the parameters established by the commissioner
270.30 of human services. The payment agreement must delineate the ~~services that have been~~
270.31 ~~customized for each recipient and specify the~~ amount of each component service included
270.32 in each recipient's customized living service ~~to be provided~~ plan. The lead agency
270.33 shall ensure that there is a documented need within the parameters established by the
270.34 commissioner for all component customized living services authorized. The lead agency

271.1 shall not authorize 24-hour customized living services unless there is a documented need
271.2 for 24-hour supervision.

271.3 (b) For purposes of this section, "24-hour supervision" means that the recipient
271.4 requires assistance due to needs related to one or more of the following:

271.5 (1) intermittent assistance with toileting, positioning, or transferring;

271.6 (2) cognitive or behavioral issues;

271.7 (3) a medical condition that requires clinical monitoring; or

271.8 (4) ~~other conditions or needs as defined by the commissioner of human services~~ for
271.9 all new participants enrolled in the program on or after January 1, 2011, and all other
271.10 participants at their first reassessment after January 1, 2011, dependency in at least two
271.11 of the following activities of daily living as determined by assessment under section
271.12 256B.0911: bathing; dressing; grooming; walking; or eating; and needs medication
271.13 management and at least 50 hours of service per month. The lead agency shall ensure that
271.14 the frequency and mode of supervision of the recipient and the qualifications of staff
271.15 providing supervision are described and meet the needs of the recipient. ~~Customized~~
271.16 ~~living services must not include rent or raw food costs.~~

271.17 (c) The ~~negotiated~~ payment rate for 24-hour customized living services must be
271.18 based on the amount of component services to be provided utilizing component rates
271.19 established by the commissioner. Counties and tribes will use tools issued by the
271.20 commissioner to develop and document customized living plans and authorize rates.

271.21 ~~Negotiated~~ (d) Component service rates must not exceed payment rates for
271.22 comparable elderly waiver or medical assistance services and must reflect economies
271.23 of scale.

271.24 (e) The individually ~~negotiated~~ authorized 24-hour customized living payments,
271.25 in combination with the payment for other elderly waiver services, including case
271.26 management, must not exceed the recipient's community budget cap specified in
271.27 subdivision 3a. Customized living services must not include rent or raw food costs.

271.28 (f) The individually authorized 24-hour customized living payment rates shall not
271.29 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
271.30 living services in effect and in the Medicaid management information systems on March
271.31 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
271.32 to 9549.0059, to which elderly waiver service clients are assigned. When there are
271.33 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
271.34 shall multiply the calculated service payment rate maximum for the A classification by
271.35 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
271.36 9549.0059, to determine the applicable payment rate maximum. Service payment rate

272.1 maximums shall be updated annually based on legislatively adopted changes to all service
272.2 rates for home and community-based service providers.

272.3 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
272.4 may establish alternative payment rate systems for 24-hour customized living services in
272.5 housing with services establishments which are freestanding buildings with a capacity of
272.6 16 or fewer, by applying a single hourly rate for covered component services provided
272.7 in either:

272.8 (1) licensed corporate adult foster homes; or

272.9 (2) specialized dementia care units which meet the requirements of section 144D.065
272.10 and in which:

272.11 (i) each resident is offered the option of having their own apartment; or

272.12 (ii) the units are licensed as board and lodge establishments with maximum capacity
272.13 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
272.14 subparts 1, 2, 3, and 4, item A.

272.15 Sec. 48. Minnesota Statutes 2008, section 256B.0915, subdivision 5, is amended to
272.16 read:

272.17 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
272.18 shall receive an initial assessment of strengths, informal supports, and need for services
272.19 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
272.20 client served under the elderly waiver must be conducted at least every 12 months and at
272.21 other times when the case manager determines that there has been significant change in
272.22 the client's functioning. This may include instances where the client is discharged from
272.23 the hospital. There must be a determination that the client requires nursing facility level of
272.24 care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments
272.25 to initiate and maintain participation in the waiver program.

272.26 (b) Regardless of other assessments identified in section 144.0724, subdivision
272.27 4, as appropriate to determine nursing facility level of care for purposes of medical
272.28 assistance payment for nursing facility services, only face-to-face assessments conducted
272.29 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
272.30 level of care determination will be accepted for purposes of initial and ongoing access to
272.31 waiver service payment.

272.32 **EFFECTIVE DATE.** This section is effective January 1, 2011.

272.33 Sec. 49. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
272.34 subdivision to read:

273.1 <u>Subd. 10.</u> <u>**Waiver payment rates; managed care organizations.**</u> <u>The</u>
273.2 <u>commissioner shall adjust the elderly waiver capitation payment rates for managed care</u>
273.3 <u>organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum</u>
273.4 <u>service rate limits for customized living services and 24-hour customized living services</u>
273.5 <u>under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical</u>
273.6 <u>assistance rates paid to customized living providers by managed care organizations</u>
273.7 <u>under this section shall not exceed the maximum service rate limits determined by the</u>
273.8 <u>commissioner under subdivisions 3e and 3h.</u>

273.9 Sec. 50. Minnesota Statutes 2008, section 256B.0916, subdivision 2, is amended to
273.10 read:

273.11 Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000,
273.12 the commissioner shall distribute all funding available for home and community-based
273.13 waiver services for persons with developmental disabilities to individual counties or to
273.14 groups of counties that form partnerships to jointly plan, administer, and authorize funding
273.15 for eligible individuals. The commissioner shall encourage counties to form partnerships
273.16 that have a sufficient number of recipients and funding to adequately manage the risk
273.17 and maximize use of available resources.
273.18 (b) Counties must submit a request for funds and a plan for administering the
273.19 program as required by the commissioner. The plan must identify the number of clients to
273.20 be served, their ages, and their priority listing based on:
273.21 (1) requirements in Minnesota Rules, part 9525.1880;<u> and</u>
273.22 (2) ~~unstable living situations due to the age or incapacity of the primary caregiver;~~
273.23 <u>statewide priorities identified in section 256B.092, subdivision 12.</u>
273.24 ~~(3) the need for services to avoid out-of-home placement of children;~~
273.25 ~~(4) the need to serve persons affected by private sector ICF/MR closures; and~~
273.26 ~~(5) the need to serve persons whose consumer support grant exception amount~~
273.27 ~~was eliminated in 2004.~~
273.28 The plan must also identify changes made to improve services to eligible persons and to
273.29 improve program management.
273.30 (c) In allocating resources to counties, priority must be given to groups of counties
273.31 that form partnerships to jointly plan, administer, and authorize funding for eligible
273.32 individuals and to counties determined by the commissioner to have sufficient waiver
273.33 capacity to maximize resource use.

274.1 (d) Within 30 days after receiving the county request for funds and plans, the
274.2 commissioner shall provide a written response to the plan that includes the level of
274.3 resources available to serve additional persons.

274.4 (e) Counties are eligible to receive medical assistance administrative reimbursement
274.5 for administrative costs under criteria established by the commissioner.

274.6 Sec. 51. Minnesota Statutes 2008, section 256B.0917, is amended by adding a
274.7 subdivision to read:

274.8 Subd. 14. **Essential community supports grants.** (a) The purpose of the essential
274.9 community supports grant program is to provide targeted services to persons 65 years and
274.10 older who need essential community support, but whose needs do not meet the level of
274.11 care required for nursing facility placement under section 144.0724, subdivision 11.

274.12 (b) Within the limits of the appropriation and not to exceed $400 per person per
274.13 month, funding must be available to a person who:

274.14 (1) is age 65 or older;

274.15 (2) is not eligible for medical assistance;

274.16 (3) would otherwise be financially eligible for the alternative care program under
274.17 section 256B.0913, subdivision 4;

274.18 (4) has received a community assessment under section 256B.0911, subdivision 3a
274.19 or 3b, and does not require the level of care provided in a nursing facility;

274.20 (5) has a community support plan; and

274.21 (6) has been determined by a community assessment under section 256B.0911,
274.22 subdivision 3a or 3b, to be a person who would require provision of at least one of the
274.23 following services, as defined in the approved elderly waiver plan, in order to maintain
274.24 their community residence:

274.25 (i) caregiver support;

274.26 (ii) homemaker;

274.27 (iii) chore; or

274.28 (iv) a personal emergency response device or system.

274.29 (c) The person receiving any of the essential community supports in this subdivision
274.30 must also receive service coordination as part of their community support plan.

274.31 (d) A person who has been determined to be eligible for an essential community
274.32 support grant must be reassessed at least annually and continue to meet the criteria in
274.33 paragraph (b) to remain eligible for an essential community support grant.

275.1 (e) The commissioner shall allocate grants to counties and tribes under contract with
275.2 the department based upon the historic use of the medical assistance elderly waiver and
275.3 alternative care grant programs and other criteria as determined by the commissioner.

275.4 **EFFECTIVE DATE.** This section is effective January 1, 2011.

275.5 Sec. 52. Minnesota Statutes 2008, section 256B.092, subdivision 8a, is amended to
275.6 read:

275.7 Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes
275.8 to place a person in another county for services, the county of financial responsibility shall
275.9 seek concurrence from the proposed county of service and the placement shall be made
275.10 cooperatively between the two counties. Arrangements shall be made between the two
275.11 counties for ongoing social service, including annual reviews of the person's individual
275.12 service plan. The county where services are provided may not make changes in the
275.13 person's service plan without approval by the county of financial responsibility.

275.14 (b) When a person has been screened and authorized for services in an intermediate
275.15 care facility for persons with developmental disabilities or for home and community-based
275.16 services for persons with developmental disabilities, the case manager shall assist that
275.17 person in identifying a service provider who is able to meet the needs of the person
275.18 according to the person's individual service plan. If the identified service is to be provided
275.19 in a county other than the county of financial responsibility, the county of financial
275.20 responsibility shall request concurrence of the county where the person is requesting to
275.21 receive the identified services. The county of service may refuse to concur if:

275.22 (1) it can demonstrate that the provider is unable to provide the services identified in
275.23 the person's individual service plan as services that are needed and are to be provided; or

275.24 (2) in the case of an intermediate care facility for persons with developmental
275.25 disabilities, there has been no authorization for admission by the admission review team
275.26 as required in section 256B.0926~~; or~~.

275.27 ~~(3) in the case of home and community-based services for persons with~~
275.28 ~~developmental disabilities, the county of service can demonstrate that the prospective~~
275.29 ~~provider has failed to substantially comply with the terms of a past contract or has had a~~
275.30 ~~prior contract terminated within the last 12 months for failure to provide adequate services,~~
275.31 ~~or has received a notice of intent to terminate the contract.~~

275.32 (c) The county of service shall notify the county of financial responsibility of
275.33 concurrence or refusal to concur no later than 20 working days following receipt of the
275.34 written request. Unless other mutually acceptable arrangements are made by the involved
275.35 county agencies, the county of financial responsibility is responsible for costs of social

276.1 services and the costs associated with the development and maintenance of the placement.
276.2 The county of service may request that the county of financial responsibility purchase
276.3 case management services from the county of service or from a contracted provider
276.4 of case management when the county of financial responsibility is not providing case
276.5 management as defined in this section and rules adopted under this section, unless other
276.6 mutually acceptable arrangements are made by the involved county agencies. Standards
276.7 for payment limits under this section may be established by the commissioner. Financial
276.8 disputes between counties shall be resolved as provided in section 256G.09.

276.9 Sec. 53. Minnesota Statutes 2008, section 256B.092, is amended by adding a
276.10 subdivision to read:

276.11 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
276.12 established a new service called residential support that is available on the CAC, CADI,
276.13 DD, and TBI waivers. Existing waiver service descriptions must be modified to the extent
276.14 necessary to ensure there is no duplication between other services. Residential support
276.15 services must be provided by vendors licensed as a community residential setting as
276.16 defined in section 245A.11, subdivision 8.
276.17 (b) Residential support services must meet the following criteria:
276.18 (1) providers of residential support services must own or control the residential site;
276.19 (2) the residential site must not be the primary residence of the license holder;
276.20 (3) the residential site must have a designated program supervisor responsible for
276.21 program oversight, development, and implementation of policies and procedures;
276.22 (4) the provider of residential support services must provide supervision, training,
276.23 and assistance as described in the person's community support plan; and
276.24 (5) the provider of residential support services must meet the requirements of
276.25 licensure and additional requirements of the person's community support plan.
276.26 (c) Providers of residential support services that meet the definition in paragraph (a)
276.27 must be registered using a process determined by the commissioner beginning July 1, 2009.

276.28 Sec. 54. Minnesota Statutes 2008, section 256B.092, is amended by adding a
276.29 subdivision to read:

276.30 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
276.31 establish statewide priorities for individuals on the waiting list for developmental
276.32 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
276.33 include, but are not limited to, individuals who continue to have a need for waiver services
276.34 after they have maximized the use of state plan services and other funding resources,

277.1 including natural supports, prior to accessing waiver services, and who meet at least one
277.2 of the following criteria:
277.3 (1) have unstable living situations due to the age, incapacity, or sudden loss of
277.4 the primary caregivers;
277.5 (2) are moving from an institution due to bed closures;
277.6 (3) experience a sudden closure of their current living arrangement;
277.7 (4) require protection from confirmed abuse, neglect, or exploitation;
277.8 (5) experience a sudden change in need that can no longer be met through state plan
277.9 services or other funding resources alone; or
277.10 (6) meet other priorities established by the department.
277.11 (b) When allocating resources to lead agencies, the commissioner must take into
277.12 consideration the number of individuals waiting who meet statewide priorities and the
277.13 lead agencies' current use of waiver funds and existing service options.
277.14 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
277.15 provide recommendations to the legislature on whether to continue the use of statewide
277.16 priorities in the November 1, 2011, annual report required by the commissioner in sections
277.17 256B.0916, subdivision 7, and 256B.49, subdivision 21.

277.18 Sec. 55. **[256B.0948] FOSTER CARE RATE LIMITS.**
277.19 The commissioner shall decrease by five percent rates for adult foster care and
277.20 supportive living services that are reimbursed under section 256B.092 or 256B.49, and
277.21 are above the 95th percentile of the statewide rates for the service. The reduction in rates
277.22 shall take into account the acuity of individuals served based on the methodology used to
277.23 allocate dollars to local lead agency budgets, and assure that affected service rates are not
277.24 reduced below the rate level represented by the above percentile due to this rate change.
277.25 Lead agency contracts for services specified in this section shall be amended to implement
277.26 these rate changes for services rendered on or after July 1, 2009. The commissioner shall
277.27 make corresponding reductions to waiver allocations and capitated rates.

277.28 Sec. 56. Minnesota Statutes 2008, section 256B.37, subdivision 1, is amended to read:
277.29 Subdivision 1. **Subrogation.** Upon furnishing medical assistance or alternative
277.30 care services under section 256B.0913 to any person who has private accident or health
277.31 care coverage, or receives or has a right to receive health or medical care from any
277.32 type of organization or entity, or has a cause of action arising out of an occurrence that
277.33 necessitated the payment of medical assistance, the state agency or the state agency's agent
277.34 shall be subrogated, to the extent of the cost of medical care furnished, to any rights the

278.1 person may have under the terms of the coverage, or against the organization or entity
278.2 providing or liable to provide health or medical care, or under the cause of action.
278.3 The right of subrogation created in this section includes all portions of the cause
278.4 of action, notwithstanding any settlement allocation or apportionment that purports to
278.5 dispose of portions of the cause of action not subject to subrogation.

278.6 Sec. 57. Minnesota Statutes 2008, section 256B.37, subdivision 5, is amended to read:

278.7 Subd. 5. **Private benefits to be used first.** Private accident and health care coverage
278.8 including Medicare for medical services is primary coverage and must be exhausted before
278.9 medical assistance ~~is~~ or alternative care services are paid for medical services including
278.10 home health care, personal care assistant services, hospice, supplies and equipment, or
278.11 services covered under a Centers for Medicare and Medicaid Services waiver. When a
278.12 person who is otherwise eligible for medical assistance has private accident or health care
278.13 coverage, including Medicare or a prepaid health plan, the private health care benefits
278.14 available to the person must be used first and to the fullest extent.

278.15 Sec. 58. Minnesota Statutes 2008, section 256B.434, subdivision 4, is amended to read:

278.16 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
278.17 have their payment rates determined under this section rather than section 256B.431, the
278.18 commissioner shall establish a rate under this subdivision. The nursing facility must enter
278.19 into a written contract with the commissioner.
278.20 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
278.21 contract under this section is the payment rate the facility would have received under
278.22 section 256B.431.
278.23 (c) A nursing facility's case mix payment rates for the second and subsequent years
278.24 of a facility's contract under this section are the previous rate year's contract payment
278.25 rates plus an inflation adjustment and, for facilities reimbursed under this section or
278.26 section 256B.431, an adjustment to include the cost of any increase in Health Department
278.27 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
278.28 inflation adjustment must be based on the change in the Consumer Price Index-All Items
278.29 (United States City average) (CPI-U) forecasted by the commissioner of finance's national
278.30 economic consultant, as forecasted in the fourth quarter of the calendar year preceding
278.31 the rate year. The inflation adjustment must be based on the 12-month period from the
278.32 midpoint of the previous rate year to the midpoint of the rate year for which the rate is
278.33 being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001,
278.34 July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1,

279.1 2008, October 1, 2009, ~~and~~ October 1, 2010, October 1, 2011, and October 1, 2012. This
279.2 paragraph shall apply only to the property-related payment rate, except that adjustments
279.3 to include the cost of any increase in Health Department licensing fees taking effect on
279.4 or after July 1, 2001, shall be provided. Beginning in 2005, adjustment to the property
279.5 payment rate under this section and section 256B.431 shall be effective on October 1.
279.6 In determining the amount of the property-related payment rate adjustment under this
279.7 paragraph, the commissioner shall determine the proportion of the facility's rates that are
279.8 property-related based on the facility's most recent cost report.

279.9 (d) The commissioner shall develop additional incentive-based payments of up to
279.10 five percent above a facility's operating payment rate for achieving outcomes specified
279.11 in a contract. The commissioner may solicit contract amendments and implement those
279.12 which, on a competitive basis, best meet the state's policy objectives. The commissioner
279.13 shall limit the amount of any incentive payment and the number of contract amendments
279.14 under this paragraph to operate the incentive payments within funds appropriated for this
279.15 purpose. The contract amendments may specify various levels of payment for various
279.16 levels of performance. Incentive payments to facilities under this paragraph may be in the
279.17 form of time-limited rate adjustments or onetime supplemental payments. In establishing
279.18 the specified outcomes and related criteria, the commissioner shall consider the following
279.19 state policy objectives:

279.20 (1) successful diversion or discharge of residents to the residents' prior home or other
279.21 community-based alternatives;

279.22 (2) adoption of new technology to improve quality or efficiency;

279.23 (3) improved quality as measured in the Nursing Home Report Card;

279.24 (4) reduced acute care costs; and

279.25 (5) any additional outcomes proposed by a nursing facility that the commissioner
279.26 finds desirable.

279.27 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
279.28 take action to come into compliance with existing or pending requirements of the life
279.29 safety code provisions or federal regulations governing sprinkler systems must receive
279.30 reimbursement for the costs associated with compliance if all of the following conditions
279.31 are met:

279.32 (1) the expenses associated with compliance occurred on or after January 1, 2005,
279.33 and before December 31, 2008;

279.34 (2) the costs were not otherwise reimbursed under subdivision 4f or section
279.35 144A.071 or 144A.073; and

280.1 (3) the total allowable costs reported under this paragraph are less than the minimum
280.2 threshold established under section 256B.431, subdivision 15, paragraph (e), and
280.3 subdivision 16.
280.4 The commissioner shall use money appropriated for this purpose to provide to qualifying
280.5 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
280.6 2008. Nursing facilities that have spent money or anticipate the need to spend money
280.7 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
280.8 system or (2) replacing all or portions of an existing sprinkler system may submit to the
280.9 commissioner by June 30, 2007, on a form provided by the commissioner the actual
280.10 costs of a completed project or the estimated costs, based on a project bid, of a planned
280.11 project. The commissioner shall calculate a rate adjustment equal to the allowable
280.12 costs of the project divided by the resident days reported for the report year ending
280.13 September 30, 2006. If the costs from all projects exceed the appropriation for this
280.14 purpose, the commissioner shall allocate the money appropriated on a pro rata basis
280.15 to the qualifying facilities by reducing the rate adjustment determined for each facility
280.16 by an equal percentage. Facilities that used estimated costs when requesting the rate
280.17 adjustment shall report to the commissioner by January 31, 2009, on the use of this
280.18 money on a form provided by the commissioner. If the nursing facility fails to provide
280.19 the report, the commissioner shall recoup the money paid to the facility for this purpose.
280.20 If the facility reports expenditures allowable under this subdivision that are less than
280.21 the amount received in the facility's annualized rate adjustment, the commissioner shall
280.22 recoup the difference.

280.23 Sec. 59. Minnesota Statutes 2008, section 256B.434, is amended by adding a
280.24 subdivision to read:

280.25 Subd. 21. **Payment of post-PERA pension benefit costs.** Nursing facilities that
280.26 convert or converted after September 30, 2006, from public to private ownership shall
280.27 have a portion of their post-PERA pension costs treated as a component of the historic
280.28 operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior
280.29 to October 1, 2016, the commissioner shall determine the pension costs to be included
280.30 in the facility's base for determining rates under this section by using the following
280.31 formula: post-privatization pension benefit costs as a percent of salary shall be determined
280.32 from either the cost report for the first full reporting year after privatization or the most
280.33 recent report year available, whichever is later. This percentage shall be applied to the
280.34 salary costs of the alternative payment system base rate year to determine the allowable
280.35 amount of pension costs. The adjustments provided for in sections 256B.431, 256B.434,

281.1 256B.441, and any other law enacted after the base rate year and prior to the year for
281.2 which rates are being determined shall be applied to the allowable amount. The adjusted
281.3 allowable amount shall be added to the operating rate effective the first rate year PERA
281.4 ceases to remain as a pass-through component of the rate.

281.5 Sec. 60. Minnesota Statutes 2008, section 256B.437, subdivision 6, is amended to read:

281.6 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
281.7 services shall calculate the amount of the planned closure rate adjustment available under
281.8 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

281.9 (1) the amount available is the net reduction of nursing facility beds multiplied
281.10 by $2,080;

281.11 (2) the total number of beds in the nursing facility or facilities receiving the planned
281.12 closure rate adjustment must be identified;

281.13 (3) capacity days are determined by multiplying the number determined under
281.14 clause (2) by 365; and

281.15 (4) the planned closure rate adjustment is the amount available in clause (1), divided
281.16 by capacity days determined under clause (3).

281.17 (b) A planned closure rate adjustment under this section is effective on the first day
281.18 of the month following completion of closure of the facility designated for closure in the
281.19 application and becomes part of the nursing facility's total operating payment rate.

281.20 (c) Applicants may use the planned closure rate adjustment to allow for a property
281.21 payment for a new nursing facility or an addition to an existing nursing facility or as an
281.22 operating payment rate adjustment. Applications approved under this subdivision are
281.23 exempt from other requirements for moratorium exceptions under section 144A.073,
281.24 subdivisions 2 and 3.

281.25 (d) Upon the request of a closing facility, the commissioner must allow the facility a
281.26 closure rate adjustment as provided under section 144A.161, subdivision 10.

281.27 (e) A facility that has received a planned closure rate adjustment may reassign it
281.28 to another facility that is under the same ownership at any time within three years of its
281.29 effective date. The amount of the adjustment shall be computed according to paragraph (a).

281.30 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
281.31 the commissioner shall recalculate planned closure rate adjustments for facilities that
281.32 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
281.33 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
281.34 from the date the per bed dollar amount is increased.

282.1 (g) For planned closures approved after June 30, 2009, the commissioner of human
282.2 services shall calculate the amount of the planned closure rate adjustment available under
282.3 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

282.4 Sec. 61. Minnesota Statutes 2008, section 256B.441, subdivision 55, is amended to
282.5 read:

282.6 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
282.7 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
282.8 under this section shall be phased in by blending the operating rate with the operating
282.9 payment rate determined under section 256B.434. For purposes of this subdivision, the
282.10 rate to be used that is determined under section 256B.434 shall not include the portion of
282.11 the operating payment rate related to performance-based incentive payments under section
282.12 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the
282.13 operating payment rate for each facility shall be 13 percent of the operating payment rate
282.14 from this section, and 87 percent of the operating payment rate from section 256B.434.
282.15 For the rate ~~year~~ period beginning October 1, 2009, through September 30, 2013, the
282.16 operating payment rate for each facility shall be 14 percent of the operating payment rate
282.17 from this section, and 86 percent of the operating payment rate from section 256B.434.
282.18 ~~For the rate year beginning October 1, 2010, the operating payment rate for each facility~~
282.19 ~~shall be 14 percent of the operating payment rate from this section, and 86 percent of the~~
282.20 ~~operating payment rate from section 256B.434. For the rate year beginning October 1,~~
282.21 ~~2011, the operating payment rate for each facility shall be 31 percent of the operating~~
282.22 ~~payment rate from this section, and 69 percent of the operating payment rate from section~~
282.23 ~~256B.434. For the rate year beginning October 1, 2012, the operating payment rate for~~
282.24 ~~each facility shall be 48 percent of the operating payment rate from this section, and 52~~
282.25 ~~percent of the operating payment rate from section 256B.434.~~ For the rate year beginning
282.26 October 1, 2013, the operating payment rate for each facility shall be 65 percent of the
282.27 operating payment rate from this section, and 35 percent of the operating payment rate
282.28 from section 256B.434. For the rate year beginning October 1, 2014, the operating
282.29 payment rate for each facility shall be 82 percent of the operating payment rate from this
282.30 section, and 18 percent of the operating payment rate from section 256B.434. For the rate
282.31 year beginning October 1, 2015, the operating payment rate for each facility shall be the
282.32 operating payment rate determined under this section. The blending of operating payment
282.33 rates under this section shall be performed separately for each RUG's class.

283.1 (b) For the rate year beginning October 1, 2008, the commissioner shall apply limits
283.2 to the operating payment rate increases under paragraph (a) by creating a minimum
283.3 percentage increase and a maximum percentage increase.

283.4 (1) Each nursing facility that receives a blended October 1, 2008, operating payment
283.5 rate increase under paragraph (a) of less than one percent, when compared to its operating
283.6 payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00,
283.7 shall receive a rate adjustment of one percent.

283.8 (2) The commissioner shall determine a maximum percentage increase that will
283.9 result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing
283.10 facilities with a blended October 1, 2008, operating payment rate increase under paragraph
283.11 (a) greater than the maximum percentage increase determined by the commissioner, when
283.12 compared to its operating payment rate on September 30, 2008, computed using rates with
283.13 a RUG's weight of 1.00, shall receive the maximum percentage increase.

283.14 (3) Nursing facilities with a blended October 1, 2008, operating payment rate
283.15 increase under paragraph (a) greater than one percent and less than the maximum
283.16 percentage increase determined by the commissioner, when compared to its operating
283.17 payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00,
283.18 shall receive the blended October 1, 2008, operating payment rate increase determined
283.19 under paragraph (a).

283.20 (4) The October 1, 2009, through October 1, 2015, operating payment rate for
283.21 facilities receiving the maximum percentage increase determined in clause (2) shall be
283.22 the amount determined under paragraph (a) less the difference between the amount
283.23 determined under paragraph (a) for October 1, 2008, and the amount allowed under clause
283.24 (2). This rate restriction does not apply to rate increases provided in any other section.

283.25 (c) A portion of the funds received under this subdivision that are in excess of
283.26 operating payment rates that a facility would have received under section 256B.434, as
283.27 determined in accordance with clauses (1) to (3), shall be subject to the requirements in
283.28 section 256B.434, subdivision 19, paragraphs (b) to (h).

283.29 (1) Determine the amount of additional funding available to a facility, which shall be
283.30 equal to total medical assistance resident days from the most recent reporting year times
283.31 the difference between the blended rate determined in paragraph (a) for the rate year being
283.32 computed and the blended rate for the prior year.

283.33 (2) Determine the portion of all operating costs, for the most recent reporting year,
283.34 that are compensation related. If this value exceeds 75 percent, use 75 percent.

283.35 (3) Subtract the amount determined in clause (2) from 75 percent.

284.1 (4) The portion of the fund received under this subdivision that shall be subject to
284.2 the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal
284.3 the amount determined in clause (1) times the amount determined in clause (3).

284.4 Sec. 62. Minnesota Statutes 2008, section 256B.441, subdivision 58, is amended to
284.5 read:

284.6 Subd. 58. **Implementation delay.** Within six months prior to the effective date of
284.7 (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits
284.8 under subdivision 50; and (3) the removal of planned closure rate adjustments and single
284.9 bed room incentives from external fixed costs under subdivision 53, the commissioner
284.10 shall compare the average operating cost for all facilities combined from the most recent
284.11 cost reports to the average medical assistance operating payment rates for all facilities
284.12 combined from the same time period. Each provision shall not go into effect until the
284.13 average medical assistance operating payment rate is at least 92 percent of the average
284.14 operating cost. The rebasing of property payment rates under subdivision 1, and the
284.15 removal of planned closure rate adjustments and single-bed room incentives from external
284.16 fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating
284.17 payment rate from this section is phased in as described in subdivision 55.

284.18 Sec. 63. Minnesota Statutes 2008, section 256B.441, is amended by adding a
284.19 subdivision to read:

284.20 Subd. 59. **Single-bed payments for medical assistance recipients.** Effective
284.21 October 1, 2009, the amount paid for a private room under Minnesota Rules, part
284.22 9549.0070, subpart 3, is reduced from 115 percent to 111.5 percent.

284.23 Sec. 64. Minnesota Statutes 2008, section 256B.49, is amended by adding a
284.24 subdivision to read:

284.25 Subd. 11a. **Waivered services waiting list.** (a) The commissioner shall establish
284.26 statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver
284.27 services, as of January 1, 2010. The statewide priorities must include, but are not limited
284.28 to, individuals who continue to have a need for waiver services after they have maximized
284.29 the use of state plan services and other funding resources, including natural supports, prior
284.30 to accessing waiver services, and who meet at least one of the following criteria:
284.31 (1) have unstable living situations due to the age, incapacity, or sudden loss of
284.32 the primary caregivers;
284.33 (2) are moving from an institution due to bed closures;

285.1 (3) experience a sudden closure of their current living arrangement;

285.2 (4) require protection from confirmed abuse, neglect, or exploitation;

285.3 (5) experience a sudden change in need that can no longer be met through state plan
285.4 services or other funding resources alone; or

285.5 (6) meet other priorities established by the department.

285.6 (b) When allocating resources to lead agencies, the commissioner must take into
285.7 consideration the number of individuals waiting who meet statewide priorities and the
285.8 lead agencies' current use of waiver funds and existing service options.

285.9 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
285.10 provide recommendations to the legislature on whether to continue the use of statewide
285.11 priorities in the November 1, 2011, annual report required by the commissioner in sections
285.12 256B.0916, subdivision 7, and 256B.49, subdivision 21.

285.13 Sec. 65. Minnesota Statutes 2008, section 256B.49, subdivision 12, is amended to read:

285.14 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
285.15 of care provided in a nursing facility as determined under sections 144.0724, subdivision
285.16 11, and 256B.0911, or hospital shall be informed of the home and community-based
285.17 support alternatives to the provision of inpatient hospital services or nursing facility
285.18 services. Each person must be given the choice of either institutional or home and
285.19 community-based services using the provisions described in section 256B.77, subdivision
285.20 2, paragraph (p).

285.21 **EFFECTIVE DATE.** This section is effective January 1, 2011.

285.22 Sec. 66. Minnesota Statutes 2008, section 256B.49, subdivision 13, is amended to read:

285.23 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
285.24 waiver shall be provided case management services by qualified vendors as described
285.25 in the federally approved waiver application. The case management service activities
285.26 provided will include:

285.27 (1) assessing the needs of the individual within 20 working days of a recipient's
285.28 request;

285.29 (2) developing the written individual service plan within ten working days after the
285.30 assessment is completed;

285.31 (3) informing the recipient or the recipient's legal guardian or conservator of service
285.32 options;

285.33 (4) assisting the recipient in the identification of potential service providers;

285.34 (5) assisting the recipient to access services;

286.1 (6) coordinating, evaluating, and monitoring of the services identified in the service
286.2 plan;
286.3 (7) completing the annual reviews of the service plan; and
286.4 (8) informing the recipient or legal representative of the right to have assessments
286.5 completed and service plans developed within specified time periods, and to appeal county
286.6 action or inaction under section 256.045, subdivision 3, including the determination of
286.7 nursing facility level of care.
286.8 (b) The case manager may delegate certain aspects of the case management service
286.9 activities to another individual provided there is oversight by the case manager. The case
286.10 manager may not delegate those aspects which require professional judgment including
286.11 assessments, reassessments, and care plan development.

286.12 **EFFECTIVE DATE.** This section is effective January 1, 2011.

286.13 Sec. 67. Minnesota Statutes 2008, section 256B.49, subdivision 14, is amended to read:

286.14 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
286.15 strengths, informal support systems, and need for services shall be completed within
286.16 20 working days of the recipient's request. Reassessment of each recipient's strengths,
286.17 support systems, and need for services shall be conducted at least every 12 months and at
286.18 other times when there has been a significant change in the recipient's functioning.
286.19 (b) There must be a determination that the client requires a hospital level of care or a
286.20 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
286.21 subsequent assessments to initiate and maintain participation in the waiver program.
286.22 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
286.23 appropriate to determine nursing facility level of care for purposes of medical assistance
286.24 payment for nursing facility services, only face-to-face assessments conducted according
286.25 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
286.26 determination or a nursing facility level of care determination must be accepted for
286.27 purposes of initial and ongoing access to waiver services payment.
286.28 (d) Persons with developmental disabilities who apply for services under the nursing
286.29 facility level waiver programs shall be screened for the appropriate level of care according
286.30 to section 256B.092.
286.31 ~~(c)~~ (e) Recipients who are found eligible for home and community-based services
286.32 under this section before their 65th birthday may remain eligible for these services after
286.33 their 65th birthday if they continue to meet all other eligibility factors.

286.34 **EFFECTIVE DATE.** The section is effective January 1, 2011.

287.1 Sec. 68. Minnesota Statutes 2008, section 256B.49, is amended by adding a
287.2 subdivision to read:

287.3 Subd. 22. **Residential support services.** For the purposes of this section, the
287.4 provisions of section 256B.092, subdivision 11, are controlling.

287.5 Sec. 69. **[256B.4912] HOME AND COMMUNITY-BASED WAIVERS;**
287.6 **PROVIDERS AND PAYMENT.**

287.7 Subdivision 1. **Provider qualifications.** For the home and community-based
287.8 waivers providing services to seniors and individuals with disabilities, the commissioner
287.9 shall establish:

287.10 (1) agreements with enrolled waiver service providers to ensure providers meet
287.11 qualifications defined in the waiver plans;

287.12 (2) regular reviews of provider qualifications; and

287.13 (3) processes to gather the necessary information to determine provider
287.14 qualifications.

287.15 By July 2010, staff that provide direct contact, as defined in section 245C.02, subdivision
287.16 11, that are employees of waiver service providers must meet the requirements of chapter
287.17 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal
287.18 approval, this requirement must also apply to consumer-directed community supports.

287.19 Subd. 2. **Rate-setting methodologies.** The commissioner shall establish
287.20 statewide rate-setting methodologies that meet federal waiver requirements for home
287.21 and community-based waiver services for individuals with disabilities. The rate-setting
287.22 methodologies must abide by the principles of transparency and equitability across the
287.23 state. The methodologies must involve a uniform process of structuring rates for each
287.24 service and must promote quality and participant choice.

287.25 Sec. 70. Minnesota Statutes 2008, section 256B.5011, subdivision 2, is amended to
287.26 read:

287.27 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
287.28 care facility must include provisions for:

287.29 (1) modifying payments when significant changes occur in the needs of the
287.30 consumers;

287.31 (2) ~~the establishment and use of a quality improvement plan. Using criteria and~~
287.32 ~~options for performance measures developed by the commissioner, each intermediate care~~
287.33 ~~facility must identify a minimum of one performance measure on which to focus its efforts~~
287.34 ~~for quality improvement during the contract period;~~

288.1 ~~(3)~~ appropriate and necessary statistical information required by the commissioner;
288.2 ~~(4)~~ <u>(3)</u> annual aggregate facility financial information; and
288.3 ~~(5)~~ <u>(4)</u> additional requirements for intermediate care facilities not meeting the
288.4 standards set forth in the service contract.
288.5 (b) The commissioner of human services and the commissioner of health, in
288.6 consultation with representatives from counties, advocacy organizations, and the provider
288.7 community, shall review the consolidated standards under chapter 245B and the supervised
288.8 living facility rule under Minnesota Rules, chapter 4665, to determine what provisions
288.9 in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for
288.10 intermediate care facilities in order to enable facilities to implement the performance
288.11 measures in their contract and provide quality services to residents without a duplication
288.12 of or increase in regulatory requirements.

288.13 Sec. 71. Minnesota Statutes 2008, section 256B.5012, is amended by adding a
288.14 subdivision to read:

288.15 <u>Subd. 8.</u> <u>**ICF/MR rate decreases effective July 1, 2009.**</u> <u>Effective July 1, 2009,</u>
288.16 <u>the commissioner shall decrease each facility reimbursed under this section operating</u>
288.17 <u>payment adjustments equal to 3.0 percent of the operating payment rates in effect on June</u>
288.18 <u>30, 2009. For each facility, the commissioner shall implement the rate reduction, based on</u>
288.19 <u>occupied beds, using the percentage specified in this subdivision multiplied by the total</u>
288.20 <u>payment rate, including the variable rate but excluding the property-related payment rate,</u>
288.21 <u>in effect on the preceding date. The total rate reduction shall include the adjustment</u>
288.22 <u>provided in section 256B.502, subdivision 7.</u>

288.23 Sec. 72. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

288.24 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
288.25 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
288.26 basis beginning January 1, 1996. Managed care contracts which were in effect on June
288.27 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
288.28 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
288.29 commissioner may issue separate contracts with requirements specific to services to
288.30 medical assistance recipients age 65 and older.
288.31 (b) A prepaid health plan providing covered health services for eligible persons
288.32 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
288.33 of its contract with the commissioner. Requirements applicable to managed care programs

289.1 under chapters 256B, 256D, and 256L, established after the effective date of a contract
289.2 with the commissioner take effect when the contract is next issued or renewed.

289.3 (c) Effective for services rendered on or after January 1, 2003, the commissioner
289.4 shall withhold five percent of managed care plan payments under this section for the
289.5 prepaid medical assistance and general assistance medical care programs pending
289.6 completion of performance targets. Each performance target must be quantifiable,
289.7 objective, measurable, and reasonably attainable, except in the case of a performance
289.8 target based on a federal or state law or rule. Criteria for assessment of each performance
289.9 target must be outlined in writing prior to the contract effective date. The managed
289.10 care plan must demonstrate, to the commissioner's satisfaction, that the data submitted
289.11 regarding attainment of the performance target is accurate. The commissioner shall
289.12 periodically change the administrative measures used as performance targets in order
289.13 to improve plan performance across a broader range of administrative services. The
289.14 performance targets must include measurement of plan efforts to contain spending
289.15 on health care services and administrative activities. The commissioner may adopt
289.16 plan-specific performance targets that take into account factors affecting only one plan,
289.17 including characteristics of the plan's enrollee population. The withheld funds must be
289.18 returned no sooner than July of the following year if performance targets in the contract
289.19 are achieved. The commissioner may exclude special demonstration projects under
289.20 subdivision 23. A managed care plan or a county-based purchasing plan under section
289.21 256B.692 may include as admitted assets under section 62D.044 any amount withheld
289.22 under this paragraph that is reasonably expected to be returned.

289.23 (d)(1) Effective for services rendered on or after January 1, 2009, the commissioner
289.24 shall withhold three percent of managed care plan payments under this section for the
289.25 prepaid medical assistance and general assistance medical care programs. The withheld
289.26 funds must be returned no sooner than July 1 and no later than July 31 of the following
289.27 year. The commissioner may exclude special demonstration projects under subdivision 23.

289.28 (2) A managed care plan or a county-based purchasing plan under section 256B.692
289.29 may include as admitted assets under section 62D.044 any amount withheld under
289.30 this paragraph. The return of the withhold under this paragraph is not subject to the
289.31 requirements of paragraph (c).

289.32 (e) Effective for services provided on or after January 1, 2010, the commissioner
289.33 shall require that managed care plans use the assessment and authorization processes,
289.34 forms, timelines, standards, documentation, and data reporting requirements, protocols,
289.35 billing processes, and policies consistent with medical assistance fee-for-service or the
289.36 Department of Human Services contract requirements consistent with medical assistance

290.1 fee-for-service or the Department of Human Services contract requirements for all
290.2 personal care assistance services under section 256B.0659.

290.3 Sec. 73. Minnesota Statutes 2008, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

291.1 (d) The county agency shall continue to pay a monthly allowance of $68 for
291.2 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
291.3 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
291.4 until the person has not received Minnesota supplemental aid for one full calendar month
291.5 or until the person's living arrangement changes and the person no longer meets the criteria
291.6 for the restaurant meal allowance, whichever occurs first.

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

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

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

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

291.33 (g) Notwithstanding this subdivision, recipients of home and community-based
291.34 services may relocate to services without 24-hour supervision and receive the equivalent
291.35 of the recipient's group residential housing allocation in Minnesota supplemental
291.36 assistance shelter needy funding if the cost of the services and housing is equal to or less

292.1 than provided to the recipient in home and community-based services and the relocation is
292.2 the recipient's choice and is approved by the recipient or guardian.

292.3 (h) To access housing and services as provided in paragraph (g), the recipient may
292.4 choose housing that may or may not be owned, operated, or controlled by the recipient's
292.5 service provider.

292.6 (i) The provisions in paragraphs (g) and (h) are effective to June 30, 2011. The
292.7 commissioner shall assess the development of publicly owned housing, other housing
292.8 alternatives, and whether a public equity housing fund may be established that would
292.9 maintain the state's interest, to the extent paid from group residential housing and
292.10 Minnesota supplemental aid shelter needy funds in provider-owned housing so that when
292.11 sold, the state would recover its share for a public equity fund to be used for future public
292.12 needs under this chapter. The commissioner shall report findings and recommendations to
292.13 the legislative committees and budget divisions with jurisdiction over health and human
292.14 services policy and financing by January 15, 2012.

292.15 (j) In selecting prospective services needed by recipients for whom home and
292.16 community-based services have been authorized, the recipient and the recipient's guardian
292.17 shall first consider alternatives to home and community-based services. Minnesota
292.18 supplemental aid shelter needy funding for recipients who utilize Minnesota supplemental
292.19 aid shelter needy funding as provided in this section shall remain permanent unless the
292.20 recipient with the recipient's guardian later chooses to access home and community-based
292.21 services.

292.22 Sec. 74. Minnesota Statutes 2008, section 626.556, subdivision 3c, is amended to read:

292.23 Subd. 3c. **Local welfare agency, Department of Human Services or Department**
292.24 **of Health responsible for assessing or investigating reports of maltreatment.** (a)
292.25 The county local welfare agency is the agency responsible for assessing or investigating
292.26 allegations of maltreatment in child foster care, family child care, ~~and~~ legally unlicensed
292.27 child care ~~and in~~, juvenile correctional facilities licensed under section 241.021 located
292.28 in the local welfare agency's county, and unlicensed personal care assistance provider
292.29 organizations providing services and receiving reimbursements under chapter 256B.

292.30 (b) The Department of Human Services is the agency responsible for assessing or
292.31 investigating allegations of maltreatment in facilities licensed under chapters 245A and
292.32 245B, except for child foster care and family child care.

292.33 (c) The Department of Health is the agency responsible for assessing or investigating
292.34 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58~~,~~
292.35 ~~and in unlicensed home health care~~ and 144A.46.

(d) The commissioners of human services, public safety, and education must jointly submit a written report by January 15, 2007, to the education policy and finance committees of the legislature recommending the most efficient and effective allocation of agency responsibility for assessing or investigating reports of maltreatment and must specifically address allegations of maltreatment that currently are not the responsibility of a designated agency.

Sec. 75. Minnesota Statutes 2008, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead agency.** "Lead agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead agency for the facilities which are licensed or are required to be licensed as hospitals, home care providers, nursing homes, residential care homes, or boarding care homes.

(b) The Department of Human Services is the lead agency for the programs licensed or required to be licensed as adult day care, adult foster care, programs for people with developmental disabilities, mental health programs, or chemical health programs~~, or personal care provider organizations~~.

(c) The county social service agency or its designee is the lead agency for all other reports, including reports involving vulnerable adults receiving services from an unlicensed personal care provider organization under section 256B.0659.

Sec. 76. **DEVELOPMENT OF ALTERNATIVE SERVICES.**

The commissioner of human services, in consultation with advocates, consumers, and legislators, shall develop 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. In the development of these services, the commissioner shall:

(1) take into consideration ways in which these alternative services will qualify for federal financial participation; and

(2) analyze a variety of alternatives, including but not limited to a 1915(i) state plan option.

The commissioner shall report to the legislature by January 15, 2011, with plans for implementation of these services by July 1, 2011.

Sec. 77. **30-DAY NOTICE REQUIRED.**

294.1 Notwithstanding any contrary provision in law, persons impacted by amendments
294.2 in this article to Minnesota Statutes, sections 256B.0625, subdivision 19c; 256B.0655,
294.3 subdivision 4; 256B.0659; and 256B.0911, subdivision 1, must be given a 30-day notice
294.4 of action by the commissioner. This section expires July 1, 2011.

294.5 Sec. 78. **COLA COMPENSATION REQUIREMENTS.**

294.6 Effective July 1, 2009, providers who received rate increases under Laws 2007,
294.7 chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15,
294.8 section 17, and Minnesota Statutes, section 256B.5012, subdivision 7, for state fiscal years
294.9 2008 and 2009 are no longer required to continue or retain employee compensation or
294.10 wage-related increases required by those sections. This paragraph shall not apply to
294.11 employees covered by a collective bargaining agreement.

294.12 Sec. 79. **PROVIDER RATE AND GRANT REDUCTIONS.**

294.13 (a) The commissioner of human services shall decrease grants, allocations,
294.14 reimbursement rates, or rate limits, as applicable, by 3.0 percent effective July 1, 2009, for
294.15 services rendered on or after that date. County or tribal contracts for services specified
294.16 in this section must be amended to pass through these rate reductions within 60 days of
294.17 the effective date of the decrease and must be retroactive from the effective date of the
294.18 rate decrease.

294.19 (b) The annual rate decreases described in this section must be provided to:

294.20 (1) home and community-based waivered services for persons with developmental
294.21 disabilities or related conditions, including consumer-directed community supports, under
294.22 Minnesota Statutes, section 256B.501;

294.23 (2) home and community-based waivered services for the elderly, including
294.24 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

294.25 (3) waivered services under community alternatives for disabled individuals,
294.26 including consumer-directed community supports, under Minnesota Statutes, section
294.27 256B.49;

294.28 (4) community alternative care waivered services, including consumer-directed
294.29 community supports, under Minnesota Statutes, section 256B.49;

294.30 (5) traumatic brain injury waivered services, including consumer-directed
294.31 community supports, under Minnesota Statutes, section 256B.49;

294.32 (6) nursing services and home health services under Minnesota Statutes, section
294.33 256B.0625, subdivision 6a;

294.34 (7) personal care services and qualified professional supervision of personal care
294.35 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

295.1 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
295.2 subdivision 7;
295.3 (9) day training and habilitation services for adults with developmental disabilities
295.4 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
295.5 additional cost of rate adjustments on day training and habilitation services, provided as a
295.6 social service under Minnesota Statutes, section 256M.60;
295.7 (10) alternative care services under Minnesota Statutes, section 256B.0913;
295.8 (11) the group residential housing supplementary service rate under Minnesota
295.9 Statutes, section 256I.05, subdivision 1a;
295.10 (12) semi-independent living services (SILS) under Minnesota Statutes, section
295.11 252.275, including SILS funding under county social services grants formerly funded
295.12 under Minnesota Statutes, chapter 256I;
295.13 (13) community support services for deaf and hard-of-hearing adults with mental
295.14 illness who use or wish to use sign language as their primary means of communication
295.15 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
295.16 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
295.17 and Laws 1997, First Special Session chapter 5, section 20;
295.18 (14) physical therapy services under Minnesota Statutes, sections 256B.0625,
295.19 subdivision 8, and 256D.03, subdivision 4;
295.20 (15) occupational therapy services under Minnesota Statutes, sections 256B.0625,
295.21 subdivision 8a, and 256D.03, subdivision 4;
295.22 (16) speech-language therapy services under Minnesota Statutes, section 256D.03,
295.23 subdivision 4, and Minnesota Rules, part 9505.0390;
295.24 (17) respiratory therapy services under Minnesota Statutes, section 256D.03,
295.25 subdivision 4, and Minnesota Rules, part 9505.0295;
295.26 (18) consumer support grants under Minnesota Statutes, section 256.476;
295.27 (19) family support grants under Minnesota Statutes, section 252.32;
295.28 (20) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
295.29 and 256B.0928;
295.30 (21) disability linkage line grants under Minnesota Statutes, section 256.01,
295.31 subdivision 24; and
295.32 (22) housing access grants under Minnesota Statutes, section 256B.0658.
295.33 (c) A managed care plan receiving state payments for the services in this section
295.34 must include these decreases in their payments to providers effective on October 1
295.35 following the effective date of the rate decrease.

296.1 Sec. 80. **RECOMMENDATIONS FOR PERSONAL CARE ASSISTANCE**
296.2 **SERVICES CHANGES, CONSULTATION WITH STAKEHOLDERS, AND DATA**
296.3 **REPORTING.**

296.4 The commissioner shall:
296.5 (1) consult with existing stakeholder groups convened under the commissioner's
296.6 authority, including the home and community-based expert services panel beginning in
296.7 August 2009 on implementation of the changes in the personal care assistance program,
296.8 assistance for recipients whose services and housing must change, alternative services
296.9 for those whose personal care assistance services are terminated or reduced, costs for
296.10 those whose services will change, data on the effects of the changes in the personal care
296.11 assistance program for recipients, and ongoing data on personal care assistance services
296.12 for public reporting; and
296.13 (2) report data on the training developed and delivered for all types of participants in
296.14 the personal care assistance program, audit and financial integrity measures and results,
296.15 information developed for consumers and responsible parties, available demographic,
296.16 health care service use, and housing information about individuals who no longer qualify
296.17 for personal care assistance, and quality assurance measures and results to the legislative
296.18 committees with jurisdiction over health and human services policy and finance by
296.19 January 15, 2010, and January 15, 2011.

296.20 Sec. 81. **ESTABLISHING A SINGLE SET OF STANDARDS.**

296.21 (a) The commissioner of human services shall consult with disability service
296.22 providers, advocates, counties, and consumer families to develop a single set of standards
296.23 governing services for people with disabilities receiving services under the home and
296.24 community-based waiver services program to replace all or portions of existing laws and
296.25 rules including, but not limited to, data practices, licensure of facilities and providers,
296.26 background studies, reporting of maltreatment of minors, reporting of maltreatment of
296.27 vulnerable adults, and the psychotropic medication checklist. The standards must:
296.28 (1) enable optimum consumer choice;
296.29 (2) be consumer driven;
296.30 (3) link services to individual needs and life goals;
296.31 (4) be based on quality assurance and individual outcomes;
296.32 (5) utilize the people closest to the recipient, who may include family, friends, and
296.33 health and service providers, in conjunction with the recipient's risk management plan to
296.34 assist the recipient or the recipient's guardian in making decisions that meet the recipient's
296.35 needs in a cost-effective manner and assure the recipient's health and safety;

297.1 (6) utilize person-centered planning; and

297.2 (7) maximize federal financial participation.

297.3 (b) The commissioner may consult with existing stakeholder groups convened under
297.4 the commissioner's authority, including the home and community-based expert services
297.5 panel established by the commissioner in 2008, to meet all or some of the requirements
297.6 of this section.

297.7 (c) The commissioner shall provide the reports and plans required by this section to
297.8 the legislative committees and budget divisions with jurisdiction over health and human
297.9 services policy and finance by January 15, 2012.

297.10 Sec. 82. **COMMON SERVICE MENU FOR HOME AND COMMUNITY-BASED**
297.11 **WAIVER PROGRAMS.**

297.12 The commissioner of human services shall confer with representatives of recipients,
297.13 advocacy groups, counties, providers, and health plans to develop and update a common
297.14 service menu for home and community-based waiver programs. The commissioner may
297.15 consult with existing stakeholder groups convened under the commissioner's authority to
297.16 meet all or some of the requirements of this section.

297.17 Sec. 83. **INTERMEDIATE CARE FACILITIES FOR PERSONS WITH**
297.18 **DEVELOPMENTAL DISABILITIES REPORT.**

297.19 The commissioner of human services shall consult with providers and advocates of
297.20 intermediate care facilities for persons with developmental disabilities to monitor progress
297.21 made in response to the commissioner's December 15, 2008, report to the legislature
297.22 regarding intermediate care facilities for persons with developmental disabilities.

297.23 Sec. 84. **HOUSING OPTIONS.**

297.24 The commissioner of human services, in consultation with the commissioner of
297.25 administration and the Minnesota Housing Finance Agency, and representatives of
297.26 counties, residents' advocacy groups, consumers of housing services, and provider
297.27 agencies shall explore ways to maximize the availability and affordability of housing
297.28 choices available to persons with disabilities or who need care assistance due to other
297.29 health challenges. A goal shall also be to minimize state physical plant costs in order to
297.30 serve more persons with appropriate program and care support. Consideration shall be
297.31 given to:

297.32 (1) improved access to rent subsidies;

297.33 (2) use of cooperatives, land trusts, and other limited equity ownership models;

298.1 (3) whether a public equity housing fund should be established that would maintain
298.2 the state's interest, to the extent paid from state funds, including group residential housing
298.3 and Minnesota supplemental aid shelter-needy funds in provider-owned housing, so that
298.4 when sold, the state would recover its share for a public equity fund to be used for future
298.5 public needs under this chapter;

298.6 (4) the desirability of the state acquiring an ownership interest or promoting the
298.7 use of publicly owned housing;

298.8 (5) promoting more choices in the market for accessible housing that meets the
298.9 needs of persons with physical challenges; and

298.10 (6) what consumer ownership models, if any, are appropriate.

298.11 The commissioner shall provide a written report on the findings of the evaluation of
298.12 housing options to the chairs and ranking minority members of the house of representatives
298.13 and senate standing committees with jurisdiction over health and human services policy
298.14 and funding by December 15, 2010. This report shall replace the November 1, 2010,
298.15 annual report by the commissioner required in Minnesota Statutes, sections 256B.0916,
298.16 subdivision 7, and 256B.49, subdivision 21.

298.17 Sec. 85. **REVISOR'S INSTRUCTION.**

298.18 Subdivision 1. **Renumbering of Minnesota Statutes, section 256B.0652,**
298.19 **authorization and review of home care services.** (a) The revisor of statutes shall
298.20 renumber each section of Minnesota Statutes listed in column A with the number in
298.21 column B.

	Column A	Column B
298.22		
298.23	256B.0652, subdivision 3	256B.0652, subdivision 14
298.24	256B.0651, subdivision 6, paragraph (a)	256B.0652, subdivision 3
298.25	256B.0651, subdivision 6, paragraph (b)	256B.0652, subdivision 4
298.26	256B.0651, subdivision 6, paragraph (c)	256B.0652, subdivision 7
298.27	256B.0651, subdivision 7, paragraph (a)	256B.0652, subdivision 8
298.28	256B.0651, subdivision 7, paragraph (b)	256B.0652, subdivision 14
298.29	256B.0651, subdivision 8	256B.0652, subdivision 9
298.30	256B.0651, subdivision 9	256B.0652, subdivision 10
298.31	256B.0651, subdivision 11	256B.0652, subdivision 11

299.1 256B.0654, subdivision 2	256B.0652, subdivision 5
299.2 256B.0655, subdivision 4	256B.0652, subdivision 6

299.3 (b) The revisor of statutes shall make necessary cross-reference changes in statutes
299.4 and rules consistent with the renumbering in paragraph (a). The Department of Human
299.5 Services shall assist the revisor with any cross-reference changes. The revisor may make
299.6 changes necessary to correct the punctuation, grammar, or structure of the remaining text
299.7 to conform with the intent of the renumbering in paragraph (a).

299.8 Subd. 2. **Renumbering personal care assistance services.** The revisor of statutes
299.9 shall replace any reference to Minnesota Statutes, section 256B.0655 with section
299.10 256B.0659, wherever it appears in statutes or rules. The revisor shall correct any cross
299.11 reference changes that are necessary as a result of this section. The Department of Human
299.12 Services shall assist the revisor in making these changes, and if necessary, shall draft a
299.13 corrections bill with changes for introduction in the 2010 legislative session. The revisor
299.14 may make changes to punctuation, grammar, or sentence structure to preserve the integrity
299.15 of statutes and effectuate the intention of this section.

299.16 Sec. 86. **REPEALER.**

299.17 (a) Minnesota Statutes 2008, sections 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e,
299.18 1h, 1i, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13; and 256B.071, subdivisions 1, 2, 3, and 4, are
299.19 repealed.

299.20 (b) Minnesota Statutes 2008, sections 256B.19, subdivision 1d; and 256B.431,
299.21 subdivision 23, are repealed effective May 1, 2009.

299.22 (c) Minnesota Statutes 2008, section 256B.0655, subdivisions 1f, 1g, and 2, are
299.23 repealed effective January 1, 2010.

299.24 ARTICLE 9

299.25 STATE-COUNTY RESULTS, ACCOUNTABILITY, AND SERVICE 299.26 DELIVERY REFORM ACT

299.27 Section 1. **[402A.01] CITATION.**

299.28 Sections 402A.01 to 402A.50 may be cited as the "State-County Results,
299.29 Accountability, and Service Delivery Reform Act."

299.30 Sec. 2. **[402A.10] DEFINITIONS.**

299.31 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
299.32 in this section have the meanings given.

300.1 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
300.2 services.

300.3 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
300.4 Service Delivery Redesign Council established in section 402A.20.

300.5 Subd. 4. **Essential human services or essential services.** "Essential human
300.6 services" or "essential services" means assistance and services to recipients or potential
300.7 recipients of public welfare and other services delivered by counties that are mandated in
300.8 federal and state law that are to be available in all counties of the state.

300.9 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
300.10 county, or group of counties operating by execution of a joint powers agreement under
300.11 section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of
300.12 the county board of commissioners to participate in the redesign under this chapter.

300.13 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
300.14 on Performance and Outcome Reforms.

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

300.16 Sec. 3. **[402A.15] STEERING COMMITTEE ON PERFORMANCE AND**
300.17 **OUTCOME REFORMS.**

300.18 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome
300.19 Reforms shall develop a uniform process to establish and review performance and
300.20 outcome standards for all essential human services based on the current level of resources
300.21 available, and to develop appropriate reporting measures and a uniform accountability
300.22 process for responding to a county's or human service authority's failure to make adequate
300.23 progress on achieving performance measures. The accountability process shall focus on
300.24 the performance measures rather than inflexible implementation requirements.

300.25 (b) The steering committee shall:

300.26 (1) by November 1, 2009, establish an agreed upon list of essential services;

300.27 (2) by February 15, 2010, develop and recommend to the legislature a uniform,
300.28 graduated process, in addition to the remedies identified in section 402A.18, for responding
300.29 to a county's failure to make adequate progress on achieving performance measures; and

300.30 (3) by December 15, 2012, for each essential service make recommendations to the
300.31 legislature regarding (1) performance measures and goals based on those measures for
300.32 each essential service, (2) a system for reporting on the performance measures and goals,
300.33 and (3) appropriate resources, including funding, needed to achieve those performance
300.34 measures and goals. The resource recommendations shall take into consideration program

301.1 demand and the unique differences of local areas in geography and the populations
301.2 served. Priority shall be given to services with the greatest variation in availability and
301.3 greatest administrative demands. By January 15 of each year starting January 15, 2011,
301.4 the steering committee shall report its recommendations to the governor and legislative
301.5 committees with jurisdiction over health and human services. As part of its report, the
301.6 steering committee shall, as appropriate, recommend statutory provisions, rules and
301.7 requirements, and reports that should be repealed or eliminated.

301.8 (c) As far as possible, the performance measures, reporting system, and funding
301.9 shall be consistent across program areas. The development of performance measures shall
301.10 consider the manner in which data will be collected and performance will be reported.
301.11 The steering committee shall consider state and local administrative costs related to
301.12 collecting data and reporting outcomes when developing performance measures. The
301.13 steering committee shall correlate the performance measures and goals to available
301.14 levels of resources, including state and local funding. The steering committee shall
301.15 take into consideration that the goal of implementing changes to program monitoring
301.16 and reporting the progress toward achieving outcomes is to significantly minimize the
301.17 cost of administrative requirements and to allow funds freed by reduced administrative
301.18 expenditures to be used to provide additional services, allow flexibility in service design
301.19 and management, and focus energies on achieving program and client outcomes.

301.20 (d) In making its recommendations, the steering committee shall consider input from
301.21 the council established in section 402A.20. The steering committee shall review the
301.22 measurable goals established in a memorandum of understanding entered into under
301.23 section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied
301.24 as statewide performance outcomes.

301.25 (e) The steering committee shall form work groups that include persons who provide
301.26 or receive essential services and representatives of organizations who advocate on behalf
301.27 of those persons.

301.28 (f) By December 15, 2009, the steering committee shall establish a three-year
301.29 schedule for completion of its work. The schedule shall be published on the Department of
301.30 Human Services Web site and reported to the legislative committees with jurisdiction over
301.31 health and human services. In addition, the commissioner shall post quarterly updates on
301.32 the progress of the steering committee on the Department of Human Services Web site.

301.33 Subd. 2. **Composition.** (a) The steering committee shall include:

301.34 (1) the commissioner of human services, or designee, and two additional
301.35 representatives of the department;

302.1 (2) two county commissioners, representative of rural and urban counties, selected
302.2 by the Association of Minnesota Counties;
302.3 (3) two county directors of human services, representative of rural and urban
302.4 counties, selected by the Minnesota Association of County Social Service Administrators;
302.5 and
302.6 (4) three clients or client advocates representing different populations receiving
302.7 services from the Department of Human Services, who are appointed by the commissioner.
302.8 (b) The commissioner, or designee, and a county commissioner shall serve as
302.9 cochairs of the committee. The committee shall be convened within 60 days of final
302.10 enactment of this legislation.
302.11 (c) State agency staff shall serve as informational resources and staff to the steering
302.12 committee. Statewide county associations may assemble county program data as required.
302.13 (d) To promote information sharing and coordination between the steering committee
302.14 and council, one of the county representatives from paragraph (a), clause (2), and one of the
302.15 county representatives from paragraph (a), clause (3), must also serve as a representative
302.16 on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).

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

302.18 Sec. 4. **[402A.18] COMMISSIONER POWER TO REMEDY FAILURE TO**
302.19 **MEET PERFORMANCE OUTCOMES.**

302.20 Subdivision 1. **Underperforming county; specific service.** If the commissioner
302.21 determines that a county or service delivery authority is deficient in achieving minimum
302.22 performance outcomes for a specific essential service, the commissioner may impose
302.23 the following remedies:
302.24 (1) voluntary incorporation of the administration and operation of the specific
302.25 essential service with an existing service delivery authority or another county. A
302.26 service delivery authority or county incorporating an underperforming county shall
302.27 not be financially liable for the costs associated with remedying performance outcome
302.28 deficiencies;
302.29 (2) mandatory incorporation of the administration and operation of the specific
302.30 essential service with an existing service delivery authority or another county. A
302.31 service delivery authority or county incorporating an underperforming county shall
302.32 not be financially liable for the costs associated with remedying performance outcome
302.33 deficiencies; or
302.34 (3) transfer of authority for program administration and operation of the specific
302.35 essential service to the commissioner.

303.1 Subd. 2. **Underperforming county; more than one-half of service.** If the
303.2 commissioner determines that a county or service delivery authority is deficient in
303.3 achieving minimum performance outcomes for more than one-half of the defined essential
303.4 service, the commissioner may impose the following remedies:

303.5 (1) voluntary incorporation of the administration and operation of the specific
303.6 essential service with an existing service delivery authority or another county. A
303.7 service delivery authority or county incorporating an underperforming county shall
303.8 not be financially liable for the costs associated with remedying performance outcome
303.9 deficiencies;

303.10 (2) mandatory incorporation of the administration and operation of the specific
303.11 essential service with an existing service delivery authority or another county. A
303.12 service delivery authority or county incorporating an underperforming county shall
303.13 not be financially liable for the costs associated with remedying performance outcome
303.14 deficiencies; or

303.15 (3) transfer of authority for program administration and operation of the specific
303.16 essential service to the commissioner.

303.17 Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may
303.18 impose the remedies authorized under this section, the following conditions must be met:

303.19 (1) the county or service delivery authority determined by the commissioner
303.20 to be deficient in achieving minimum performance outcomes has the opportunity, in
303.21 coordination with the council, to develop a program outcome improvement plan. The
303.22 program outcome improvement plan must be developed no later than six months from the
303.23 date of the deficiency determination; and

303.24 (2) the council has conducted an assessment of the program outcome improvement
303.25 plan to determine if the county or service delivery authority has made satisfactory progress
303.26 toward performance outcomes and has made a recommendation about remedies to the
303.27 commissioner. The review and recommendation must be made to the commissioner within
303.28 12 months from the date of the deficiency determination.

303.29 Sec. 5. **[402A.20] COUNCIL.**

303.30 Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service
303.31 Delivery Redesign Council is established. Appointed council members must be appointed
303.32 by their respective agencies, associations, or governmental units by November 1, 2009.
303.33 The council shall be cochaired by the commissioner of human services, or designee, and a
303.34 county representative from paragraph (b), clause (4) or (5), appointed by the Association
303.35 of Minnesota Counties. Recommendations of the council must be approved by a majority

304.1 of the council members. The provisions of section 15.059 do not apply to this council,
304.2 and this council does not expire.

304.3 (b) The council must consist of the following members:

304.4 (1) two legislators appointed by the speaker of the house, one from the minority
304.5 and one from the majority;

304.6 (2) two legislators appointed by the Senate Rules Committee, one from the majority
304.7 and one from the minority;

304.8 (3) the commissioner of human services, or designee, and three employees from
304.9 the department;

304.10 (4) two county commissioners appointed by the Association of Minnesota Counties;

304.11 (5) two county representatives appointed by the Minnesota Association of County
304.12 Social Service Administrators;

304.13 (6) one representative appointed by AFSCME as a nonvoting member; and

304.14 (7) one representative appointed by the Teamsters as a nonvoting member.

304.15 (c) Administrative support to the council may be provided by the Association of
304.16 Minnesota Counties and affiliates.

304.17 (d) Member agencies and associations are responsible for initial and subsequent
304.18 appointments to the council.

304.19 Subd. 2. **Council duties.** The council shall:

304.20 (1) provide review of the redesign process;

304.21 (2) certify, in accordance with section 402A.30, subdivision 4, the formation of
304.22 a service delivery authority, including the memorandum of understanding in section
304.23 402A.30, subdivision 2, paragraph (b);

304.24 (3) ensure the consistency of the memoranda of understanding entered into
304.25 under section 402A.30, subdivision 2, paragraph (b), with the performance standards
304.26 recommended by the steering committee and enacted by the legislature;

304.27 (4) ensure the consistency of the memoranda of understanding, to the extent
304.28 appropriate, or other memoranda of understanding entered into by other service delivery
304.29 authorities;

304.30 (5) establish a process to take public input on the service delivery framework
304.31 specified in the memorandum of understanding in section 402A.30, subdivision 2,
304.32 paragraph (b);

304.33 (6) form work groups as necessary to carry out the duties of the council under the
304.34 redesign;

305.1 (7) serve as a forum for resolving conflicts among participating counties or between
305.2 participating counties and the commissioner of human services, provided nothing in this
305.3 section is intended to create a formal binding legal process;
305.4 (8) engage in the program improvement process established in section 402A.18,
305.5 subdivision 3; and
305.6 (9) identify and recommend incentives for counties to participate in human services
305.7 authorities.

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

305.9 Sec. 6. **[402A.30] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

305.10 Subdivision 1. **Establishment.** After certification by the council and approval by
305.11 the commissioner, in accordance with subdivision 4, a county or consortium of counties
305.12 may establish a service delivery authority to redesign the delivery of some or all essential
305.13 services. Once a county or consortium of counties establishes a service delivery authority,
305.14 no county that is a participant in the service delivery authority may participate in or be
305.15 a member of any other service delivery authority. The service delivery authority may
305.16 allow an additional county or counties to join the service delivery authority subject to the
305.17 approval of the council and the commissioner.

305.18 Subd. 2. **New state-county governance framework.** (a) To establish a service
305.19 delivery authority, each participating county and the state must enter into a binding
305.20 memorandum of understanding to establish a joint state-county service delivery
305.21 framework:
305.22 (b) The memorandum of understanding must:
305.23 (1) comply with current state and federal law except where waivers are approved
305.24 under clause (7);
305.25 (2) define the scope of essential services over which the service delivery authority
305.26 has jurisdiction;
305.27 (3) designate a single administrative structure to oversee the delivery of services over
305.28 which the service delivery authority has jurisdiction and identify a single administrative
305.29 agent for purposes of contact and communication with the department;
305.30 (4) define measurable performance and outcome goals in key operational areas
305.31 that the service delivery authority is expected to achieve, provided that the performance
305.32 goals must, at a minimum, satisfy performance outcomes recommended by the steering
305.33 committee and enacted into law;

306.1 (5) identify the state and local resources, including funding and administrative and
306.2 information technology support, and other requirements necessary for the service delivery
306.3 authority to achieve the performance and outcome goals;
306.4 (6) state the relief available to the service delivery authority if the resource
306.5 commitments identified in clause (5) are not met;
306.6 (7) identify in the agreement the waivers from statutory requirements that are needed
306.7 to ensure greater local control and flexibility to determine the most cost-effective means
306.8 of achieving specified measurable goals and the date by which the commissioner shall
306.9 grant the identified waivers;
306.10 (8) set forth a graduated accountability process and penalties for responding to a
306.11 county's failure to make adequate progress on achieving performance and outcome goals;
306.12 (9) set forth a reasonable level of targeted reductions in overhead and administrative
306.13 costs for each county participating in the service delivery authority; and
306.14 (10) set forth the terms under which a county may withdraw from participation.
306.15 The memorandum of understanding may be later amended to add additional services over
306.16 which the service delivery authority has jurisdiction.
306.17 (c) Nothing in this chapter precludes local governments from utilizing sections
306.18 465.81 and 465.82 to establish procedures for local governments to merge, with the
306.19 consent of the voters. Any agreement under paragraph (b) must be governed by this
306.20 chapter. Nothing in this chapter limits the authority of a county board to enter into
306.21 contractual agreements for services not covered by the provisions of a memorandum of
306.22 understanding establishing a service delivery authority with other agencies or with other
306.23 units of government.

306.24 Subd. 3. **Duties.** The service delivery authority shall:
306.25 (1) within the scope of essential services set forth in the memorandum of
306.26 understanding establishing the authority, carry out the responsibilities required of local
306.27 agencies under chapter 393 and human services boards under chapter 402;
306.28 (2) manage the public resources devoted to human services and other public services
306.29 delivered or purchased by the counties that are subsidized or regulated by the Department
306.30 of Human Services under chapters 245 and 267;
306.31 (3) employ staff to assist in carrying out its duties;
306.32 (4) develop and maintain a continuity of operations plan to ensure the continued
306.33 operation or resumption of essential human services functions in the event of any business
306.34 interruption according to local, state, and federal emergency planning requirements;
306.35 (5) receive and expend funds received for the redesign process under the
306.36 memorandum of understanding;

307.1 (6) plan and deliver services directly or through contract with other governmental
307.2 or nongovernmental providers;
307.3 (7) rent, purchase, sell, and otherwise dispose of real and personal property as
307.4 necessary to carry out the redesign; and
307.5 (8) carry out any other service designated as a responsibility of a county.

307.6 Subd. 4. **Process for establishing a service delivery authority.** (a) The county or
307.7 consortium of counties proposing to form a service delivery authority shall, in conjunction
307.8 with the commissioner, prevent a proposed memorandum of understanding to the council
307.9 accompanied by a resolution from the board of commissioners of each participating
307.10 county stating the county's intent to participate in a service delivery authority.
307.11 (b) The council shall certify a county or consortium of counties as a service delivery
307.12 authority if:
307.13 (1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and
307.14 (2) the county or consortium of counties are:
307.15 (i) a single county with a population of 55,000 or more;
307.16 (ii) a consortium of counties with a total combined population of 55,000 or more and
307.17 the counties comprising the consortium are in reasonable geographic proximity; or
307.18 (iii) four or more counties in reasonable geographic proximity without regard
307.19 to population.
307.20 The council may recommend that the commissioner of human services exempt a
307.21 single county or multicounty service delivery authority from the minimum population
307.22 standard if that service delivery authority can demonstrate that it can otherwise meet
307.23 the requirements of this chapter.
307.24 (c) After the council has certified a county or consortium of counties as a service
307.25 delivery authority, the commissioner may enter into the memoranda of understanding with
307.26 the participating counties to form the service delivery authority.

307.27 Subd. 5. **Single county service delivery authority.** For counties with populations
307.28 over 55,000, the board of county commissioners may be the service delivery authority and
307.29 retain existing authority under law.

307.30 Sec. 7. **[402A.45] ESSENTIAL SERVICES OUTSIDE THE JURISDICTION OF**
307.31 **A SERVICE DELIVERY AUTHORITY.**

307.32 (a) With the approval of the council, a county that is a participant in a service
307.33 delivery authority may enter into cooperative arrangements with other service delivery
307.34 authorities or other counties to provide essential services that are not within the jurisdiction
307.35 and duties of the service delivery authority.

308.1 (b) With the approval of the council, a service delivery authority may enter into a
308.2 cooperative arrangement with a nonparticipating county to provide an essential service
308.3 within the jurisdiction and duties of the service delivery authority.

308.4 Sec. 8. **[402A.50] PRIVATE SECTOR FUNDING.**

308.5 The council may support stakeholder agencies, if not otherwise prohibited by law, to
308.6 separately or jointly seek and receive funds to provide expert technical assistance to the
308.7 council, the council's work group, and any subwork groups for executing the provisions
308.8 of the redesign.

308.9 Sec. 9. **APPROPRIATION.**

308.10 $350,000 is appropriated for the biennium beginning July 1, 2009, from the general
308.11 fund to the State-County Results, Accountability, and Service Delivery Redesign Council,
308.12 for the purposes of the State-County Results, Accountability, and Service Delivery Reform
308.13 Act under Minnesota Statutes, sections 402A.01 to 402A.50. The council shall establish a
308.14 methodology for distributing funds to certified service delivery authorities for the purposes
308.15 of carrying out the requirements of the redesign.

308.16 **ARTICLE 10**
308.17 **PUBLIC HEALTH**

308.18 Section 1. Minnesota Statutes 2008, section 103I.208, subdivision 2, is amended to
308.19 read:

308.20 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:
308.21 (1) for a water supply well that is not in use under a maintenance permit, $175
308.22 annually;
308.23 (2) for construction of a monitoring well, $215, which includes the state core
308.24 function fee;
308.25 (3) for a monitoring well that is unsealed under a maintenance permit, $175 annually;
308.26 (4) for a monitoring well owned by a federal agency, state agency, or local unit of
308.27 government that is unsealed under a maintenance permit, $50 annually. "Local unit of
308.28 government" means a statutory or home rule charter city, town, county, or soil and water
308.29 conservation district, watershed district, an organization formed for the joint exercise of
308.30 powers under section 471.59, a board of health or community health board, or other
308.31 special purpose district or authority with local jurisdiction in water and related land
308.32 resources management;
308.33 (5) for monitoring wells used as a leak detection device at a single motor fuel retail
308.34 outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural

309.1 chemical facility site, the construction permit fee is $215, which includes the state core
309.2 function fee, per site regardless of the number of wells constructed on the site, and
309.3 the annual fee for a maintenance permit for unsealed monitoring wells is $175 per site
309.4 regardless of the number of monitoring wells located on site;

309.5 ~~(5)~~ (6) for a groundwater thermal exchange device, in addition to the notification fee
309.6 for water supply wells, $215, which includes the state core function fee;

309.7 ~~(6)~~ (7) for a vertical heat exchanger with less than ten tons of heating/cooling
309.8 capacity, $215;

309.9 (8) for a vertical heat exchanger with ten to 50 tons of heating/cooling capacity, $425;

309.10 (9) for a vertical heat exchanger with greater than 50 tons of heating/cooling
309.11 capacity, $650;

309.12 ~~(7)~~ (10) for a dewatering well that is unsealed under a maintenance permit, $175
309.13 annually for each dewatering well, except a dewatering project comprising more than five
309.14 dewatering wells shall be issued a single permit for $875 annually for dewatering wells
309.15 recorded on the permit; and

309.16 ~~(8)~~ (11) for an elevator boring, $215 for each boring.

309.17 Sec. 2. Minnesota Statutes 2008, section 144.121, subdivision 1a, is amended to read:

309.18 Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with
309.19 ionizing radiation-producing equipment must pay an annual initial or annual renewal
309.20 registration fee consisting of a base facility fee of ~~$66~~ $100 and an additional fee for
309.21 each radiation source, as follows:

309.22	(1) medical or veterinary equipment	$ ~~53~~ 100
309.23	(2) dental x-ray equipment	$ ~~33~~ 40
309.24	~~(3) accelerator~~	~~$ 66~~
309.25	~~(4) radiation therapy equipment~~	~~$ 66~~
309.26 309.27	~~(5)~~ (3) x-ray equipment not used on humans or animals	$ ~~53~~ 100
309.28 309.29 309.30	~~(6)~~ (4) devices with sources of ionizing radiation not used on humans or animals	$ ~~53~~ 100

309.31 (b) A facility with radiation therapy and accelerator equipment must pay an annual
309.32 registration fee of $500. A facility with an industrial accelerator must pay an annual
309.33 registration fee of $150.

310.1 (c) Electron microscopy equipment is exempt from the registration fee requirements
310.2 of this section.

310.3 Sec. 3. Minnesota Statutes 2008, section 144.121, subdivision 1b, is amended to read:

310.4 Subd. 1b. **Penalty fee for late registration.** Applications for initial or renewal
310.5 registrations submitted to the commissioner after the time specified by the commissioner
310.6 shall be accompanied by ~~a penalty fee of $20~~ an amount equal to 25 percent of the fee
310.7 due in addition to the fees prescribed in subdivision 1a.

310.8 Sec. 4. Minnesota Statutes 2008, section 144.1222, subdivision 1a, is amended to read:

310.9 Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction,
310.10 installation, or alteration or requests for a variance that are submitted to the commissioner
310.11 according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate
310.12 fees. All public pool construction plans submitted for review after January 1, 2009,
310.13 must be certified by a professional engineer registered in the state of Minnesota. If the
310.14 commissioner determines, upon review of the plans, that inadequate fees were paid, the
310.15 necessary additional fees shall be paid before plan approval. For purposes of determining
310.16 fees, a project is defined as a proposal to construct or install a public pool, spa, special
310.17 purpose pool, or wading pool and all associated water treatment equipment and drains,
310.18 gutters, decks, water recreation features, spray pads, and those design and safety features
310.19 that are within five feet of any pool or spa. The commissioner shall charge the following
310.20 fees for plan review and inspection of public pools and spas and for requests for variance
310.21 from the public pool and spa rules:

310.22 (1) each pool, ~~$800~~ $1,500;

310.23 (2) each spa pool, ~~$500~~ $800;

310.24 (3) each slide, ~~$400~~ $600;

310.25 (4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses
310.26 (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum
310.27 fee of ~~$10,000~~ $15,000;

310.28 (5) alterations to an existing pool without changing the size or configuration of
310.29 the pool, ~~$400~~ $600;

310.30 (6) removal or replacement of pool disinfection equipment only, ~~$75~~ $100; and

310.31 (7) request for variance from the public pool and spa rules, $500.

310.32 Sec. 5. Minnesota Statutes 2008, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966. The fee is $101 per specimen. Effective July 1, 2010, the fee shall be increased to $106 per specimen. The increased fee amount shall be deposited in the general fund. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 6. Minnesota Statutes 2008, section 144.72, subdivision 1, is amended to read:

Subdivision 1. **~~Permits~~ License required.** The state commissioner of health is authorized to issue ~~permits for the operation of youth camps which are required to obtain the permits~~ a license according to chapter 157.

Sec. 7. Minnesota Statutes 2008, section 144.72, subdivision 3, is amended to read:

Subd. 3. **Issuance of ~~permits~~ license.** If the commissioner should determine from the application that the health and safety of the persons using the camp will be properly safeguarded, the commissioner may, prior to actual inspection of the camp, issue the ~~permit~~ license in writing. ~~No fee shall be charged for the permit.~~ The ~~permit~~ license shall be posted in a conspicuous place on the premises occupied by the camp.

Sec. 8. Minnesota Statutes 2008, section 144.9501, is amended by adding a subdivision to read:

Subd. 8a. **Disclosure pamphlet.** "Disclosure pamphlet" means the EPA pamphlet titled "Renovate Right: Important Lead Hazard Information for Families, Child Care Providers and Schools" developed under section 406(a) of the Toxic Substance Control Act.

312.1 Sec. 9. Minnesota Statutes 2008, section 144.9501, subdivision 22b, is amended to
312.2 read:

312.3 Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an
312.4 individual who performs clearance inspections for ~~nonabatement or nonorder lead hazard~~
312.5 ~~reduction~~ renovation sites~~,~~ and lead dust sampling ~~in other settings, or visual assessment~~
312.6 ~~for deteriorated paint~~ for nonabatement sites, and who is registered with the commissioner
312.7 under section 144.9505.

312.8 Sec. 10. Minnesota Statutes 2008, section 144.9501, subdivision 26a, is amended to
312.9 read:

312.10 Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:
312.11 (1) abatement;
312.12 (2) interim controls;
312.13 (3) a clearance inspection;
312.14 (4) a lead hazard screen;
312.15 (5) a lead inspection;
312.16 (6) a lead risk assessment;
312.17 (7) lead project designer services;
312.18 (8) lead sampling technician services; ~~or~~
312.19 (9) swab team services~~.~~;
312.20 (10) renovation activities; or
312.21 (11) activities performed to comply with lead orders issued by a board of health.
312.22 (b) Regulated lead work does not include abatement, interim controls, swab team
312.23 services, or renovation activities that disturb painted surfaces that total no more than:
312.24 ~~(1) activities such as remodeling, renovation, installation, rehabilitation, or~~
312.25 ~~landscaping activities, the primary intent of which is to remodel, repair, or restore a~~
312.26 ~~structure or dwelling, rather than to permanently eliminate lead hazards, even though these~~
312.27 ~~activities may incidentally result in a reduction in lead hazards; or~~
312.28 ~~(2) interim control activities that are not performed as a result of a lead order and~~
312.29 ~~that do not disturb painted surfaces that total more than:~~
312.30 ~~(i)~~ (1) 20 square feet (two square meters) on exterior surfaces; or
312.31 ~~(ii) two~~ (2) six square feet (~~0.2~~ 0.6 square meters) in an interior room~~; or~~.
312.32 ~~(iii) ten percent of the total surface area on an interior or exterior type of component~~
312.33 ~~with a small surface area.~~

313.1 Sec. 11. Minnesota Statutes 2008, section 144.9501, is amended by adding a
313.2 subdivision to read:

313.3 Subd. 26b. **Renovation.** "Renovation" means the modification of any affected
313.4 property that results in the disturbance of painted surfaces, unless that activity is performed
313.5 as an abatement. A renovation performed for the purpose of converting a building or part
313.6 of a building into an affected property is a renovation under this subdivision.

313.7 Sec. 12. Minnesota Statutes 2008, section 144.9505, subdivision 1g, is amended to
313.8 read:

313.9 Subd. 1g. **Certified lead firm.** ~~A person within the state intending to directly~~
313.10 ~~perform or cause to be performed through subcontracting or similar delegation any~~
313.11 ~~regulated lead work shall first obtain certification from the commissioner~~ A person who
313.12 employs individuals to perform regulated lead work outside of the person's property must
313.13 obtain certification as a lead firm. The certificate must be in writing, contain an expiration
313.14 date, be signed by the commissioner, and give the name and address of the person to
313.15 whom it is issued. The certification fee is $100, is nonrefundable, and must be submitted
313.16 with each application. The certificate or a copy of the certificate must be readily available
313.17 at the worksite for review by the contracting entity, the commissioner, and other public
313.18 health officials charged with the health, safety, and welfare of the state's citizens.

313.19 Sec. 13. Minnesota Statutes 2008, section 144.9505, subdivision 4, is amended to read:

313.20 Subd. 4. **Notice of regulated lead work.** (a) At least five working days before
313.21 starting work at each regulated lead worksite, the person performing the regulated lead
313.22 work shall give written notice to the commissioner and the appropriate board of health.
313.23 (b) This provision does not apply to lead hazard screen, lead inspection, lead risk
313.24 assessment, lead sampling technician, renovation, or lead project design activities.

313.25 Sec. 14. Minnesota Statutes 2008, section 144.9508, subdivision 2, is amended to read:

313.26 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner
313.27 shall adopt rules establishing regulated lead work standards and methods in accordance
313.28 with the provisions of this section, for lead in paint, dust, drinking water, and soil in
313.29 a manner that protects public health and the environment for all residences, including
313.30 residences also used for a commercial purpose, child care facilities, playgrounds, and
313.31 schools.
313.32 (b) In the rules required by this section, the commissioner shall require lead hazard
313.33 reduction of intact paint only if the commissioner finds that the intact paint is on a

314.1 chewable or lead-dust producing surface that is a known source of actual lead exposure to
314.2 a specific individual. The commissioner shall prohibit methods that disperse lead dust into
314.3 the air that could accumulate to a level that would exceed the lead dust standard specified
314.4 under this section. The commissioner shall work cooperatively with the commissioner
314.5 of administration to determine which lead hazard reduction methods adopted under this
314.6 section may be used for lead-safe practices including prohibited practices, preparation,
314.7 disposal, and cleanup. The commissioner shall work cooperatively with the commissioner
314.8 of the Pollution Control Agency to develop disposal procedures. In adopting rules under
314.9 this section, the commissioner shall require the best available technology for regulated
314.10 lead work methods, paint stabilization, and repainting.

314.11 (c) The commissioner of health shall adopt regulated lead work standards and
314.12 methods for lead in bare soil in a manner to protect public health and the environment.
314.13 The commissioner shall adopt a maximum standard of 100 parts of lead per million in
314.14 bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts
314.15 of lead per million. Soil lead hazard reduction methods shall focus on erosion control
314.16 and covering of bare soil.

314.17 (d) The commissioner shall adopt regulated lead work standards and methods for
314.18 lead in dust in a manner to protect the public health and environment. Dust standards
314.19 shall use a weight of lead per area measure and include dust on the floor, on the window
314.20 sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust
314.21 removal and other practices which minimize the formation of lead dust from paint, soil, or
314.22 other sources.

314.23 (e) The commissioner shall adopt lead hazard reduction standards and methods for
314.24 lead in drinking water both at the tap and public water supply system or private well
314.25 in a manner to protect the public health and the environment. The commissioner may
314.26 adopt the rules for controlling lead in drinking water as contained in Code of Federal
314.27 Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include
314.28 an educational approach of minimizing lead exposure from lead in drinking water.

314.29 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
314.30 removal of exterior lead-based coatings from residences and steel structures by abrasive
314.31 blasting methods is conducted in a manner that protects health and the environment.

314.32 (g) All regulated lead work standards shall provide reasonable margins of safety that
314.33 are consistent with more than a summary review of scientific evidence and an emphasis on
314.34 overprotection rather than underprotection when the scientific evidence is ambiguous.

314.35 (h) No unit of local government shall have an ordinance or regulation governing
314.36 regulated lead work standards or methods for lead in paint, dust, drinking water, or soil

315.1 that require a different regulated lead work standard or method than the standards or
315.2 methods established under this section.

315.3 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit
315.4 of local government of an innovative lead hazard reduction method which is consistent
315.5 in approach with methods established under this section.

315.6 (j) The commissioner shall adopt rules for issuing lead orders required under section
315.7 144.9504, rules for notification of abatement or interim control activities requirements,
315.8 and other rules necessary to implement sections 144.9501 to 144.9512.

315.9 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the
315.10 Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property
315.11 where a child or pregnant female resides is conducted in a manner that protects health
315.12 and the environment.

315.13 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of
315.14 the Toxic Substances Control Act.

315.15 Sec. 15. Minnesota Statutes 2008, section 144.9508, subdivision 3, is amended to read:

315.16 Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to
315.17 license lead supervisors, lead workers, lead project designers, lead inspectors, ~~and~~ lead
315.18 risk assessors, and lead sampling technicians. The commissioner shall also adopt rules
315.19 requiring certification of firms that perform regulated lead work ~~and rules requiring~~
315.20 ~~registration of lead sampling technicians~~. The commissioner shall require periodic renewal
315.21 of licenses~~,~~ and certificates~~, and registrations~~ and shall establish the renewal periods.

315.22 Sec. 16. Minnesota Statutes 2008, section 144.9508, subdivision 4, is amended to read:

315.23 Subd. 4. **Lead training course.** The commissioner shall establish by rule
315.24 requirements for training course providers and the renewal period for each lead-related
315.25 training course required for certification or licensure. The commissioner shall establish
315.26 criteria in rules for the content and presentation of training courses intended to qualify
315.27 trainees for licensure under subdivision 3. The commissioner shall establish criteria
315.28 in rules for the content and presentation of training courses for lead ~~interim control~~
315.29 ~~workers~~ renovation and lead sampling technicians. Training course permit fees shall be
315.30 nonrefundable and must be submitted with each application in the amount of $500 for an
315.31 initial training course, $250 for renewal of a permit for an initial training course, $250 for
315.32 a refresher training course, and $125 for renewal of a permit of a refresher training course.

315.33 Sec. 17. Minnesota Statutes 2008, section 144.9512, subdivision 2, is amended to read:

316.1 Subd. 2. **Grants; administration.** Within the limits of the available appropriation,
316.2 the commissioner shall make grants to ~~a~~ nonprofit ~~organization currently operating the~~
316.3 ~~CLEARCorps lead hazard reduction project~~ organizations to train workers to provide lead
316.4 screening, education, outreach, and swab team services for residential property. Projects
316.5 that provide Americorps funding or positions, or leverage matching funds, as part of the
316.6 delivery of the services must be given priority for the grant funds.

316.7 Sec. 18. Minnesota Statutes 2008, section 144.966, is amended by adding a subdivision
316.8 to read:

316.9 Subd. 3a. **Support services to families.** The commissioner shall contract with
316.10 a nonprofit organization to provide support and assistance to families with children
316.11 who are deaf or have a hearing loss. The family support provided must include direct
316.12 parent-to-parent assistance and information on communication, educational, and medical
316.13 options. The commissioner shall give preference to a nonprofit organization that has the
316.14 ability to provide these services throughout the state.

316.15 Sec. 19. Minnesota Statutes 2008, section 144.97, subdivision 2, is amended to read:

316.16 Subd. 2. ~~**Certification**~~ **Accreditation.** ~~"Certification" means written~~
316.17 ~~acknowledgment of a laboratory's demonstrated capability to perform tests for a specific~~
316.18 ~~purpose~~ "Accreditation" means written acknowledgment that a laboratory has the
316.19 policies, procedures, equipment, and practices to produce reliable data in the analysis of
316.20 environmental samples.

316.21 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.22 Sec. 20. Minnesota Statutes 2008, section 144.97, subdivision 4, is amended to read:

316.23 Subd. 4. ~~**Contract**~~ **Commercial laboratory.** "~~Contract~~ Commercial laboratory"
316.24 means a laboratory that performs tests on samples on a contract or fee-for-service basis.

316.25 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.26 Sec. 21. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision
316.27 to read:

316.28 Subd. 5a. **Field of testing.** "Field of testing" means the combination of analyte,
316.29 method, matrix, and test category for which a laboratory may hold accreditation.

316.30 **EFFECTIVE DATE.** This section is effective July 1, 2009.

Sec. 22. Minnesota Statutes 2008, section 144.97, subdivision 6, is amended to read:

Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other entity, including governmental, that examines, analyzes, or tests samples in a specified physical location.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 23. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision to read:

Subd. 8. **Test category.** "Test category" means the combination of program and category as provided by section 144.98, subdivisions 3, paragraph (b), clauses (1) to (10), and 3a, paragraph (a), clauses (1) to (5).

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 24. Minnesota Statutes 2008, section 144.98, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** The commissioner of health ~~may certify~~ shall accredit environmental laboratories ~~that test environmental samples~~ according to national standards developed using a consensus process as established by Circular A-119, published by the United States Office of Management and Budget.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 25. Minnesota Statutes 2008, section 144.98, subdivision 2, is amended to read:

Subd. 2. **Rules and standards.** The commissioner may adopt rules to ~~implement this section, including:~~ carry out the commissioner's responsibilities under the national standards specified in subdivisions 1 and 2a.

~~(1) procedures, requirements, and fee adjustments for laboratory certification, including provisional status and recertification;~~

~~(2) standards and fees for certificate approval, suspension, and revocation;~~

~~(3) standards for environmental samples;~~

~~(4) analysis methods that assure reliable test results;~~

~~(5) laboratory quality assurance, including internal quality control, proficiency testing, and personnel training; and~~

~~(6) criteria for recognition of certification programs of other states and the federal government.~~

EFFECTIVE DATE. This section is effective July 1, 2009.

318.1 Sec. 26. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
318.2 to read:

318.3 Subd. 2a. **Standards.** The commissioner shall accredit laboratories according to
318.4 the most current environmental laboratory accreditation standards under subdivision 1
318.5 and as accepted by the accreditation bodies recognized by the National Environmental
318.6 Laboratory Accreditation Program (NELAP) of the NELAC Institute.

318.7 **EFFECTIVE DATE.** This section is effective July 1, 2009.

318.8 Sec. 27. Minnesota Statutes 2008, section 144.98, subdivision 3, is amended to read:

318.9 Subd. 3. **Annual fees.** (a) An application for ~~certification~~ accreditation under
318.10 subdivision ~~1~~ 6 must be accompanied by the ~~biennial fee~~ annual fees specified in this
318.11 subdivision. The ~~fees are for~~ annual fees include:

318.12 (1) base ~~certification~~ accreditation fee, ~~$1,600~~ $1,500;

318.13 (2) sample preparation techniques ~~fees~~ fee, ~~$100~~ $200 per technique; ~~and~~

318.14 (3) an administrative fee for laboratories located outside this state, $3,750; and

318.15 (4) test category ~~certification~~ fees~~:~~.

	~~Test Category~~	~~Certification Fee~~
318.16-318.17	~~Clean water program bacteriology~~	~~$800~~
318.18	~~Safe drinking water program bacteriology~~	~~$800~~
318.19	~~Clean water program inorganic chemistry~~	~~$800~~
318.20	~~Safe drinking water program inorganic chemistry~~	~~$800~~
318.21	~~Clean water program chemistry metals~~	~~$1,200~~
318.22	~~Safe drinking water program chemistry metals~~	~~$1,200~~
318.23	~~Resource conservation and recovery program chemistry metals~~	~~$1,200~~
318.24	~~Clean water program volatile organic compounds~~	~~$1,500~~
318.25	~~Safe drinking water program volatile organic compounds~~	~~$1,500~~
318.26-318.27	~~Resource conservation and recovery program volatile organic compounds~~	~~$1,500~~
318.28	~~Underground storage tank program volatile organic compounds~~	~~$1,500~~
318.29	~~Clean water program other organic compounds~~	~~$1,500~~
318.30	~~Safe drinking water program other organic compounds~~	~~$1,500~~
318.31	~~Resource conservation and recovery program other organic compounds~~	~~$1,500~~

319.1 ~~Clean water program radiochemistry~~ ~~$2,500~~

319.2 ~~Safe drinking water program radiochemistry~~ ~~$2,500~~

319.3 ~~Resource conservation and recovery program agricultural contaminants~~ ~~$2,500~~

319.4 ~~Resource conservation and recovery program emerging contaminants~~ ~~$2,500~~

319.5 (b) ~~Laboratories located outside of this state that require an on-site inspection shall be~~
319.6 ~~assessed an additional $3,750 fee.~~ For the programs in subdivision 3a, the commissioner
319.7 may accredit laboratories for fields of testing under the categories listed in clauses (1) to
319.8 (10) upon completion of the application requirements provided by subdivision 6 and
319.9 receipt of the fees for each category under each program that accreditation is requested.
319.10 The categories offered and related fees include:

319.11 (1) microbiology, $450;

319.12 (2) inorganics, $450;

319.13 (3) metals, $1,000;

319.14 (4) volatile organics, $1,300;

319.15 (5) other organics, $1,300;

319.16 (6) radiochemistry, $1,500;

319.17 (7) emerging contaminants, $1,500;

319.18 (8) agricultural contaminants, $1,250;

319.19 (9) toxicity (bioassay), $1,000; and

319.20 (10) physical characterization, $250.

319.21 (c) The total ~~biennial certification~~ annual fee includes the base fee, the sample
319.22 preparation techniques fees, the test category fees per program, and, when applicable, ~~the~~
319.23 ~~on-site inspection fee~~ an administrative fee for out-of-state laboratories.

319.24 ~~(d) Fees must be set so that the total fees support the laboratory certification program.~~
319.25 ~~Direct costs of the certification service include program administration, inspections, the~~
319.26 ~~agency's general support costs, and attorney general costs attributable to the fee function.~~

319.27 ~~(e) A change fee shall be assessed if a laboratory requests additional analytes~~
319.28 ~~or methods at any time other than when applying for or renewing its certification. The~~
319.29 ~~change fee is equal to the test category certification fee for the analyte.~~

319.30 ~~(f) A variance fee shall be assessed if a laboratory requests and is granted a variance~~
319.31 ~~from a rule adopted under this section. The variance fee is $500 per variance.~~

319.32 ~~(g) Refunds or credits shall not be made for analytes or methods requested but~~
319.33 ~~not approved.~~

319.34 ~~(h) Certification of a laboratory shall not be awarded until all fees are paid.~~

320.1 Sec. 28. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
320.2 to read:

320.3 Subd. 3a. **Available programs, categories, and analytes.** (a) The commissioner
320.4 shall accredit laboratories that test samples under the following programs:
320.5 (1) the clean water program, such as compliance monitoring under the federal Clean
320.6 Water Act, and ambient monitoring of surface and groundwater, or analysis of biological
320.7 tissue;
320.8 (2) the safe drinking water program, including compliance monitoring under the
320.9 federal Safe Drinking Water Act, and the state requirements for monitoring private wells;
320.10 (3) the resource conservation and recovery program, including federal and state
320.11 requirements for monitoring solid and hazardous wastes, biological tissue, leachates, and
320.12 groundwater monitoring wells not intended as drinking water sources;
320.13 (4) the underground storage tank program; and
320.14 (5) the clean air program, including air and emissions testing under the federal Clean
320.15 Air Act, and state and federal requirements for vapor intrusion monitoring.
320.16 (b) The commissioner shall maintain and publish a list of analytes available for
320.17 accreditation. The list must be reviewed at least once every six months and the changes
320.18 published in the State Register and posted on the program's Web site. The commissioner
320.19 shall publish the notification of changes and review comments on the changes no less than
320.20 30 days from the date the list is published.

320.21 Sec. 29. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
320.22 to read:

320.23 Subd. 3b. **Additional fees.** (a) Laboratories located outside of this state that require
320.24 an on-site assessment more frequent than once every two years must pay an additional
320.25 assessed fee of $3,000 per assessment for each additional on-site assessment conducted.
320.26 The laboratory must pay the fee within 15 business days of receiving the commissioner's
320.27 notification that an on-site assessment is required. The commissioner may conduct
320.28 additional on-site assessments to determine a laboratory's continued compliance with
320.29 the standards provided in subdivision 2a.
320.30 (b) A late fee of $200 shall be added to the annual fee for accredited laboratories
320.31 submitting renewal applications to the commissioner after November 1.
320.32 (c) A change fee shall be assessed if a laboratory requests additional fields of testing
320.33 at any time other than when initially applying for or renewing its accreditation. A change
320.34 fee does not apply for applications to add fields of testing for new analytes in response
320.35 to the published notice under subdivision 3a, paragraph (b), if the laboratory holds valid

321.1 accreditation for the changed test category and applies for additional analytes within the
321.2 same test category. The change fee is equal to the applicable test category fee for the
321.3 field of testing requested. An application that requests accreditation of multiple fields of
321.4 testing within a test category requires a single payment of the applicable test category fee
321.5 per application submitted.

321.6 (d) A variance fee shall be assessed if a laboratory requests a variance from a
321.7 standard provided in subdivision 2a. The variance fee is $500 per variance.

321.8 (e) The commissioner shall assess a fee for changes to laboratory information
321.9 regarding ownership, name, address, or personnel. Laboratories must submit changes
321.10 through the application process under subdivision 6. The information update fee is $250
321.11 per application.

321.12 (f) Fees must be set so that the total fees support the laboratory accreditation
321.13 program. Direct costs of the accreditation service include program administration,
321.14 assessments, the agency's general support costs, and attorney general costs attributable
321.15 to the fee function.

321.16 Sec. 30. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
321.17 to read:

321.18 Subd. 3c. **Refunds and nonpayment.** Refunds or credits shall not be made for
321.19 applications received but not approved. Accreditation of a laboratory shall not be awarded
321.20 until all fees are paid.

321.21 Sec. 31. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
321.22 to read:

321.23 Subd. 6. **Application.** (a) Laboratories seeking accreditation must apply on a form
321.24 provided by the commissioner, include the laboratory's procedures and quality manual,
321.25 and pay the applicable fees.

321.26 (b) Laboratories may be fixed-base or mobile. The commissioner shall accredit
321.27 mobile laboratories individually and require a vehicle identification number, license
321.28 plate number, or other uniquely identifying information in addition to the application
321.29 requirements of paragraph (a).

321.30 (c) Laboratories maintained on separate properties, even though operated under the
321.31 same management or ownership, must apply separately. Laboratories with more than one
321.32 building on the same or adjoining properties do not need to submit a separate application.

321.33 (d) The commissioner may accredit laboratories located out-of-state. Accreditation
321.34 for out-of-state laboratories may be obtained directly from the commissioner following

322.1 the requirements in paragraph (a), or out-of-state laboratories may be accredited through
322.2 a reciprocal agreement if the laboratory:
322.3 (1) is accredited by a NELAP-recognized accreditation body for those fields of
322.4 testing in which the laboratory requests accreditation from the commissioner;
322.5 (2) submits an application and documentation according to this subdivision; and
322.6 (3) submits a current copy of the laboratory's unexpired accreditation from a
322.7 NELAP-recognized accreditation body showing the fields of accreditation for which the
322.8 laboratory is currently accredited.
322.9 (e) Under the conflict of interest determinations provided in section 43A.38,
322.10 subdivision 6, clause (a), the commissioner shall not accredit governmental laboratories
322.11 operated by agencies of the executive branch of the state. If accreditation is required,
322.12 laboratories operated by agencies of the executive branch of the state must apply for
322.13 accreditation through any other NELAP-recognized accreditation body.

322.14 **EFFECTIVE DATE.** This section is effective July 1, 2009.

322.15 Sec. 32. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
322.16 to read:

322.17 Subd. 6a. **Implementation and effective date.** All laboratories must comply with
322.18 standards under this section by July 1, 2009. Fees under subdivisions 3 and 3b apply to
322.19 applications received and accreditations issued after June 30, 2009. Accreditations issued
322.20 on or before June 30, 2009, shall expire upon their current expiration date.

322.21 Sec. 33. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
322.22 to read:

322.23 Subd. 7. **Initial accreditation and annual accreditation renewal.** (a) The
322.24 commissioner shall issue or renew accreditation after receipt of the completed application
322.25 and documentation required in this section, provided the laboratory maintains compliance
322.26 with the standards specified in subdivision 2a, and attests to the compliance on the
322.27 application form.
322.28 (b) The commissioner shall prorate the fees in subdivision 3 for laboratories
322.29 applying for accreditation after December 31. The fees are prorated on a quarterly basis
322.30 beginning with the quarter in which the commissioner receives the completed application
322.31 from the laboratory.
322.32 (c) Applications for renewal of accreditation must be received by November 1 and
322.33 no earlier than October 1 of each year. The commissioner shall send annual renewal

323.1 notices to laboratories 90 days before expiration. Failure to receive a renewal notice does
323.2 not exempt laboratories from meeting the annual November 1 renewal date.
323.3 (d) The commissioner shall issue all accreditations for the calendar year for which
323.4 the application is made, and the accreditation shall expire on December 31 of that year.
323.5 (e) The accreditation of any laboratory that fails to submit a renewal application
323.6 and fees to the commissioner expires automatically on December 31 without notice or
323.7 further proceeding. Any person who operates a laboratory as accredited after expiration of
323.8 accreditation or without having submitted an application and paid the fees is in violation
323.9 of the provisions of this section and is subject to enforcement action under sections
323.10 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired
323.11 accreditation may reapply under subdivision 6.

323.12 **EFFECTIVE DATE.** This section is effective July 1, 2009.

323.13 Sec. 34. Minnesota Statutes 2008, section 144.99, subdivision 1, is amended to read:

323.14 Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and
323.15 sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12),
323.16 (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to
323.17 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97
323.18 to 144.98; 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and
323.19 all rules, orders, stipulation agreements, settlements, compliance agreements, licenses,
323.20 registrations, certificates, and permits adopted or issued by the department or under any
323.21 other law now in force or later enacted for the preservation of public health may, in
323.22 addition to provisions in other statutes, be enforced under this section.

323.23 **EFFECTIVE DATE.** This section is effective July 1, 2009.

323.24 Sec. 35. Minnesota Statutes 2008, section 153A.17, is amended to read:

323.25 **153A.17 EXPENSES; FEES.**

323.26 ~~The expenses for administering the certification requirements including the~~
323.27 ~~complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15~~
323.28 ~~and the Consumer Information Center under section 153A.18 must be paid from~~
323.29 ~~initial application and examination fees, renewal fees, penalties, and fines. All fees~~
323.30 ~~are nonrefundable. The certificate application fee is $350, the examination fee is $250~~
323.31 ~~for the written portion and $250 for the practical portion each time one or the other is~~
323.32 ~~taken, and the trainee application fee is $200. The penalty fee for late submission of a~~
323.33 ~~renewal application is $200. The fee for verification of certification to other jurisdictions~~
323.34 ~~or entities is $25. All fees, penalties, and fines received must be deposited in the state~~

324.1 government special revenue fund. The commissioner may prorate the certification fee for
324.2 new applicants based on the number of quarters remaining in the annual certification
324.3 period. (a) The expenses for administering the certification requirements, including the
324.4 complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15,
324.5 and the Consumer Information Center under section 153A.18, must be paid from initial
324.6 application and examination fees, renewal fees, penalties, and fines.

324.7 (b) The fees are as follows:

324.8 (1) the initial and annual renewal certification application fee is $600;

324.9 (2) the initial examination fee for the written portion is $500, and for each time it
324.10 is taken, thereafter;

324.11 (3) the initial examination fee for the practical portion is $1,200, and $600 for each
324.12 time it is taken, thereafter; for individuals meeting the requirements of section 148.515,
324.13 subdivision 2, the fee for the practical portion of the hearing instrument dispensing
324.14 examination is $250 each time it is taken;

324.15 (4) the trainee application fee is $200;

324.16 (5) the penalty fee for late submission of a renewal application is $200; and

324.17 (6) the fee for verification of certification to other jurisdictions or entities is $25.

324.18 (c) The commissioner may prorate the certification fee for new applicants based on
324.19 the number of quarters remaining in the annual certification period.

324.20 (d) All fees are nonrefundable. All fees, penalties, and fines received must be
324.21 deposited in the state government special revenue fund.

324.22 (e) Beginning July 1, 2009, until June 30, 2016, a surcharge of $100 shall be paid
324.23 at the time of initial certification application or renewal to recover the commissioner's
324.24 accumulated direct expenditures for administering the requirements of this chapter.

324.25 Sec. 36. Minnesota Statutes 2008, section 157.15, is amended by adding a subdivision
324.26 to read:

324.27 Subd. 20. **Youth camp.** "Youth camp" has the meaning given in section 144.71,
324.28 subdivision 2.

324.29 Sec. 37. Minnesota Statutes 2008, section 157.16, is amended to read:

324.30 **157.16 LICENSES REQUIRED; FEES.**

324.31 Subdivision 1. **License required annually.** A license is required annually for every
324.32 person, firm, or corporation engaged in the business of conducting a food and beverage
324.33 service establishment, youth camp, hotel, motel, lodging establishment, public pool, or
324.34 resort. Any person wishing to operate a place of business licensed in this section shall

325.1 first make application, pay the required fee specified in this section, and receive approval
325.2 for operation, including plan review approval. ~~Seasonal and temporary food stands and~~
325.3 Special event food stands are not required to submit plans. Nonprofit organizations
325.4 operating a special event food stand with multiple locations at an annual one-day event
325.5 shall be issued only one license. Application shall be made on forms provided by the
325.6 commissioner and shall require the applicant to state the full name and address of the
325.7 owner of the building, structure, or enclosure, the lessee and manager of the food and
325.8 beverage service establishment, hotel, motel, lodging establishment, public pool, or resort;
325.9 the name under which the business is to be conducted; and any other information as may
325.10 be required by the commissioner to complete the application for license.

325.11 Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage
325.12 service establishments, youth camps, hotels, motels, lodging establishments, public pools,
325.13 and resorts shall be issued ~~for the calendar year for which application is made and shall~~
325.14 ~~expire on December 31 of such year~~ on an annual basis. Any person who operates a place
325.15 of business after the expiration date of a license or without having submitted an application
325.16 and paid the fee shall be deemed to have violated the provisions of this chapter and shall
325.17 be subject to enforcement action, as provided in the Health Enforcement Consolidation
325.18 Act, sections 144.989 to 144.993. In addition, a penalty of ~~$50~~ $60 shall be added to the
325.19 total of the license fee for any food and beverage service establishment operating without
325.20 a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or
325.21 a special event food stand, and a penalty of ~~$100~~ $120 shall be added to the total of the
325.22 license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth
325.23 camps, public pools, and resorts operating without a license for a period of up to 30 days.
325.24 A late fee of ~~$300~~ $360 shall be added to the license fee for establishments operating more
325.25 than 30 days without a license.

325.26 Subd. 2a. **Food manager certification.** An applicant for certification or certification
325.27 renewal as a food manager must submit to the commissioner a ~~$28~~ $35 nonrefundable
325.28 certification fee payable to the Department of Health. The commissioner shall issue a
325.29 duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant
325.30 submits a completed application on a form provided by the commissioner for a duplicate
325.31 certificate and pays $20 to the department for the cost of duplication.

325.32 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required
325.33 for food and beverage service establishments, youth camps, hotels, motels, lodging
325.34 establishments, public pools, and resorts licensed under this chapter. Food and beverage
325.35 service establishments must pay the highest applicable fee under paragraph (d), clause

326.1 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
326.2 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
326.3 licensed under this chapter for the same calendar year is one-half of the appropriate annual
326.4 license fee, plus any penalty that may be required. The license fee for operators opening
326.5 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
326.6 that may be required.

326.7 (b) All food and beverage service establishments, except special event food stands,
326.8 and all hotels, motels, lodging establishments, public pools, and resorts shall pay an
326.9 annual base fee of $150.

326.10 (c) A special event food stand shall pay a flat fee of ~~$40~~ $50 annually. "Special event
326.11 food stand" means a fee category where food is prepared or served in conjunction with
326.12 celebrations, county fairs, or special events from a special event food stand as defined
326.13 in section 157.15.

326.14 (d) In addition to the base fee in paragraph (b), each food and beverage service
326.15 establishment, other than a special event food stand, and each hotel, motel, lodging
326.16 establishment, public pool, and resort shall pay an additional annual fee for each fee
326.17 category, additional food service, or required additional inspection specified in this
326.18 paragraph:

326.19 (1) Limited food menu selection, ~~$50~~ $60. "Limited food menu selection" means a
326.20 fee category that provides one or more of the following:

326.21 (i) prepackaged food that receives heat treatment and is served in the package;

326.22 (ii) frozen pizza that is heated and served;

326.23 (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

326.24 (iv) soft drinks, coffee, or nonalcoholic beverages; or

326.25 (v) cleaning for eating, drinking, or cooking utensils, when the only food served
326.26 is prepared off site.

326.27 (2) Small establishment, including boarding establishments, ~~$100~~ $120. "Small
326.28 establishment" means a fee category that has no salad bar and meets one or more of
326.29 the following:

326.30 (i) possesses food service equipment that consists of no more than a deep fat fryer, a
326.31 grill, two hot holding containers, and one or more microwave ovens;

326.32 (ii) serves dipped ice cream or soft serve frozen desserts;

326.33 (iii) serves breakfast in an owner-occupied bed and breakfast establishment;

326.34 (iv) is a boarding establishment; or

326.35 (v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum
326.36 patron seating capacity of not more than 50.

(3) Medium establishment, ~~$260~~ $310. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, ~~$460~~ $540. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$50~~ $60.

(6) Beer or wine table service, ~~$50~~ $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, ~~$135~~ $165.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, ~~$8~~ $10, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$800~~ $1,000. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public pool, ~~$180~~ $325; each additional public pool, ~~$100~~ $175. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

(10) First spa, ~~$110~~ $175; each additional spa, ~~$50~~ $100. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, ~~$50~~ $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in

328.1 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
328.2 individual sewage treatment system which uses subsurface treatment and disposal.

328.3 (12) Additional food service, ~~$130~~ $150. "Additional food service" means a location
328.4 at a food service establishment, other than the primary food preparation and service area,
328.5 used to prepare or serve food to the public.

328.6 (13) Additional inspection fee, ~~$300~~ $360. "Additional inspection fee" means a
328.7 fee to conduct the second inspection each year for elementary and secondary education
328.8 facility school lunch programs when required by the Richard B. Russell National School
328.9 Lunch Act.

328.10 (e) A fee ~~of $350~~ for review of ~~the~~ construction plans must accompany the initial
328.11 license application for restaurants, hotels, motels, lodging establishments, ~~or~~ resorts ~~with~~
328.12 ~~five or more sleeping units.~~, seasonal food stands, and mobile food units. The fee for
328.13 this construction plan review is as follows:

	Service Area	Type	Fee
328.14	**Service Area**	**Type**	**Fee**
328.15	Food	limited food menu	$275
328.16		small establishment	$400
328.17		medium establishment	$450
328.18		large food establishment	$500
328.19		additional food service	$150
328.20	Transient food service	food cart	$250
328.21		seasonal permanent food stand	$250
328.22		seasonal temporary food stand	$250
328.23		mobile food unit	$350
328.24	Alcohol	beer or wine table service	$150
328.25		alcohol service from bar	$250
328.26	Lodging	less than 25 rooms	$375
328.27		25 to less than 100 rooms	$400
328.28		100 rooms or more	$500
328.29		less than five cabins	$350
328.30		five to less than ten cabins	$400
328.31		ten cabins or more	$450

329.1 (f) When existing food and beverage service establishments, hotels, motels, lodging
329.2 establishments, ~~or~~ resorts, seasonal food stands, and mobile food units are extensively
329.3 remodeled, a fee ~~of $250~~ must be submitted with the remodeling plans. ~~A fee of $250~~
329.4 ~~must be submitted for new construction or remodeling for a restaurant with a limited food~~
329.5 ~~menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for~~
329.6 ~~a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.~~
329.7 The fee for this construction plan review is as follows:

	Service Area	**Type**	**Fee**
329.9	Food	limited food menu	$250
329.10		small establishment	$300
329.11		medium establishment	$350
329.12		large food establishment	$400
329.13		additional food service	$150
329.14	Transient food service	food cart	$250
329.15		seasonal permanent food stand	$250
329.16		seasonal temporary food stand	$250
329.17		mobile food unit	$250
329.18	Alcohol	beer or wine table service	$150
329.19		alcohol service from bar	$250
329.20	Lodging	less than 25 rooms	$250
329.21		25 to less than 100 rooms	$300
329.22		100 rooms or more	$450
329.23		less than five cabins	$250
329.24		five to less than ten cabins	$350
329.25		ten cabins or more	$400

329.26 (g) ~~Seasonal temporary food stands and~~ Special event food stands are not required to
329.27 submit construction or remodeling plans for review.
329.28 (h) Youth camps shall pay an annual single fee for food and lodging as follows:
329.29 (1) camps with up to 99 campers, $325;
329.30 (2) camps with 100 to 199 campers, $550; and
329.31 (3) camps with 200 or more campers; $750.

330.1 Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that
330.2 operates a licensed boarding establishment, food and beverage service establishment,
330.3 seasonal temporary or permanent food stand, special event food stand, mobile food unit,
330.4 food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the
330.5 commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee
330.6 for establishments licensed by the Department of Health is required at the same time the
330.7 licensure fee is due. For establishments licensed by local governments, the fee is due by
330.8 July 1 of each year.

330.9 Subd. 4. **Posting requirements.** Every food and beverage service establishment,
330.10 for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must have
330.11 the license posted in a conspicuous place at the establishment. Mobile food units, food
330.12 carts, and seasonal temporary food stands shall be issued decals with the initial license and
330.13 each calendar year with license renewals. The current license year decal must be placed on
330.14 the unit or stand in a location determined by the commissioner. Decals are not transferable.

330.15 Sec. 38. Minnesota Statutes 2008, section 157.22, is amended to read:

330.16 **157.22 EXEMPTIONS.**

330.17 This chapter ~~shall not be construed to~~ does not apply to:
330.18 (1) interstate carriers under the supervision of the United States Department of
330.19 Health and Human Services;
330.20 (2) any building constructed and primarily used for religious worship;
330.21 (3) any building owned, operated, and used by a college or university in accordance
330.22 with health regulations promulgated by the college or university under chapter 14;
330.23 (4) any person, firm, or corporation whose principal mode of business is licensed
330.24 under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food
330.25 or beverage establishment; provided that the holding of any license pursuant to sections
330.26 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable
330.27 provisions of this chapter or the rules of the state commissioner of health relating to
330.28 food and beverage service establishments;
330.29 (5) family day care homes and group family day care homes governed by sections
330.30 245A.01 to 245A.16;
330.31 (6) nonprofit senior citizen centers for the sale of home-baked goods;
330.32 (7) fraternal or patriotic organizations that are tax exempt under section 501(c)(3),
330.33 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of
330.34 1986, or organizations related to or affiliated with such fraternal or patriotic organizations.

331.1 Such organizations may organize events at which home-prepared food is donated by
331.2 organization members for sale at the events, provided:
331.3 (i) the event is not a circus, carnival, or fair;
331.4 (ii) the organization controls the admission of persons to the event, the event agenda,
331.5 or both; and
331.6 (iii) the organization's licensed kitchen is not used in any manner for the event;
331.7 (8) food not prepared at an establishment and brought in by individuals attending a
331.8 potluck event for consumption at the potluck event. An organization sponsoring a potluck
331.9 event under this clause may advertise the potluck event to the public through any means.
331.10 Individuals who are not members of an organization sponsoring a potluck event under this
331.11 clause may attend the potluck event and consume the food at the event. Licensed food
331.12 establishments other than schools cannot be sponsors of potluck events. A school may
331.13 sponsor and hold potluck events in areas of the school other than the school's kitchen,
331.14 provided that the school's kitchen is not used in any manner for the potluck event. For
331.15 purposes of this clause, "school" means a public school as defined in section 120A.05,
331.16 subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization
331.17 at which a child is provided with instruction in compliance with sections 120A.22 and
331.18 120A.24. Potluck event food shall not be brought into a licensed food establishment
331.19 kitchen; ~~and~~
331.20 (9) a home school in which a child is provided instruction at home; and
331.21 (10) concession stands operated in conjunction with school-sponsored events on
331.22 school property are exempt from the 21-day restriction.

331.23 Sec. 39. Minnesota Statutes 2008, section 327.14, is amended by adding a subdivision
331.24 to read:

331.25 Subd. 9. **Special event recreational camping area.** "Special event recreational
331.26 camping area" means a recreational camping area which operates no more than two times
331.27 annually and for no more than 14 consecutive days.

331.28 Sec. 40. Minnesota Statutes 2008, section 327.15, is amended to read:

331.29 **327.15 LICENSE REQUIRED; RENEWAL; ~~PLANS FOR EXPANSION~~ FEES.**

331.30 Subdivision 1. **License required; plan review.** No person, firm or corporation shall
331.31 establish, maintain, conduct or operate a manufactured home park or recreational camping
331.32 area within this state without first obtaining ~~a~~ an annual license ~~therefor~~ from the state
331.33 Department of Health. Any person wishing to obtain a license shall submit an application,
331.34 pay the required fee specified in this section, and receive approval for operation, including

332.1 plan review approval. Application shall be made on forms provided by the commissioner
332.2 and shall require the applicant to state the full name and address of the owner of the
332.3 manufactured home park or recreational camping area, the name under which the business
332.4 is to be conducted, and any other information as may be required by the commissioner
332.5 to complete the application for license. Any person, firm, or corporation desiring to
332.6 operate either a manufactured home park or a recreational camping area on the same site
332.7 in connection with the other, need only obtain one license. ~~A license shall expire and be~~
332.8 ~~renewed as prescribed by the commissioner pursuant to section 144.122.~~ The license shall
332.9 state the number of manufactured home sites and recreational camping sites allowed
332.10 according to state commissioner of health approval. ~~No renewal license shall be issued if~~
332.11 ~~the number of sites specified in the application exceeds those of the original application~~
332.12 The number of licensed sites shall not be increased unless the plans for expansion ~~or~~
332.13 ~~the construction for expansion~~ are ~~first~~ submitted and the expansion is approved by
332.14 the Department of Health. ~~Any manufactured home park or recreational camping area~~
332.15 ~~located in more than one municipality shall be dealt with as two separate manufactured~~
332.16 ~~home parks or camping areas.~~ The license shall be conspicuously displayed in the office
332.17 of the manufactured home park or camping area. The license is not transferable ~~as to~~ to
332.18 another person or place.

332.19 Subd. 2. **License renewal.** Initial and renewal licenses for all manufactured home
332.20 parks and recreational camping areas shall be issued annually and shall have an expiration
332.21 date included on the license. Any person who operates a manufactured home park or
332.22 recreational camping area after the expiration date of a license or without having submitted
332.23 an application and paid the fee shall be deemed to have violated the provisions of this
332.24 chapter and shall be subject to enforcement action, as provided in the Health Enforcement
332.25 Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $120 shall
332.26 be added to the total of the license fee for any manufactured home park or recreational
332.27 camping area operating without a license for a period of up to 30 days. A late fee of $360
332.28 shall be added to the license fee for any manufactured home park or recreational camping
332.29 area operating more than 30 days without a license.

332.30 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)
332.31 The following fees are required for manufactured home parks and recreational camping
332.32 areas licensed under this chapter. Recreational camping areas and manufactured home
332.33 parks shall pay the highest applicable fee under paragraph (c). The license fee for new
332.34 operators of a manufactured home park or recreational camping area previously licensed
332.35 under this chapter for the same calendar year is one-half of the appropriate annual license
332.36 fee, plus any penalty that may be required. The license fee for operators opening on

333.1 or after October 1 is one-half of the appropriate annual license fee, plus any penalty
333.2 that may be required.

333.3 (b) All manufactured home parks and recreational camping areas shall pay the
333.4 following annual base fee:

333.5 (1) a manufactured home park, $150; and

333.6 (2) a recreational camping area with:

333.7 (i) 24 or less sites, $50;

333.8 (ii) 25-99 sites, $212; and

333.9 (iii) 100 or more sites, $300.

333.10 In addition to the base fee, manufactured home parks and recreational camping areas shall
333.11 pay $4 for each licensed site. This paragraph does not apply to special event recreational
333.12 camping areas or to operators of a manufactured home park or a recreational camping area
333.13 licensed under section 157.16 for the same location.

333.14 (c) In addition to the fee in paragraph (b), each manufactured home park or
333.15 recreational camping area shall pay an additional annual fee for each fee category
333.16 specified in this paragraph:

333.17 (1) Manufactured home parks and recreational camping areas with public swimming
333.18 pools and spas shall pay the appropriate fees specified in section 157.16.

333.19 (2) Individual private sewer or water, $60. "Individual private water" means a fee
333.20 category with a water supply other than a community public water supply as defined in
333.21 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
333.22 individual sewage treatment system which uses subsurface treatment and disposal.

333.23 (d) The following fees must accompany a plan review application for initial
333.24 construction of a manufactured home park or recreational camping area:

333.25 (1) for initial construction of less than 25 sites, $375;

333.26 (2) for initial construction of 25 to less than 100 sites, $400; and

333.27 (3) for initial construction of 100 or more sites, $500.

333.28 (e) The following fees must accompany a plan review application when an existing
333.29 manufactured home park or recreational camping area is expanded:

333.30 (1) for expansion of less than 25 sites, $250;

333.31 (2) for expansion of 25 and less than 100 sites, $300; and

333.32 (3) for expansion of 100 or more sites, $450.

333.33 Subd. 4. **Fees, special event recreational camping areas.** (a) The following fees
333.34 are required for special event recreational camping areas licensed under this chapter.

333.35 (b) All special event recreational camping areas shall pay an annual fee of $150 plus
333.36 $1 for each licensed site.

334.1 (c) A special event recreational camping area shall pay a late fee of $360 for failing
334.2 to obtain a license prior to operating.

334.3 (d) The following fees must accompany a plan review application for initial
334.4 construction of a special event recreational camping area:

334.5 (1) for initial construction of less than 25 special event recreational camping sites,
334.6 $375;

334.7 (2) for initial construction of 25 to less than 100 sites, $400; and

334.8 (3) for initial construction of 100 or more sites, $500.

334.9 (e) The following fees must accompany a plan review application for expansion of a
334.10 special event recreational camping area:

334.11 (1) for expansion of less than 25 sites, $250;

334.12 (2) for expansion of 25 and less than 100 sites, $300; and

334.13 (3) for expansion of 100 or more sites, $450.

334.14 Sec. 41. Minnesota Statutes 2008, section 327.16, is amended to read:

334.15 **327.16 ~~LICENSE~~ PLAN REVIEW APPLICATION.**

334.16 Subdivision 1. **Made to state Department of Health.** The plan review application
334.17 for ~~license to operate and maintain~~ a manufactured home park or recreational camping
334.18 area shall be made to the state Department of Health, at such office and in such manner
334.19 as may be prescribed by that department.

334.20 Subd. 2. **Contents.** The ~~applicant for a primary license or annual license shall make~~
334.21 ~~application in writing~~ plan review application shall be made upon a form provided by the
334.22 state Department of Health setting forth:

334.23 (1) The full name and address of the applicant or applicants, or names and addresses
334.24 of the partners if the applicant is a partnership, or the names and addresses of the officers
334.25 if the applicant is a corporation.

334.26 (2) A legal description of the site, lot, field, or tract of land upon which the applicant
334.27 proposes to operate and maintain a manufactured home park or recreational camping area.

334.28 (3) The proposed and existing facilities on and about the site, lot, field, or tract of
334.29 land for the proposed construction or alteration and maintaining of a sanitary community
334.30 building for toilets, urinals, sinks, wash basins, slop-sinks, showers, drains, laundry
334.31 facilities, source of water supply, sewage, garbage and waste disposal; except that no
334.32 toilet facilities shall be required in any manufactured home park which permits only
334.33 manufactured homes equipped with toilet facilities discharging to water carried sewage
334.34 disposal systems; and method of fire and storm protection.

335.1 (4) The proposed method of lighting the structures and site, lot, field, or tract of land
335.2 upon which the manufactured home park or recreational camping area is to be located.
335.3 (5) The calendar months of the year which the applicant will operate the
335.4 manufactured home park or recreational camping area.
335.5 (6) Plans and drawings for new construction or alteration, including buildings, wells,
335.6 plumbing and sewage disposal systems.

335.7 Subd. 3. **~~Fees;~~ Approval.** The application for ~~the primary license~~ plan review shall
335.8 be submitted with all plans and specifications enumerated in subdivision 2, ~~and payment~~
335.9 ~~of a fee in an amount prescribed by the state commissioner of health pursuant to section~~
335.10 ~~144.122~~ and shall be accompanied by an approved zoning permit from the municipality or
335.11 county wherein the park is to be located, or a statement from the municipality or county
335.12 that it does not require an approved zoning permit. ~~The fee for the annual license shall be~~
335.13 ~~in an amount prescribed by the state commissioner of health pursuant to section 144.122.~~
335.14 ~~All license fees paid to the commissioner of health shall be turned over to the state~~
335.15 ~~treasury.~~ The fee submitted for the ~~primary license~~ plan review shall be retained by the
335.16 state even though the proposed project is not approved and a license is denied.
335.17 When construction has been completed in accordance with approved plans and
335.18 specifications the state commissioner of health shall promptly cause the manufactured
335.19 home park or recreational camping area and appurtenances thereto to be inspected. When
335.20 the inspection and report has been made and the state commissioner of health finds that
335.21 all requirements of sections 327.10, 327.11, 327.14 to 327.28, and such conditions of
335.22 health and safety as the state commissioner of health may require, have been met by
335.23 the applicant, the state commissioner of health shall forthwith issue the ~~primary~~ license
335.24 in the name of the state.

335.25 Subd. 4. **~~Sanitary facilities~~ Compliance with current state law.** ~~During the~~
335.26 ~~pendency of the application for such primary license any change in the sanitary or safety~~
335.27 ~~facilities of the intended manufactured home park or recreational camping area shall be~~
335.28 ~~immediately reported in writing to the state Department of Health through the office~~
335.29 ~~through which the application was made. If no objection is made by the state Department~~
335.30 ~~of Health to such change in such sanitary or safety facilities within 60 days of the date~~
335.31 ~~such change is reported, it shall be deemed to have the approval of the state Department of~~
335.32 ~~Health.~~ Any manufactured home park or recreational camping area must be constructed
335.33 and operated according to all applicable state electrical, fire, plumbing, and building codes.

335.34 Subd. 5. **Permit.** When the plans and specifications have been approved, the state
335.35 Department of Health shall issue an approval report permitting the applicant to construct

336.1 or make alterations upon a manufactured home park or recreational camping area and the
336.2 appurtenances thereto according to the plans and specifications presented.

336.3 Such approval does not relieve the applicant from securing building permits in
336.4 municipalities that require permits or from complying with any other municipal ordinance
336.5 or ordinances, applicable thereto, not in conflict with this statute.

336.6 Subd. 6. **Denial of construction.** If the application to construct or make alterations
336.7 upon a manufactured home park or recreational camping area and the appurtenances
336.8 thereto or a ~~primary~~ license to operate and maintain the same is denied by the state
336.9 commissioner of health, the commissioner shall so state in writing giving the reason
336.10 or reasons for denying the application. If the objections can be corrected the applicant
336.11 may amend the application and resubmit it for approval, and if denied the applicant may
336.12 appeal from the decision of the state commissioner of health as provided in section
336.13 144.99, subdivision 10.

336.14 Sec. 42. Minnesota Statutes 2008, section 327.20, subdivision 1, is amended to read:

336.15 Subdivision 1. **Rules.** No domestic animals or house pets of occupants of
336.16 manufactured home parks or recreational camping areas shall be allowed to run at large,
336.17 or commit any nuisances within the limits of a manufactured home park or recreational
336.18 camping area. Each manufactured home park or recreational camping area licensed under
336.19 the provisions of sections 327.10, 327.11, and 327.14 to 327.28 shall, among other things,
336.20 provide for the following~~, in the manner hereinafter specified~~:

336.21 (1) A responsible attendant or caretaker shall be in charge of every manufactured
336.22 home park or recreational camping area at all times, who shall maintain the park or
336.23 area, and its facilities and equipment in a clean, orderly and sanitary condition. In any
336.24 manufactured home park containing more than 50 lots, the attendant, caretaker, or other
336.25 responsible park employee, shall be readily available at all times in case of emergency.

336.26 (2) All manufactured home parks shall be well drained and be located so that the
336.27 drainage of the park area will not endanger any water supply. No wastewater from
336.28 manufactured homes or recreational camping vehicles shall be deposited on the surface of
336.29 the ground. All sewage and other water carried wastes shall be discharged into a municipal
336.30 sewage system whenever available. When a municipal sewage system is not available, a
336.31 sewage disposal system acceptable to the state commissioner of health shall be provided.

336.32 (3) No manufactured home shall be located closer than three feet to the side lot lines
336.33 of a manufactured home park, if the abutting property is improved property, or closer than
336.34 ten feet to a public street or alley. Each individual site shall abut or face on a driveway
336.35 or clear unoccupied space of not less than 16 feet in width, which space shall have

337.1 unobstructed access to a public highway or alley. There shall be an open space of at least
337.2 ten feet between the sides of adjacent manufactured homes including their attachments
337.3 and at least three feet between manufactured homes when parked end to end. The space
337.4 between manufactured homes may be used for the parking of motor vehicles and other
337.5 property, if the vehicle or other property is parked at least ten feet from the nearest
337.6 adjacent manufactured home position. The requirements of this paragraph shall not apply
337.7 to recreational camping areas and variances may be granted by the state commissioner
337.8 of health in manufactured home parks when the variance is applied for in writing and in
337.9 the opinion of the commissioner the variance will not endanger the health, safety, and
337.10 welfare of manufactured home park occupants.

337.11 (4) An adequate supply of water of safe, sanitary quality shall be furnished at each
337.12 manufactured home park or recreational camping area. The source of the water supply
337.13 shall first be approved by the state Department of Health.

337.14 (5) All plumbing shall be installed in accordance with the rules of the state
337.15 commissioner of labor and industry and the provisions of the Minnesota Plumbing Code.

337.16 (6) In the case of a manufactured home park with less than ten manufactured homes,
337.17 a plan for the sheltering or the safe evacuation to a safe place of shelter of the residents of
337.18 the park in times of severe weather conditions, such as tornadoes, high winds, and floods.
337.19 The shelter or evacuation plan shall be developed with the assistance and approval of
337.20 the municipality where the park is located and shall be posted at conspicuous locations
337.21 throughout the park. The park owner shall provide each resident with a copy of the
337.22 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.
337.23 Nothing in this paragraph requires the Department of Health to review or approve any
337.24 shelter or evacuation plan developed by a park. Failure of a municipality to approve a plan
337.25 submitted by a park shall not be grounds for action against the park by the Department of
337.26 Health if the park has made a good faith effort to develop the plan and obtain municipal
337.27 approval.

337.28 (7) A manufactured home park with ten or more manufactured homes, licensed prior
337.29 to March 1, 1988, shall provide a safe place of shelter for park residents or a plan for the
337.30 evacuation of park residents to a safe place of shelter within a reasonable distance of the
337.31 park for use by park residents in times of severe weather, including tornadoes and high
337.32 winds. The shelter or evacuation plan must be approved by the municipality by March 1,
337.33 1989. The municipality may require the park owner to construct a shelter if it determines
337.34 that a safe place of shelter is not available within a reasonable distance from the park. A
337.35 copy of the municipal approval and the plan shall be submitted by the park owner to the

338.1 Department of Health. The park owner shall provide each resident with a copy of the
338.2 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.
338.3 (8) A manufactured home park with ten or more manufactured homes, receiving
338.4 ~~a primary~~ an initial license after March 1, 1988, must provide the type of shelter required
338.5 by section 327.205, except that for manufactured home parks established as temporary,
338.6 emergency housing in a disaster area declared by the President of the United States or
338.7 the governor, an approved evacuation plan may be provided in lieu of a shelter for a
338.8 period not exceeding 18 months.
338.9 (9) For the purposes of this subdivision, "park owner" and "resident" have the
338.10 ~~meaning~~ meanings given them in section 327C.01.

338.11 Sec. 43. Minnesota Statutes 2008, section 327.20, is amended by adding a subdivision
338.12 to read:

338.13 Subd. 4. **Special event recreational camping areas.** Each special event camping
338.14 area licensed under sections 327.10, 327.11, and 327.14 to 327.28 is subject to this section.
338.15 (1) Recreational camping vehicles and tents, including attachments, must be
338.16 separated from each other and other structures by at least seven feet.
338.17 (2) A minimum area of 300 square feet per site must be provided and the total
338.18 number of sites must not exceed one site for every 300 square feet of usable land area.
338.19 (3) Each site must abut or face a driveway or clear unoccupied space of at least 16
338.20 feet in width, which space must have unobstructed access to a public roadway.
338.21 (4) If no approved on-site water supply system is available, hauled water may be
338.22 used, provided that persons using hauled water comply with Minnesota Rules, parts
338.23 4720.4000 to 4720.4600.
338.24 (5) Nonburied sewer lines may be permitted provided they are of approved materials,
338.25 watertight, and properly maintained.
338.26 (6) If a sanitary dumping station is not provided on-site, arrangements must be
338.27 made with a licensed sewage pumper to service recreational camping vehicle holding
338.28 tanks as needed.
338.29 (7) Toilet facilities must be provided consisting of toilets connected to an approved
338.30 sewage disposal system, portable toilets, or approved, properly constructed privies.
338.31 (8) Toilets must be provided in the ratio of one toilet for each sex for each 150 sites.
338.32 (9) Toilets must be not more than 400 feet from any site.
338.33 (10) If a central building or buildings are provided with running water, then toilets
338.34 and handwashing lavatories must be provided in the building or buildings that meet the
338.35 requirements of this subdivision.

339.1 (11) Showers, if provided, must be provided in the ratio of one shower for each sex
339.2 for each 250 sites. Showerheads must be provided, where running water is available, for
339.3 each camping event exceeding two nights.

339.4 (12) Central toilet and shower buildings, if provided, must be constructed with
339.5 adequate heating, ventilation, and lighting, and floors of impervious material sloped
339.6 to drain. Walls must be of a washable material. Permanent facilities must meet the
339.7 requirements of the Americans with Disabilities Act.

339.8 (13) An adequate number of durable, covered, watertight containers must be
339.9 provided for all garbage and refuse. Garbage and refuse must be collected as often as
339.10 necessary to prevent nuisance conditions.

339.11 (14) Campgrounds must be located in areas free of poison ivy or other noxious
339.12 weeds considered detrimental to health. Sites must not be located in areas of tall grass or
339.13 weeds and sites must be adequately drained.

339.14 (15) Campsites for recreational vehicles may not be located on inclines of greater
339.15 than eight percent grade or one inch drop per lineal foot.

339.16 (16) A responsible attendant or caretaker must be available on-site at all times during
339.17 the operation of any special event recreational camping area that has 50 or more sites.

339.18 Sec. 44. **MINNESOTA COLORECTAL CANCER PREVENTION**
339.19 **DEMONSTRATION PROJECT.**

339.20 Subdivision 1. **Establishment.** The commissioner of health shall award grants
339.21 to Hennepin County Medical Center and MeritCare Bemidji for a colorectal screening
339.22 demonstration project to provide screening to uninsured and underinsured women and
339.23 men. The project shall expire December 31, 2010.

339.24 Subd. 2. **Eligibility.** To be eligible for colorectal screening under this demonstration
339.25 project, an applicant must:

339.26 (1) be at least 50 years of age, or under the age of 50 and at high risk for colon cancer;

339.27 (2) be uninsured, or if insured, have coverage that does not cover the full cost of
339.28 colorectal cancer screenings;

339.29 (3) not be eligible for medical assistance, general assistance medical care, or
339.30 MinnesotaCare programs; and

339.31 (4) have a gross family income at or below 250 percent of the federal poverty level.

339.32 Subd. 3. **Services.** Services provided under this project shall include:

339.33 (1) colorectal cancer screening, according to standard practices of medicine, or
339.34 guidelines provided by the Institute for Clinical Systems Improvement or the American
339.35 Cancer Society;

340.1 (2) follow-up services for abnormal tests; and

340.2 (3) diagnostic services to determine the extent and proper course of treatment.

340.3 Subd. 4. **Project evaluation.** The commissioner of health shall evaluate the
340.4 demonstration project and make recommendations for increasing the number of persons in
340.5 Minnesota who receive recommended colon cancer screening. The commissioner of health
340.6 shall submit the evaluation and recommendations to the legislature by January 15, 2011.

340.7 Sec. 45. **RESEARCH OF EXPOSURE PATHWAYS FOR**
340.8 **PERFLUOROCHEMICALS.**

340.9 The commissioner of health shall study and report to the legislature by January
340.10 15, 2011, on the exposure pathways for perfluorochemicals, focusing on food sources
340.11 that might be affected by contact with contaminated water or air. This research will be
340.12 performed to the extent that nonstate funds and environmental health tracking funds are
340.13 available and include garden vegetables produced or consumed by a representative sample
340.14 of the population from the east metropolitan area including indigenous people and people
340.15 of color. In developing and performing the research, the commissioner must convene and
340.16 consult with a citizen advisory group consisting of residents from the east metropolitan
340.17 area, including indigenous people and people of color.

340.18 Sec. 46. **FEASIBILITY PILOT PROJECT FOR CANCER SURVEILLANCE.**

340.19 The commissioner of health must provide a grant to the Hennepin County Medical
340.20 Center for a one-year feasibility pilot project to collect occupational, residential, and
340.21 military service history data from newly diagnosed cancer patients at the Hennepin
340.22 County Medical Center's Cancer Center. Funding for this grant shall come from the
340.23 Department of Health's current resources for the Chronic Disease and Environmental
340.24 Epidemiology Section.

340.25 Under this pilot project, Hennepin County Medical Center will design an expansion
340.26 of its existing cancer registry to include the collection of additional data, including the
340.27 cancer patient's occupational, residential, and military service history. Patient consent is
340.28 required for collection of these additional data. The consent must be in writing and must
340.29 contain notice informing the patient about private and confidential data concerning the
340.30 patient pursuant to Minnesota Statutes, section 13.04, subdivision 2. The patient is entitled
340.31 to opt out of the project at any time. The data collection expansion may also include the
340.32 cancer patient's possible toxic environmental exposure history, if known. The purpose of
340.33 this pilot project is to determine the following:

340.34 (1) the feasibility of collecting these data on a statewide scale;

341.1 (2) the potential design of a self-administered patient questionnaire template; and
341.2 (3) necessary qualifications for staff who will collect these data.
341.3 Hennepin County Medical Center must report the results of this pilot project to the
341.4 legislature by October 1, 2010.

341.5 Sec. 47. **SMOKING CESSATION.**

341.6 The commissioner of health must prioritize smoking prevention and smoking
341.7 cessation activities in low-income, indigenous, and minority communities in their
341.8 collaborations with the organization specifically described in Minnesota Statutes, section
341.9 144.396, subdivision 8.

341.10 Sec. 48. **MEDICAL RESPONSE UNIT REIMBURSEMENT PILOT PROGRAM.**

341.11 (a) The Department of Public Safety or its contract designee shall collaborate
341.12 with the Minnesota Ambulance Association to create the parameters of the medical
341.13 response unit reimbursement pilot program, including determining criteria for baseline
341.14 data reporting.
341.15 (b) In conducting the pilot program, the Department of Public Safety must consult
341.16 with the Minnesota Ambulance Association, Minnesota Fire Chiefs Association,
341.17 Emergency Services Regulatory Board, and the Minnesota Council of Health Plans to:
341.18 (1) identify no more than five medical response units registered as medical response
341.19 units with the Minnesota Emergency Medical Services Regulatory Board according to
341.20 Minnesota Statutes, chapter 144E, to participate in the program;
341.21 (2) outline and develop criteria for reimbursement;
341.22 (3) determine the amount of reimbursement for each unit response; and
341.23 (4) collect program data to be analyzed for a final report.
341.24 (c) Further criteria for the medical response unit reimbursement pilot program
341.25 shall include:
341.26 (1) the pilot program will expire on December 31, 2010, or when the appropriation
341.27 is extended, whichever occurs first;
341.28 (2) a report shall be made to the legislature by March 1, 2011, by the Department
341.29 of Public Safety or its contractor as to the effectiveness and value of this reimbursement
341.30 pilot program to the emergency medical services delivery system, any actual or potential
341.31 savings to the health care system, and impact on patient outcomes;
341.32 (3) participating medical response units must adhere to the requirements of this
341.33 pilot program outlined in an agreement between the Department of Public Safety and
341.34 the medical response unit, including but not limited to, requirements relating to data
341.35 collection, response criteria, and patient outcomes and disposition;

342.1 (4) individual entities licensed to provide ambulance care under Minnesota Statutes,
342.2 chapter 144E, are not eligible for participation in this pilot program;
342.3 (5) if a participating medical response unit withdraws from the pilot program, the
342.4 Department of Public Safety in consultation with the Minnesota Ambulance Association
342.5 may choose another pilot site if funding is available;
342.6 (6) medical response units must coordinate their operations under this pilot project
342.7 with the ambulance service or services licensed to provide care in their first response
342.8 geographic areas;
342.9 (7) licensed ambulance services that participate with the medical response unit in
342.10 the pilot program assume no financial or legal liability for the actions of the participating
342.11 medical response unit; and
342.12 (8) the Department of Public Safety and its pilot program partners have no ongoing
342.13 responsibility to reimburse medical response units beyond the parameters of the pilot
342.14 program.

342.15 Sec. 49. **REVIEW OF PROPOSED REGULATIONS FOR BODY ART**
342.16 **TECHNICIANS AND BODY ART ESTABLISHMENTS.**
342.17 The commissioner of health shall review proposed regulatory legislation for
342.18 body art technicians and body art establishments and develop recommendations on the
342.19 proper level of regulation needed for body art technicians and establishments in order
342.20 to protect public health. The recommendations must include a review of how other
342.21 states comply with the American Association of Blood Banks standards, how regulatory
342.22 requirements affect currently operating body art establishments, and the appropriate level
342.23 of coordination between the state and local jurisdictions that currently regulate body art
342.24 establishments. The commissioner shall submit the results of the review and possible
342.25 regulatory recommendations for body art technicians and establishments to the chairs and
342.26 ranking minority members of the legislative committees with jurisdiction over health
342.27 care by January 15, 2010.

342.28 Sec. 50. **HEARING AIDS; ENFORCEMENT.**
342.29 Costs incurred by the Minnesota Department of Health for conducting investigations
342.30 of unlicensed hearing aid dispensers shall be apportioned between all licensed or
342.31 credentialed professions that dispense hearing aids.

342.32 **EFFECTIVE DATE.** This section is effect July 1, 2011.

342.33 Sec. 51. **REPEALER.**

(a) Minnesota Statutes 2008, sections 103I.112; 144.9501, subdivision 17b; and 327.14, subdivisions 5 and 6, are repealed.

(b) Minnesota Rules, part 4626.2015, subpart 9, is repealed.

ARTICLE 11
HEALTH-RELATED FEES

Section 1. Minnesota Statutes 2008, section 148D.180, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure are as follows:

(1) for a licensed social worker, $45;

(2) for a licensed graduate social worker, $45;

(3) for a licensed independent social worker, ~~$90~~ $45;

(4) for a licensed independent clinical social worker, ~~$90~~ $45;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$150~~ $85.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required pursuant to section 148D.055.

Sec. 2. Minnesota Statutes 2008, section 148D.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216;

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

(5) for an emeritus license, $43.20; and

(6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Sec. 3. Minnesota Statutes 2008, section 148D.180, subdivision 3, is amended to read:

Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216; and

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

344.1 Sec. 4. Minnesota Statutes 2008, section 148D.180, subdivision 5, is amended to read:

344.2 Subd. 5. **Late fees.** Late fees are as follows:

344.3 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision
344.4 3; and

344.5 (2) supervision plan late fee, $40.

344.6 Sec. 5. Minnesota Statutes 2008, section 148E.180, subdivision 1, is amended to read:

344.7 Subdivision 1. **Application fees.** Application fees for licensure are as follows:

344.8 (1) for a licensed social worker, $45;

344.9 (2) for a licensed graduate social worker, $45;

344.10 (3) for a licensed independent social worker, ~~$90~~ $45;

344.11 (4) for a licensed independent clinical social worker, ~~$90~~ $45;

344.12 (5) for a temporary license, $50; and

344.13 (6) for a licensure by endorsement, ~~$150~~ $85.

344.14 The fee for criminal background checks is the fee charged by the Bureau of Criminal
344.15 Apprehension. The criminal background check fee must be included with the application
344.16 fee as required according to section 148E.055.

344.17 Sec. 6. Minnesota Statutes 2008, section 148E.180, subdivision 2, is amended to read:

344.18 Subd. 2. **License fees.** License fees are as follows:

344.19 (1) for a licensed social worker, ~~$115.20~~ $81;

344.20 (2) for a licensed graduate social worker, ~~$201.60~~ $144;

344.21 (3) for a licensed independent social worker, ~~$302.40~~ $216;

344.22 (4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

344.23 (5) for an emeritus license, $43.20; and

344.24 (6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

344.25 If the licensee's initial license term is less or more than 24 months, the required
344.26 license fees must be prorated proportionately.

344.27 Sec. 7. Minnesota Statutes 2008, section 148E.180, subdivision 3, is amended to read:

344.28 Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

344.29 (1) for a licensed social worker, ~~$115.20~~ $81;

344.30 (2) for a licensed graduate social worker, ~~$201.60~~ $144;

344.31 (3) for a licensed independent social worker, ~~$302.40~~ $216; and

344.32 (4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

345.1 Sec. 8. Minnesota Statutes 2008, section 148E.180, subdivision 5, is amended to read:

345.2 Subd. 5. **Late fees.** Late fees are as follows:
345.3 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision
345.4 3; and
345.5 (2) supervision plan late fee, $40.

345.6 Sec. 9. Minnesota Statutes 2008, section 152.126, subdivision 1, is amended to read:

345.7 Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this
345.8 subdivision have the meanings given.
345.9 (a) "Board" means the Minnesota State Board of Pharmacy established under
345.10 chapter 151.
345.11 (b) "Controlled substances" means those substances listed in section 152.02,
345.12 subdivisions 3 ~~and 4~~ to 5, and those substances defined by the board pursuant to section
345.13 152.02, subdivisions 7, 8, and 12.
345.14 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
345.15 30. Dispensing does not include the direct administering of a controlled substance to a
345.16 patient by a licensed health care professional.
345.17 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
345.18 pursuant to a valid prescription. For the purposes of this section, a dispenser does not
345.19 include a licensed hospital pharmacy that distributes controlled substances for inpatient
345.20 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.
345.21 (e) "Prescriber" means a licensed health care professional who is authorized to
345.22 prescribe a controlled substance under section 152.12, subdivision 1.
345.23 (f) "Prescription" has the meaning given in section 151.01, subdivision 16.

345.24 Sec. 10. Minnesota Statutes 2008, section 152.126, subdivision 2, is amended to read:

345.25 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish
345.26 by January 1, 2010, an electronic system for reporting the information required under
345.27 subdivision 4 for all controlled substances dispensed within the state.
345.28 (b) The board may contract with a vendor for the purpose of obtaining technical
345.29 assistance in the design, implementation, operation, and maintenance of the electronic
345.30 reporting system. ~~The vendor's role shall be limited to providing technical support to the~~
345.31 ~~board concerning the software, databases, and computer systems required to interface with~~
345.32 ~~the existing systems currently used by pharmacies to dispense prescriptions and transmit~~
345.33 ~~prescription data to other third parties.~~

346.1 Sec. 11. Minnesota Statutes 2008, section 152.126, subdivision 6, is amended to read:

346.2 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
346.3 subdivision, the data submitted to the board under subdivision 4 is private data on
346.4 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.
346.5 (b) Except as specified in subdivision 5, the following persons shall be considered
346.6 permissible users and may access the data submitted under subdivision 4 in the same or
346.7 similar manner, and for the same or similar purposes, as those persons who are authorized
346.8 to access similar private data on individuals under federal and state law:
346.9 (1) a prescriber, to the extent the information relates specifically to a current patient,
346.10 to whom the prescriber is prescribing or considering prescribing any controlled substance;
346.11 (2) a dispenser, to the extent the information relates specifically to a current patient
346.12 to whom that dispenser is dispensing or considering dispensing any controlled substance;
346.13 (3) an individual who is the recipient of a controlled substance prescription for
346.14 which data was submitted under subdivision 4, or a guardian of the individual, parent or
346.15 guardian of a minor, or health care agent of the individual acting under a health care
346.16 directive under chapter 145C;
346.17 (4) personnel of the board specifically assigned to conduct a bona fide investigation
346.18 of a specific licensee;
346.19 (5) personnel of the board engaged in the collection of controlled substance
346.20 prescription information as part of the assigned duties and responsibilities under this
346.21 section;
346.22 (6) authorized personnel of a vendor under contract with the board who are engaged
346.23 in the design, implementation, operation, and maintenance of the electronic reporting
346.24 system as part of the assigned duties and responsibilities of their employment, provided
346.25 that access to data is limited to the minimum amount necessary to ~~test and maintain the~~
346.26 ~~system databases~~ carry out such duties and responsibilities;
346.27 (7) federal, state, and local law enforcement authorities acting pursuant to a valid
346.28 search warrant; and
346.29 (8) personnel of the medical assistance program assigned to use the data collected
346.30 under this section to identify recipients whose usage of controlled substances may warrant
346.31 restriction to a single primary care physician, a single outpatient pharmacy, or a single
346.32 hospital.
346.33 For purposes of clause (3), access by an individual includes persons in the definition
346.34 of an individual under section 13.02.
346.35 (c) Any permissible user identified in paragraph (b), who directly accesses
346.36 the data electronically, shall implement and maintain a comprehensive information

347.1 security program that contains administrative, technical, and physical safeguards that
347.2 are appropriate to the user's size and complexity, and the sensitivity of the personal
347.3 information obtained. The permissible user shall identify reasonably foreseeable internal
347.4 and external risks to the security, confidentiality, and integrity of personal information
347.5 that could result in the unauthorized disclosure, misuse, or other compromise of the
347.6 information and assess the sufficiency of any safeguards in place to control the risks.

347.7 (d) The board shall not release data submitted under this section unless it is provided
347.8 with evidence, satisfactory to the board, that the person requesting the information is
347.9 entitled to receive the data.

347.10 (e) The board shall not release the name of a prescriber without the written consent
347.11 of the prescriber or a valid search warrant or court order. The board shall provide a
347.12 mechanism for a prescriber to submit to the board a signed consent authorizing the release
347.13 of the prescriber's name when data containing the prescriber's name is requested.

347.14 (f) The board shall maintain a log of all persons who access the data and shall ensure
347.15 that any permissible user complies with paragraph (c) prior to attaining direct access to
347.16 the data.

347.17 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into
347.18 pursuant to subdivision 2. A vendor shall not use data collected under this section for
347.19 any purpose not specified in this section.

347.20 Sec. 12. **REPEALER.**

347.21 Minnesota Statutes 2008, section 148D.180, subdivision 8, is repealed.

347.22 **ARTICLE 12**
347.23 **HUMAN SERVICES FORECAST ADJUSTMENTS**

347.24 Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
347.25 **SERVICES FORECAST ADJUSTMENT.**

347.26 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
347.27 from the appropriations in Laws 2008, chapter 363, from the general fund, or any other
347.28 fund named, to the Department of Human Services for the purposes specified in this
347.29 article, to be available for the fiscal year indicated for each purpose. The figure "2009"
347.30 used in this article means that the appropriation or appropriations listed are available
347.31 for the fiscal year ending June 30, 2009.

347.32 Sec. 2. **COMMISSIONER OF HUMAN**
347.33 **SERVICES**

348.1 Subdivision 1. **Total Appropriation** **$** **(478,994,000)**

348.2	Appropriations by Fund	
348.3		2009
348.4	General	(445,130,000)
348.5	Health Care Access	(19,460,000)
348.6	Federal TANF	(14,404,000)

348.7 Subd. 2. **Revenue and Pass-Through**

348.8	Federal TANF	1,107,000

348.9 Subd. 3. **Children and Economic Assistance**
348.10 **Grants**

348.11	General	27,002,000
348.12	Federal TANF	(16,211,000)

348.13 The amounts that may be spent from this
348.14 appropriation for each purpose are as follows:

348.15 (a) **MFIP/DWP Grants**

348.16	General	17,530,000
348.17	Federal TANF	(16,211,000)

348.18 (b) **MFIP Child Care Assistance Grants** 4,933,000

348.19 (c) **General Assistance Grants** 1,458,000

348.20 (d) **Minnesota Supplemental Aid Grants** 513,000

348.21 (e) **Group Residential Housing Grants** 2,568,000

348.22 Subd. 4. **Basic Health Care Grants**

348.23	General	(224,341,000)
348.24	Health Care Access	(19,460,000)

349.1 The amounts that may be spent from this
349.2 appropriation for each purpose are as follows:

349.3 (a) **MinnesotaCare**

349.4 Health Care Access (19,460,000)

349.5 (b) **MA Basic Health Care - Families and**
349.6 **Children** (100,055,000)

349.7 (c) **MA Basic Health Care - Elderly and**
349.8 **Disabled** (136,795,000)

349.9 (d) **General Assistance Medical Care** 12,539,000

349.10 Subd. 5. **Continuing Care Grants** **(247,791,000)**

349.11 The amounts that may be spent from this
349.12 appropriation for each purpose are as follows:

349.13 (a) **MA Long-Term Care Facilities** (59,204,000)

349.14 (b) **MA Long-Term Care Waivers** (168,927,000)

349.15 (c) **Chemical Dependency Entitlement Grants** (19,660,000)

349.16 Sec. 3. **EFFECTIVE DATE.**

349.17 Sections 1 and 2 are effective the day following final enactment.

349.18 **ARTICLE 13**
349.19 **APPROPRIATIONS**

349.20 Section 1. **SUMMARY OF APPROPRIATIONS.**

349.21 The amounts shown in this section summarize direct appropriations by fund made
349.22 in this article.

349.23		**2010**	**2011**	**Total**
349.24	General	$ 4,452,323,000	$ 5,280,470,000	$ 9,732,793,000
349.25	State Government Special			
349.26	Revenue	62,451,000	61,515,000	123,966,000

350.1 Health Care Access	489,995,000	568,298,000	1,058,293,000
350.2 Federal TANF	301,220,000	268,711,000	569,931,000
350.3 Lottery Prize	1,665,000	1,665,000	3,330,000
350.4 Federal Fund	110,000,000	0	110,000,000
350.5 **Total**	**$ 5,417,704,000**	**$ 6,180,659,000**	**$ 11,598,363,000**

350.6 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

350.7 The sums shown in the columns marked "Appropriations" are appropriated to the
350.8 agencies and for the purposes specified in this article. The appropriations are from the
350.9 general fund, or another named fund, and are available for the fiscal years indicated
350.10 for each purpose. The figures "2010" and "2011" used in this article mean that the
350.11 appropriations listed under them are available for the fiscal year ending June 30, 2010, or
350.12 June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal
350.13 year 2011. "The biennium" is fiscal years 2010 and 2011. Appropriations for the fiscal
350.14 year ending June 30, 2009, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
350.15–350.18	**2010**	**2011**
350.19 Sec. 3. **HUMAN SERVICES**		
350.20 Subdivision 1. **Total Appropriation**	**$ 5,230,100,000**	**$ 5,997,715,000**

350.21 Appropriations by Fund

350.22	2010	2011
350.23 General	4,376,839,000	5,211,018,000
350.24 State Government 350.25 Special Revenue	1,315,000	565,000
350.26 Health Care Access	450,792,000	527,489,000
350.27 Federal TANF	289,487,000	256,978,000
350.28 Lottery Prize	1,665,000	1,665,000
350.29 Federal Fund	110,000,000	0

351.1 **Receipts for Systems Projects.**
351.2 Appropriations and federal receipts for
351.3 information systems projects for MAXIS,
351.4 PRISM, MMIS, and SSIS must be deposited
351.5 in the state system account authorized in
351.6 Minnesota Statutes, section 256.014. Money
351.7 appropriated for computer projects approved
351.8 by the Minnesota Office of Enterprise
351.9 Technology, funded by the legislature, and
351.10 approved by the commissioner of finance,
351.11 may be transferred from one project to
351.12 another and from development to operations
351.13 as the commissioner of human services
351.14 considers necessary, except that any transfers
351.15 to one project that exceed $1,000,000 or
351.16 multiple transfers to one project that exceed
351.17 $1,000,000 in total require the express
351.18 approval of the legislature. The preceding
351.19 requirement for legislative approval does not
351.20 apply to transfers made to establish a project's
351.21 initial operating budget each year; instead,
351.22 the requirements of section 11, subdivision 2,
351.23 of this article apply to those transfers. Any
351.24 unexpended balance in the appropriation
351.25 for these projects does not cancel but is
351.26 available for ongoing development and
351.27 operations. Any computer project with a
351.28 total cost exceeding $1,000,000, including,
351.29 but not limited to, a replacement for the
351.30 proposed HealthMatch system, shall not be
351.31 commenced without the express approval of
351.32 the legislature.

351.33 **HealthMatch Systems Project.** In fiscal
351.34 year 2010, $3,054,000 shall be transferred
351.35 from the HealthMatch account in the state

352.1 systems account in the special revenue fund
352.2 to the general fund.

352.3 **Nonfederal Share Transfers.** The
352.4 nonfederal share of activities for which
352.5 federal administrative reimbursement is
352.6 appropriated to the commissioner may be
352.7 transferred to the special revenue fund.

352.8 **TANF Maintenance of Effort.**

352.9 (a) In order to meet the basic maintenance
352.10 of effort (MOE) requirements of the TANF
352.11 block grant specified under Code of Federal
352.12 Regulations, title 45, section 263.1, the
352.13 commissioner may only report nonfederal
352.14 money expended for allowable activities
352.15 listed in the following clauses as TANF/MOE
352.16 expenditures:

352.17 (1) MFIP cash, diversionary work program,
352.18 and food assistance benefits under Minnesota
352.19 Statutes, chapter 256J;

352.20 (2) the child care assistance programs
352.21 under Minnesota Statutes, sections 119B.03
352.22 and 119B.05, and county child care
352.23 administrative costs under Minnesota
352.24 Statutes, section 119B.15;

352.25 (3) state and county MFIP administrative
352.26 costs under Minnesota Statutes, chapters
352.27 256J and 256K;

352.28 (4) state, county, and tribal MFIP
352.29 employment services under Minnesota
352.30 Statutes, chapters 256J and 256K;

352.31 (5) expenditures made on behalf of
352.32 noncitizen MFIP recipients who qualify
352.33 for the medical assistance without federal
352.34 financial participation program under

353.1 Minnesota Statutes, section 256B.06,
353.2 subdivision 4, paragraphs (d), (e), and (j);
353.3 and

353.4 (6) qualifying working family credit
353.5 expenditures under Minnesota Statutes,
353.6 section 290.0671.

353.7 (b) The commissioner shall ensure that
353.8 sufficient qualified nonfederal expenditures
353.9 are made each year to meet the state's
353.10 TANF/MOE requirements. For the activities
353.11 listed in paragraph (a), clauses (2) to
353.12 (6), the commissioner may only report
353.13 expenditures that are excluded from the
353.14 definition of assistance under Code of
353.15 Federal Regulations, title 45, section 260.31.

353.16 (c) For fiscal years beginning with state
353.17 fiscal year 2003, the commissioner shall
353.18 ensure that the maintenance of effort used
353.19 by the commissioner of finance for the
353.20 February and November forecasts required
353.21 under Minnesota Statutes, section 16A.103,
353.22 contains expenditures under paragraph (a),
353.23 clause (1), equal to at least 16 percent of
353.24 the total required under Code of Federal
353.25 Regulations, title 45, section 263.1.

353.26 (d) For the federal fiscal years beginning on
353.27 or after October 1, 2007, the commissioner
353.28 may not claim an amount of TANF/MOE in
353.29 excess of the 75 percent standard in Code
353.30 of Federal Regulations, title 45, section
353.31 263.1(a)(2), except:

353.32 (1) to the extent necessary to meet the 80
353.33 percent standard under Code of Federal
353.34 Regulations, title 45, section 263.1(a)(1),
353.35 if it is determined by the commissioner

354.1 that the state will not meet the TANF work
354.2 participation target rate for the current year;

354.3 (2) to provide any additional amounts
354.4 under Code of Federal Regulations, title 45,
354.5 section 264.5, that relate to replacement of
354.6 TANF funds due to the operation of TANF
354.7 penalties; and

354.8 (3) to provide any additional amounts that
354.9 may contribute to avoiding or reducing
354.10 TANF work participation penalties through
354.11 the operation of the excess MOE provisions
354.12 of Code of Federal Regulations, title 45,
354.13 section 261.43(a)(2).

354.14 For the purposes of clauses (1) to (3),
354.15 the commissioner may supplement the
354.16 MOE claim with working family credit
354.17 expenditures to the extent such expenditures
354.18 or other qualified expenditures are otherwise
354.19 available after considering the expenditures
354.20 allowed in this section.

354.21 (e) Minnesota Statutes, section 256.011,
354.22 subdivision 3, which requires that federal
354.23 grants or aids secured or obtained under that
354.24 subdivision be used to reduce any direct
354.25 appropriations provided by law, do not apply
354.26 if the grants or aids are federal TANF funds.

354.27 (f) Notwithstanding any contrary provision
354.28 in this article, this provision expires June 30,
354.29 2013.

354.30 **Working Family Credit Expenditures as**
354.31 **TANF/MOE.** The commissioner may claim
354.32 as TANF/MOE up to $6,707,000 per year of
354.33 working family credit expenditures for fiscal
354.34 year 2010 through fiscal year 2011.

355.1 **Working Family Credit Expenditures**
355.2 **to be Claimed for TANF/MOE.** The
355.3 commissioner may count the following
355.4 amounts of working family credit expenditure
355.5 as TANF/MOE:

355.6 (1) fiscal year 2010, $30,217,000;

355.7 (2) fiscal year 2011, $55,596,000;

355.8 (3) fiscal year 2012, $28,519,000; and

355.9 (4) fiscal year 2013, $22,138,000.

355.10 Notwithstanding any contrary provision in
355.11 this article, this rider expires June 30, 2013.

355.12 **TANF Transfer to Federal Child Care**
355.13 **and Development Fund.** The following
355.14 TANF fund amounts are appropriated to the
355.15 commissioner for the purposes of MFIP and
355.16 transition year child care under Minnesota
355.17 Statutes, section 119B.05:

355.18 (1) fiscal year 2010, $5,909,000;

355.19 (2) fiscal year 2011, $9,808,000;

355.20 (3) fiscal year 2012, $10,826,000; and

355.21 (4) fiscal year 2013, $4,026,000.

355.22 The commissioner shall authorize the
355.23 transfer of sufficient TANF funds to the
355.24 federal child care and development fund to
355.25 meet this appropriation and shall ensure that
355.26 all transferred funds are expended according
355.27 to federal child care and development fund
355.28 regulations.

355.29 **Food Stamps Employment and Training.**
355.30 (a) The commissioner shall apply for and
355.31 claim the maximum allowable federal
355.32 matching funds under United States Code,

356.1 title 7, section 2025, paragraph (h), for
356.2 state expenditures made on behalf of family
356.3 stabilization services participants voluntarily
356.4 engaged in food stamp employment and
356.5 training activities, where appropriate.

356.6 (b) Notwithstanding Minnesota Statutes,
356.7 sections 256D.051, subdivisions 1a, 6b,
356.8 and 6c, and 256J.626, federal food stamps
356.9 employment and training funds received
356.10 as reimbursement of MFIP consolidated
356.11 fund grant expenditures for diversionary
356.12 work program participants and child
356.13 care assistance program expenditures for
356.14 two-parent families must be deposited in the
356.15 general fund. The amount of funds must be
356.16 limited to $3,350,000 in fiscal year 2010
356.17 and $4,440,000 in fiscal years 2011 through
356.18 2013, contingent on approval by the federal
356.19 Food and Nutrition Service.

356.20 (c) Consistent with the receipt of these federal
356.21 funds, the commissioner may adjust the
356.22 level of working family credit expenditures
356.23 claimed as TANF maintenance of effort.
356.24 Notwithstanding any contrary provision in
356.25 this article, this rider expires June 30, 2013.

356.26 **ARRA Food Support Administration.**
356.27 The funds available for food support
356.28 administration under the American Recovery
356.29 and Reinvestment Act (ARRA) of 2009
356.30 are appropriated to the commissioner
356.31 to pay actual costs of implementing the
356.32 food support benefit increases, increased
356.33 eligibility determinations, and outreach. Of
356.34 these funds, 20 percent shall be allocated
356.35 to the commissioner and 80 percent shall

357.1 be allocated to counties. The commissioner
357.2 shall allocate the county portion based on
357.3 caseload. Reimbursement shall be based on
357.4 actual costs reported by counties through
357.5 existing processes. Tribal reimbursement
357.6 must be made from the state portion based
357.7 on a caseload factor equivalent to that of a
357.8 county.

357.9 **ARRA Food Support Benefit Increases.**
357.10 The funds provided for food support benefit
357.11 increases under the Supplemental Nutrition
357.12 Assistance Program provisions of the
357.13 American Recovery and Reinvestment Act
357.14 (ARRA) of 2009 must be used for benefit
357.15 increases beginning July 1, 2009.

357.16 **Emergency Fund for the TANF Program.**
357.17 TANF Emergency Contingency funds
357.18 available under the American Recovery
357.19 and Reinvestment Act of 2009 (Public Law
357.20 111-5) are appropriated to the commissioner.
357.21 The commissioner must request TANF
357.22 Emergency Contingency funds from the
357.23 Secretary of the Department of Health
357.24 and Human Services to the extent the
357.25 commissioner meets or expects to meet the
357.26 requirements of section 403(c) of the Social
357.27 Security Act. The commissioner must seek
357.28 to maximize such grants. The funds received
357.29 must be used as appropriated. Each county
357.30 must maintain the county's current level of
357.31 emergency assistance funding under the
357.32 MFIP consolidated fund and use the funds
357.33 under this paragraph to supplement existing
357.34 emergency assistance funding levels.

357.35 Subd. 2. **Agency Management**

358.1 The amounts that may be spent from the
358.2 appropriation for each purpose are as follows:

358.3 **(a) Financial Operations**

358.4	Appropriations by Fund		
358.5	General	3,380,000	3,908,000
358.6	Health Care Access	1,281,000	1,016,000
358.7	Federal TANF	122,000	122,000

358.8 **(b) Legal and Regulatory Operations**

358.9	Appropriations by Fund		
358.10	General	13,749,000	13,534,000
358.11 358.12	State Government Special Revenue	440,000	440,000
358.13	Health Care Access	943,000	943,000
358.14	Federal TANF	100,000	100,000

358.15 **(c) Management Operations**

358.16	Appropriations by Fund		
358.17	General	4,334,000	4,562,000
358.18	Health Care Access	242,000	242,000

358.19 **Lease Cost Reduction.** Base level funding
358.20 to the commissioner shall be reduced by
358.21 $381,000 in fiscal year 2010, and $153,000
358.22 in fiscal year 2011, to reflect a reduction in
358.23 lease costs related to the Minnehaha Avenue
358.24 building.

358.25 **Base Adjustment.** The general fund base is
358.26 increased by $153,000 in each of fiscal years
358.27 2012 and 2013.

358.28 **(d) Information Technology Operations**

359.1 Appropriations by Fund

359.2 General	28,077,000	28,077,000
359.3 Health Care Access	4,856,000	4,868,000

359.4 Subd. 3. **Revenue and Pass-Through Revenue**
359.5 **Expenditures** 65,746,000 67,068,000

359.6 This appropriation is from the federal TANF
359.7 fund.

359.8 Subd. 4. **Children and Economic Assistance**
359.9 **Grants**

359.10 The amounts that may be spent from this
359.11 appropriation for each purpose are as follows:

359.12 **(a) MFIP/DWP Grants**

359.13 Appropriations by Fund

359.14 General	63,205,000	89,033,000
359.15 Federal TANF	100,404,000	85,789,000

359.16 **(b) Support Services Grants**

359.17 Appropriations by Fund

359.18 General	8,715,000	12,498,000
359.19 Federal TANF	121,257,000	102,757,000

359.20 **MFIP Consolidated Fund.** The MFIP
359.21 consolidated fund TANF appropriation is
359.22 reduced by $1,854,000 in fiscal year 2011
359.23 and fiscal year 2012.

359.24 Notwithstanding Minnesota Statutes, section
359.25 256J.626, subdivision 8, paragraph (b), the
359.26 commissioner shall reduce proportionately
359.27 the reimbursement to counties for
359.28 administrative expenses.

360.1 **Subsidized Employment Funding Through**
360.2 **ARRA.** The commissioner is authorized to
360.3 apply for TANF emergency fund grants for
360.4 subsidized employment activities. Growth
360.5 in expenditures for subsidized employment
360.6 within the supported work program and the
360.7 MFIP consolidated fund over the amount
360.8 expended in the calendar quarters in the
360.9 TANF emergency fund base year shall be
360.10 used to leverage the TANF emergency fund
360.11 grants for subsidized employment and to
360.12 fund supported work. The commissioner
360.13 shall develop procedures to maximize
360.14 reimbursement of these expenditures over the
360.15 TANF emergency fund base year quarters,
360.16 and may contract directly with employers
360.17 and providers to maximize these TANF
360.18 emergency fund grants.

360.19 **Supported Work.** Of the TANF
360.20 appropriation, $6,400,000 in fiscal year
360.21 2011 is to the commissioner for supported
360.22 work for MFIP recipients and is available
360.23 until expended. Supported work includes
360.24 paid transitional work experience and
360.25 a continuum of employment assistance,
360.26 including outreach and recruitment,
360.27 program orientation and intake, testing and
360.28 assessment, job development and marketing,
360.29 preworksite training, supported worksite
360.30 experience, job coaching, and postplacement
360.31 follow-up, in addition to extensive case
360.32 management and referral services.

360.33 **Base Adjustment.** The general fund base
360.34 is reduced by $3,783,000 in each of fiscal
360.35 years 2012 and 2013. The TANF fund base

361.1 is increased by $9,704,000 in each of fiscal
361.2 years 2012 and 2013.

361.3 **Integrated Services Program Funding.**
361.4 The TANF appropriation for integrated
361.5 services program funding is $1,250,000 in
361.6 fiscal year 2010 and $2,500,000 in fiscal year
361.7 2011.

361.8 **TANF Emergency Fund; Nonrecurrent**
361.9 **Short-Term Benefits.** TANF emergency
361.10 contingency fund grants received due to
361.11 increases in expenditures for nonrecurrent
361.12 short-term benefits must be used to offset the
361.13 increase in these expenditures for counties
361.14 under the MFIP consolidated fund, under
361.15 Minnesota Statutes, section 256J.626,
361.16 and the diversionary work program. The
361.17 commissioner shall develop procedures
361.18 to maximize reimbursement of these
361.19 expenditures over the TANF emergency fund
361.20 base year quarters. Growth in expenditures
361.21 for the diversionary work program over the
361.22 amount expended in the calendar quarters in
361.23 the TANF emergency fund base year shall be
361.24 used to leverage these funds.

361.25 **(c) MFIP Child Care Assistance Grants**

	Appropriations by Fund	
361.26		
361.27 General	61,171,000	65,214,000
361.28 Federal TANF	1,022,000	406,000

361.29 **ARRA Child Care Development Block**
361.30 **Grant Funds.** The funds available from the
361.31 child care development block grant under
361.32 ARRA must be used for MFIP child care to
361.33 the extent that those funds are not earmarked

362.1 for quality expansion or to improve the
362.2 quality of infant and toddler care.

362.3 **Acceleration of ARRA Child Care and**
362.4 **Development Fund Expenditure.** The
362.5 commissioner must liquidate all child care
362.6 and development money available under
362.7 the American Recovery and Reinvestment
362.8 Act (ARRA) of 2009, Public Law 111-5,
362.9 by September 30, 2010. In order to expend
362.10 those funds by September 30, 2010, the
362.11 commissioner may redesignate and expend
362.12 the ARRA child care and development funds
362.13 appropriated in fiscal year 2011 for purposes
362.14 under this section for related purposes that
362.15 will allow liquidation by September 30,
362.16 2010. Child care and development funds
362.17 otherwise available to the commissioner
362.18 for those related purposes shall be used to
362.19 fund the purposes from which the ARRA
362.20 child care and development funds had been
362.21 redesignated.

362.22 **(d) Basic Sliding Fee Child Care Assistance**		
362.23 **Grants**	40,104,000	45,096,000

362.24 **Base Adjustment.** The general fund base is
362.25 decreased by $260,000 in each of fiscal years
362.26 2012 and 2013.

362.27 **School Readiness Service Agreements.**
362.28 $261,000 in fiscal year 2010 and $261,000
362.29 in fiscal year 2011 are from the federal
362.30 child care development funds received from
362.31 the American Recovery and Reinvestment
362.32 Act of 2009, Public Law 111-5, to the
362.33 commissioner of human services consistent
362.34 with federal regulations for the purpose of

363.1 school readiness service agreements under
363.2 Minnesota Statutes, section 119B.231. This
363.3 is a onetime appropriation. Any unexpended
363.4 balance the first year is available in the
363.5 second year.

363.6 **Child Care Development Fund**
363.7 **Unexpended Balance.** In addition to
363.8 the amount provided in this section, the
363.9 commissioner shall expend $5,244,000 in
363.10 fiscal year 2010 from the federal child care
363.11 development fund unexpended balance
363.12 for basic sliding fee child care under
363.13 Minnesota Statutes, section 119B.03. The
363.14 commissioner shall ensure that all child
363.15 care and development funds are expended
363.16 according to the federal child care and
363.17 development fund regulations.

363.18 **Basic Sliding Fee.** $7,045,000 in fiscal year
363.19 2010 and $6,974,000 in fiscal year 2011 are
363.20 from the federal child care development
363.21 funds received from the American Recovery
363.22 and Reinvestment Act of 2009, Public
363.23 Law 111-5, to the commissioner of human
363.24 services consistent with federal regulations
363.25 for the purpose of basic sliding fee child care
363.26 assistance under Minnesota Statutes, section
363.27 119B.03. This is a onetime appropriation.
363.28 Any unexpended balance the first year is
363.29 available in the second year.

363.30 **Basic Sliding Fee Allocation for Calendar**
363.31 **Year 2010.** Notwithstanding Minnesota
363.32 Statutes, section 119B.03, subdivision 6,
363.33 in calendar year 2010, basic sliding fee
363.34 funds shall be distributed according to
363.35 this provision. Funds shall be allocated

364.1 first in amounts equal to each county's
364.2 guaranteed floor, according to Minnesota
364.3 Statutes, section 119B.03, subdivision 8,
364.4 with any remaining available funds allocated
364.5 according to the following formula:

364.6 (a) Up to one-fourth of the funds shall be
364.7 allocated in proportion to the number of
364.8 families participating in the transition year
364.9 child care program as reported during and
364.10 averaged over the most recent six months
364.11 completed at the time of the notice of
364.12 allocation. Funds in excess of the amount
364.13 necessary to serve all families in this category
364.14 shall be allocated according to paragraph (d).

364.15 (b) Up to three-fourths of the funds shall
364.16 be allocated in proportion to the average
364.17 of each county's most recent six months of
364.18 reported waiting list as defined in Minnesota
364.19 Statutes, section 119B.03, subdivision 2, and
364.20 the reinstatement list of those families whose
364.21 assistance was terminated with the approval
364.22 of the commissioner under Minnesota Rules,
364.23 part 3400.0183, subpart 1. Funds in excess
364.24 of the amount necessary to serve all families
364.25 in this category shall be allocated according
364.26 to paragraph (d).

364.27 (c) The amount necessary to serve all families
364.28 in paragraphs (a) and (b) shall be calculated
364.29 based on the basic sliding fee average cost of
364.30 care per family in the county with the highest
364.31 cost in the most recently completed calendar
364.32 year.

364.33 (d) Funds in excess of the amount necessary
364.34 to serve all families in paragraphs (a) and
364.35 (b) shall be allocated in proportion to each

365.1 county's total expenditures for the basic
365.2 sliding fee child care program reported
365.3 during the most recent fiscal year completed
365.4 at the time of the notice of allocation. To
365.5 the extent that funds are available, and
365.6 notwithstanding Minnesota Statutes, section
365.7 119B.03, subdivision 8, for the period
365.8 January 1, 2011, to December 31, 2011, each
365.9 county's guaranteed floor must be equal to its
365.10 original calendar year 2010 allocation.

365.11 **(e) Child Care Development Grants**	1,487,000	1,487,000

365.12 **Family, friends, and neighbor grants.**
365.13 $375,000 in fiscal year 2010 and $375,000
365.14 in fiscal year 2011 are from the child
365.15 care development fund required targeted
365.16 quality funds for quality expansion and
365.17 infant/toddler from the American Recovery
365.18 and Reinvestment Act of 2009, Public
365.19 Law 111-5, to the commissioner of human
365.20 services for family, friends, and neighbor
365.21 grants under Minnesota Statutes, section
365.22 119B.232. This appropriation may be used
365.23 on programs receiving family, friends, and
365.24 neighbor grant funds as of June 30, 2009,
365.25 or on new programs or projects. This is a
365.26 onetime appropriation. Any unexpended
365.27 balance the first year is available in the
365.28 second year.

365.29 **Voluntary quality rating system training,**
365.30 **coaching, consultation, and supports.**
365.31 $633,000 in fiscal year 2010 and $633,000
365.32 in fiscal year 2011 are from the federal child
365.33 care development fund required targeted
365.34 quality funds for quality expansion and
365.35 infant/toddler from the American Recovery

366.1 and Reinvestment Act of 2009, Public
366.2 Law 111-5, to the commissioner of human
366.3 services consistent with federal regulations
366.4 for the purpose of providing grants to provide
366.5 statewide child-care provider training,
366.6 coaching, consultation, and supports to
366.7 prepare for the voluntary Minnesota quality
366.8 rating system rating tool. This is a onetime
366.9 appropriation. Any unexpended balance the
366.10 first year is available in the second year.

366.11 **Voluntary quality rating system.** $184,000
366.12 in fiscal year 2010 and $1,200,000 in fiscal
366.13 year 2011 are from the federal child care
366.14 development fund required targeted funds for
366.15 quality expansion and infant/toddler from the
366.16 American Recovery and Reinvestment Act of
366.17 2009, Public Law 111-5, to the commissioner
366.18 of human services consistent with federal
366.19 regulations for the purpose of implementing
366.20 the voluntary Parent Aware quality star
366.21 rating system pilot in coordination with the
366.22 Minnesota Early Learning Foundation. The
366.23 appropriation for the first year is to complete
366.24 and promote the voluntary Parent Aware
366.25 quality rating system pilot program through
366.26 June 30, 2010, and the appropriation for the
366.27 second year is to continue the voluntary
366.28 Minnesota quality rating system pilot
366.29 through June 30, 2011. This is a onetime
366.30 appropriation. Any unexpended balance the
366.31 first year is available in the second year.

366.32 **(f) Child Support Enforcement Grants**	3,705,000	3,705,000

366.33 **(g) Children's Services Grants**

367.1 Appropriations by Fund

367.2 General	48,333,000	50,498,000
367.3 Federal TANF	340,000	240,000

367.4 **Base Adjustment.** The general fund base is
367.5 decreased by $5,371,000 in fiscal year 2012
367.6 and increased $8,737,000 in fiscal year 2013.

367.7 **Privatized Adoption Grants.** Federal
367.8 reimbursement for privatized adoption grant
367.9 and foster care recruitment grant expenditures
367.10 is appropriated to the commissioner for
367.11 adoption grants and foster care and adoption
367.12 administrative purposes.

367.13 **Adoption Assistance Incentive Grants.**
367.14 Federal funds available during fiscal year
367.15 2010 and fiscal year 2011 for the adoption
367.16 incentive grants are appropriated to the
367.17 commissioner for these purposes.

367.18 **Adoption Assistance and Relative Custody**
367.19 **Assistance.** The commissioner may transfer
367.20 unencumbered appropriation balances for
367.21 adoption assistance and relative custody
367.22 assistance between fiscal years and between
367.23 programs.

367.24 **(h) Children and Community Services Grants**	67,663,000	67,542,000

367.25 **Targeted Case Management Temporary**
367.26 **Funding Adjustment.** The commissioner
367.27 shall recover from each county and tribe
367.28 receiving a targeted case management
367.29 temporary funding payment in fiscal year
367.30 2008 an amount equal to that payment. The
367.31 commissioner shall recover one-half of the
367.32 funds by February 1, 2010, and the remainder
367.33 by February 1, 2011. At the commissioner's

368.1 discretion and at the request of a county
368.2 or tribe, the commissioner may revise
368.3 the payment schedule, but full payment
368.4 must not be delayed beyond May 1, 2011.
368.5 The commissioner may use the recovery
368.6 procedure under Minnesota Statutes, section
368.7 256.017, to recover the funds. Recovered
368.8 funds must be deposited into the general
368.9 fund.

368.10 **(i) General Assistance Grants**	48,215,000	48,608,000

368.11 **General Assistance Standard.** The
368.12 commissioner shall set the monthly standard
368.13 of assistance for general assistance units
368.14 consisting of an adult recipient who is
368.15 childless and unmarried or living apart
368.16 from parents or a legal guardian at $203.
368.17 The commissioner may reduce this amount
368.18 according to Laws 1997, chapter 85, article
368.19 3, section 54.

368.20 **Emergency General Assistance.** The
368.21 amount appropriated for emergency general
368.22 assistance funds is limited to no more
368.23 than $7,889,812 in fiscal year 2010 and
368.24 $7,889,812 in fiscal year 2011. Funds
368.25 to counties must be allocated by the
368.26 commissioner using the allocation method
368.27 specified in Minnesota Statutes, section
368.28 256D.06.

368.29 **(j) Minnesota Supplemental Aid Grants**	33,930,000	35,191,000

368.30 **Emergency Minnesota Supplemental**
368.31 **Aid Funds.** The amount appropriated for
368.32 emergency Minnesota supplemental aid
368.33 funds is limited to no more than $1,100,000
368.34 in fiscal year 2010 and $1,100,000 in fiscal

369.1 year 2011. Funds to counties must be
369.2 allocated by the commissioner using the
369.3 allocation method specified in Minnesota
369.4 Statutes, section 256D.46.

369.5 **(k) Group Residential Housing Grants**	111,778,000	114,034,000

369.6 **Group Residential Housing Costs**
369.7 **Refinanced.** (a) Effective July 1, 2011, the
369.8 commissioner shall increase the home and
369.9 community-based service rates and county
369.10 allocations provided to programs for persons
369.11 with disabilities established under section
369.12 1915(c) of the Social Security Act to the
369.13 extent that these programs will be paying
369.14 for the costs above the rate established
369.15 in Minnesota Statutes, section 256I.05,
369.16 subdivision 1.

369.17 (b) For persons receiving services under
369.18 Minnesota Statutes, section 245A.02, who
369.19 reside in licensed adult foster care beds
369.20 for which a difficulty of care payment
369.21 was being made under Minnesota Statutes,
369.22 section 256I.05, subdivision 1c, paragraph
369.23 (b), counties may request an exception to
369.24 the individual's service authorization not to
369.25 exceed the difference between the client's
369.26 monthly service expenditures plus the
369.27 amount of the difficulty of care payment.

369.28 **(l) Children's Mental Health Grants**	16,885,000	16,882,000

369.29 **Funding Usage.** Up to 75 percent of a fiscal
369.30 year's appropriation for children's mental
369.31 health grants may be used to fund allocations
369.32 in that portion of the fiscal year ending
369.33 December 31.

370.1 370.2	**(m) Other Children and Economic Assistance Grants**	16,047,000	15,339,000

370.3 **Fraud Prevention Grants.** Of this
370.4 appropriation, $379,000 in fiscal year 2010
370.5 and $379,000 in fiscal year 2011 is to the
370.6 commissioner for fraud prevention grants to
370.7 counties.

370.8 **Homeless and Runaway Youth.** $218,000
370.9 in fiscal year 2010 is for the Runaway
370.10 and Homeless Youth Act under Minnesota
370.11 Statutes, section 256K.45. Funds shall be
370.12 spent in each area of the continuum of care
370.13 to ensure that programs are meeting the
370.14 greatest need. Any unexpended balance in
370.15 the first year is available in the second year.
370.16 Beginning July 1, 2011, the base is increased
370.17 by $119,000 each year.

370.18 **ARRA Homeless Youth Funds.** To the
370.19 extent permitted under federal law, the
370.20 commissioner shall designate $2,500,000
370.21 of the Homeless Prevention and Rapid
370.22 Re-Housing Program funds provided under
370.23 the American Recovery and Reinvestment
370.24 Act of 2009, Public Law 111-5, for agencies
370.25 providing homelessness prevention and rapid
370.26 rehousing services to youth.

370.27 **Supportive Housing Services.** $1,500,000
370.28 each year is for supportive services under
370.29 Minnesota Statutes, section 256K.26. This is
370.30 a onetime appropriation. Beginning in fiscal
370.31 year 2012, the base is increased by $68,000
370.32 per year.

370.33 **Community Action Grants.** Community
370.34 action grants are reduced one time by

371.1 $1,764,000 each year. This reduction is due
371.2 to the availability of federal funds under the
371.3 American Recovery and Reinvestment Act.

371.4 **Base Adjustment.** The general fund base
371.5 is increased by $773,000 in fiscal year 2012
371.6 and $773,000 in fiscal year 2013.

371.7 **Federal ARRA Funds for Existing**
371.8 **Programs.** (a) Federal funds received by the
371.9 commissioner for the emergency food and
371.10 shelter program from the American Recovery
371.11 and Reinvestment Act of 2009, Public
371.12 Law 111-5, but not previously approved
371.13 by the legislature are appropriated to the
371.14 commissioner for the purposes of the grant
371.15 program.

371.16 (b) Federal funds received by the
371.17 commissioner for the emergency shelter
371.18 grant program including the Homelessness
371.19 Prevention and Rapid Re-Housing
371.20 Program from the American Recovery and
371.21 Reinvestment Act of 2009, Public Law
371.22 111-5, are appropriated to the commissioner
371.23 for the purposes of the grant programs.

371.24 (c) Federal funds received by the
371.25 commissioner for the emergency food
371.26 assistance program from the American
371.27 Recovery and Reinvestment Act of 2009,
371.28 Public Law 111-5, are appropriated to the
371.29 commissioner for the purposes of the grant
371.30 program.

371.31 (d) Federal funds received by the
371.32 commissioner for senior congregate meals
371.33 and senior home-delivered meals from the
371.34 American Recovery and Reinvestment Act
371.35 of 2009, Public Law 111-5, are appropriated

372.1 to the commissioner for the Minnesota Board
372.2 on Aging, for purposes of the grant programs.

372.3 (e) Federal funds received by the
372.4 commissioner for the community services
372.5 block grant program from the American
372.6 Recovery and Reinvestment Act of 2009,
372.7 Public Law 111-5, are appropriated to the
372.8 commissioner for the purposes of the grant
372.9 program.

372.10 **Long-Term Homeless Supportive**
372.11 **Service Fund Appropriation.** To the
372.12 extent permitted under federal law, the
372.13 commissioner shall designate $3,000,000
372.14 of the Homelessness Prevention and Rapid
372.15 Re-Housing Program funds provided under
372.16 the American Recovery and Reinvestment
372.17 Act of 2009, Public Law, 111-5, to the
372.18 long-term homeless service fund under
372.19 Minnesota Statutes, section 256K.26. This
372.20 appropriation shall become available by July
372.21 1, 2009. This paragraph is effective the day
372.22 following final enactment.

372.23 Subd. 5. **Children and Economic Assistance**
372.24 **Management**

372.25 The amounts that may be spent from the
372.26 appropriation for each purpose are as follows:

372.27 **(a) Children and Economic Assistance**
372.28 **Administration**

372.29 Appropriations by Fund

372.30	General	10,318,000	10,308,000
372.31	Federal TANF	496,000	496,000

373.1 **Base Adjustment.** The federal TANF base
373.2 is increased by $700,000 in each of fiscal
373.3 years 2012 and 2013.

373.4 **School Readiness Service Agreements.**
373.5 $406,000 in fiscal year 2010 and $406,000
373.6 in fiscal year 2011 are from the federal
373.7 child care development funds received from
373.8 the American Recovery and Reinvestment
373.9 Act of 2009, Public Law 111-5, to the
373.10 commissioner of human services consistent
373.11 with federal regulations for the purpose of
373.12 school readiness service agreements under
373.13 Minnesota Statutes, section 119B.231. This
373.14 is a onetime appropriation. Any unexpended
373.15 balance the first year is available in the
373.16 second year.

373.17 **(b) Children and Economic Assistance**
373.18 **Operations**

		Appropriations by Fund	
373.20	General	33,590,000	33,423,000
373.21	Health Care Access	361,000	361,000

373.22 **Financial Institution Data Match and**
373.23 **Payment of Fees.** The commissioner is
373.24 authorized to allocate up to $310,000 each
373.25 year in fiscal years 2010 and 2011 from the
373.26 PRISM special revenue account to make
373.27 payments to financial institutions in exchange
373.28 for performing data matches between account
373.29 information held by financial institutions
373.30 and the public authority's database of child
373.31 support obligors as authorized by Minnesota
373.32 Statutes, section 13B.06, subdivision 7.

374.1 **School Readiness Service Agreements.**
374.2 $106,000 in fiscal year 2010 and $241,000
374.3 in fiscal year 2011 are from the federal
374.4 child care development funds received from
374.5 the American Recovery and Reinvestment
374.6 Act of 2009, Public Law 111-5, to the
374.7 commissioner of human services consistent
374.8 with federal regulations for the purpose of
374.9 school readiness service agreements under
374.10 Minnesota Statutes, section 119B.231. This
374.11 is a onetime appropriation.

374.12 **Use of Federal Stabilization Funds.**
374.13 $33,000,000 in fiscal year 2010 is
374.14 appropriated from the fiscal stabilization
374.15 account in the federal fund to the
374.16 commissioner. This appropriation must not
374.17 be used for any activity or service for which
374.18 federal reimbursement is claimed. This is a
374.19 onetime appropriation.

374.20 Subd. 6. **Basic Health Care Grants**

374.21 The amounts that may be spent from this
374.22 appropriation for each purpose are as follows:

374.23 **(a) MinnesotaCare Grants**	391,915,000	485,448,000

374.24 This appropriation is from the health care
374.25 access fund.

374.26 **(b) MA Basic Health Care Grants - Families** 374.27 **and Children**	751,988,000	973,088,000

374.28 **Medical Education Research Costs**
374.29 **(MERC).** Of these funds, the commissioner
374.30 of human services shall transfer $38,000,000
374.31 in fiscal year 2010 to the medical education
374.32 research fund. These funds must restore the
374.33 fiscal year 2009 unallotment of the transfers

375.1 under Minnesota Statutes, section 256B.69,
375.2 subdivision 5c, paragraph (a), for the July 1,
375.3 2008, through June 30, 2009, period.

375.4 **Newborn Screening Fee.** Of the general
375.5 fund appropriation, $34,000 in fiscal
375.6 year 2011 is to the commissioner for the
375.7 hospital reimbursement increase described
375.8 under Minnesota Statutes, section 256.969,
375.9 subdivision 28.

375.10 **Local Share Payment Modification**
375.11 **Required for ARRA Compliance.**
375.12 Effective from July 1, 2009, to December
375.13 31, 2010, Hennepin County's monthly
375.14 contribution to the nonfederal share of
375.15 medical assistance costs must be reduced
375.16 to the percentage required on September
375.17 1, 2008, to meet federal requirements for
375.18 enhanced federal match under the American
375.19 Reinvestment and Recovery Act (ARRA)
375.20 of 2009. Notwithstanding the requirements
375.21 of Minnesota Statutes, section 256B.19,
375.22 subdivision 1c, paragraph (d), for the period
375.23 beginning July 1, 2009, to December 31,
375.24 2010, Hennepin County's monthly payment
375.25 under that provision is reduced to $434,688.

375.26 **Capitation Payments.** Effective from
375.27 July 1, 2009, to December 31, 2010,
375.28 notwithstanding the provisions of Minnesota
375.29 Statutes 2008, section 256B.19, subdivision
375.30 1c, paragraph (c), the commissioner shall
375.31 increase capitation payments made to the
375.32 Metropolitan Health Plan under Minnesota
375.33 Statutes 2008, section 256B.69, by
375.34 $6,800,000 to recognize higher than average

376.1 medical education costs. The increased
376.2 amount includes federal matching funds.

376.3 **Use of Savings.** Any savings derived
376.4 from implementation of the prohibition in
376.5 Minnesota Statutes, section 256B.032, on the
376.6 enrollment of low-quality, high-cost health
376.7 care providers as vendors of state health care
376.8 program services shall be used to offset on a
376.9 pro rata basis the reimbursement reductions
376.10 for basic care services in Minnesota Statutes,
376.11 section 256B.766.

376.12 **(c) MA Basic Health Care Grants - Elderly and**
376.13 **Disabled** 970,183,000 1,142,310,000

376.14 **Minnesota Disability Health Options.**
376.15 Notwithstanding Minnesota Statutes, section
376.16 256B.69, subdivision 5a, paragraph (b), for
376.17 the period beginning July 1, 2009, to June
376.18 30, 2011, the monthly enrollment of persons
376.19 receiving home and community-based
376.20 waivered services under Minnesota
376.21 Disability Health Options shall not exceed
376.22 1,000. If the budget neutrality provision
376.23 in Minnesota Statutes, section 256B.69,
376.24 subdivision 23, paragraph (f), is reached
376.25 prior to June 30, 2013, the commissioner may
376.26 waive this monthly enrollment requirement.

376.27 **Hospital Fee-for-Service Payment Delay.**
376.28 Payments from the Medicaid Management
376.29 Information System that would otherwise
376.30 have been made for inpatient hospital
376.31 services for Minnesota health care program
376.32 enrollees must be delayed as follows: for
376.33 fiscal year 2011, payments in the month of
376.34 June equal to $15,937,000 must be included

377.1 in the first payment of fiscal year 2012 and
377.2 for fiscal year 2013, payments in the month
377.3 of June equal to $6,666,000 must be included
377.4 in the first payment of fiscal year 2014. The
377.5 provisions of Minnesota Statutes, section
377.6 16A.124, do not apply to these delayed
377.7 payments. Notwithstanding any contrary
377.8 provision in this article, this paragraph
377.9 expires December 31, 2014.

377.10 **Nonhospital Fee-for-Service Payment**
377.11 **Delay.** Payments from the Medicaid
377.12 Management Information System that would
377.13 otherwise have been made for nonhospital
377.14 acute care services for Minnesota health
377.15 care program enrollees must be delayed as
377.16 follows: payments in the month of June equal
377.17 to $23,438,000 for fiscal year 2011 must be
377.18 included in the first payment for fiscal year
377.19 2012, and payments in the month of June
377.20 equal to $27,156,000 for fiscal year 2013
377.21 must be included in the first payment for
377.22 fiscal year 2014. This payment delay must
377.23 not include nursing facilities, intermediate
377.24 care facilities for persons with developmental
377.25 disabilities, home and community-based
377.26 services, prepaid health plans, personal care
377.27 provider organizations, and home health
377.28 agencies. The provisions of Minnesota
377.29 Statutes, section 16A.124, do not apply to
377.30 these delayed payments. Notwithstanding
377.31 any contrary provision in this article, this
377.32 paragraph expires December 31, 2014.

377.33 **(d) General Assistance Medical Care Grants** 345,223,000 381,081,000

377.34 **(e) Other Health Care Grants**

Appropriations by Fund		
General	295,000	295,000
Health Care Access	23,533,000	7,080,000

Base Adjustment. The health care access fund base is reduced to $190,000 in each of fiscal years 2012 and 2013.

Subd. 7. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Health Care Administration

Appropriations by Fund		
General	7,831,000	7,742,000
Health Care Access	1,812,000	906,000

(b) Health Care Operations

Appropriations by Fund		
General	19,914,000	18,949,000
Health Care Access	25,099,000	25,875,000

Base Adjustment. The health care access fund base is increased by $1,006,000 in fiscal year 2012 and $1,781,000 in fiscal year 2013. The general fund base is decreased by $237,000 in fiscal year 2012 and $237,000 in fiscal year 2013.

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

379.1 Appropriations by Fund

379.2 General	13,488,000	15,779,000
379.3 Federal	500,000	0

379.4 **Base Adjustment.** The general fund base is
379.5 increased by $5,751,000 in fiscal year 2012
379.6 and $6,705,000 in fiscal year 2013.

379.7 **Information and Assistance**
379.8 **Reimbursement.** Federal administrative
379.9 reimbursement obtained from information
379.10 and assistance services provided by the
379.11 Senior LinkAge or Disability Linkage lines
379.12 to people who are identified as eligible for
379.13 medical assistance shall be appropriated to
379.14 the commissioner for this activity.

379.15 **Community Service Development Grant**
379.16 **Reduction.** Funding for community service
379.17 development grants must be reduced by
379.18 $251,000 for fiscal year 2010; $266,000 in
379.19 fiscal year 2011; $25,000 in fiscal year 2012;
379.20 and $25,000 in fiscal year 2013. Base level
379.21 funding shall be restored in fiscal year 2014.

379.22 **Senior Nutrition Use of Federal Funds.**
379.23 For fiscal year 2010, general fund grants
379.24 for home-delivered meals and congregate
379.25 dining shall be reduced by $500,000. The
379.26 commissioner must replace these general
379.27 fund reductions with equal amounts from
379.28 federal funding for senior nutrition from the
379.29 American Recovery and Reinvestment Act
379.30 of 2009.

379.31 **(b) Alternative Care Grants**	50,234,000	48,576,000

380.1 **Base Adjustment.** The general fund base is
380.2 decreased by $3,598,000 in fiscal year 2012
380.3 and $3,470,000 in fiscal year 2013.

380.4 **Alternative Care Transfer.** Any money
380.5 allocated to the alternative care program that
380.6 is not spent for the purposes indicated does
380.7 not cancel but must be transferred to the
380.8 medical assistance account.

380.9 **(c) Medical Assistance Grants; Long-Term** 380.10 **Care Facilities.**	367,444,000	419,749,000
380.11 **(d) Medical Assistance Long-Term Care** 380.12 **Waivers and Home Care Grants**	854,373,000	1,043,411,000

380.13 **Manage Growth in TBI and CADI**
380.14 **Waivers.** During the fiscal years beginning
380.15 on July 1, 2009, and July 1, 2010, the
380.16 commissioner shall allocate money for home
380.17 and community-based waiver programs
380.18 under Minnesota Statutes, section 256B.49,
380.19 to ensure a reduction in state spending that is
380.20 equivalent to limiting the caseload growth of
380.21 the TBI waiver to 12.5 allocations per month
380.22 each year of the biennium and the CADI
380.23 waiver to 95 allocations per month each year
380.24 of the biennium. Limits do not apply: (1)
380.25 when there is an approved plan for nursing
380.26 facility bed closures for individuals under
380.27 age 65 who require relocation due to the
380.28 bed closure; (2) to fiscal year 2009 waiver
380.29 allocations delayed due to unallotment; or (3)
380.30 to transfers authorized by the commissioner
380.31 from the personal care assistance program
380.32 of individuals having a home care rating
380.33 of "CS," "MT," or "HL." Priorities for the
380.34 allocation of funds must be for individuals

381.1 anticipated to be discharged from institutional
381.2 settings or who are at imminent risk of a
381.3 placement in an institutional setting.

381.4 **Manage Growth in DD Waiver.** The
381.5 commissioner shall manage the growth in
381.6 the DD waiver by limiting the allocations
381.7 included in the February 2009 forecast to 15
381.8 additional diversion allocations each month
381.9 for the calendar years that begin on January
381.10 1, 2010, and January 1, 2011. Additional
381.11 allocations must be made available for
381.12 transfers authorized by the commissioner
381.13 from the personal care program of individuals
381.14 having a home care rating of "CS," "MT,"
381.15 or "HL."

381.16 **Adjustment to Lead Agency Waiver**
381.17 **Allocations.** Prior to the availability of the
381.18 alternative license defined in Minnesota
381.19 Statutes, section 245A.11, subdivision 8,
381.20 the commissioner shall reduce lead agency
381.21 waiver allocations for the purposes of
381.22 implementing a moratorium on corporate
381.23 foster care.

381.24 **Alternatives to Personal Care Assistance**
381.25 **Services.** Base level funding of $3,237,000
381.26 in fiscal year 2012 and $4,856,000 in
381.27 fiscal year 2013 is to implement alternative
381.28 services to personal care assistance services
381.29 for persons with mental health and other
381.30 behavioral challenges who can benefit
381.31 from other services that more appropriately
381.32 meet their needs and assist them in living
381.33 independently in the community. These
381.34 services may include, but not be limited to, a
381.35 1915(i) state plan option.

382.1 **(e) Mental Health Grants**

382.2 Appropriations by Fund

382.3 General	77,739,000	77,739,000
382.4 Health Care Access	750,000	750,000
382.5 Lottery Prize	1,508,000	1,508,000

382.6 **Funding Usage.** Up to 75 percent of a fiscal
382.7 year's appropriation for adult mental health
382.8 grants may be used to fund allocations in that
382.9 portion of the fiscal year ending December
382.10 31.

382.11 **(f) Deaf and Hard-of-Hearing Grants**	1,930,000	1,917,000
382.12 **(g) Chemical Dependency Entitlement Grants**	111,303,000	122,822,000

382.13 **Payments for Substance Abuse Treatment.**
382.14 For services provided during fiscal years
382.15 2010 and 2011, county-negotiated rates and
382.16 provider claims to the consolidated chemical
382.17 dependency fund must not exceed rates
382.18 charged for these services on January 1, 2009.
382.19 For services provided in fiscal years 2012
382.20 and 2013, statewide average rates under the
382.21 new rate methodology to be developed under
382.22 Minnesota Statutes, section 254B.12, must
382.23 not exceed the average rates charged for these
382.24 services on January 1, 2009, plus $3,787,000
382.25 for fiscal year 2012 and $5,023,000 for fiscal
382.26 year 2013. Notwithstanding any provision
382.27 to the contrary in this article, this provision
382.28 expires on June 30, 2013.

382.29 **Chemical Dependency Special Revenue**
382.30 **Account.** For fiscal year 2010, $750,000
382.31 must be transferred from the consolidated

383.1 chemical dependency treatment fund
383.2 administrative account and deposited into the
383.3 general fund.

383.4 **County CD Share of MA Costs for**
383.5 **ARRA Compliance.** Notwithstanding the
383.6 provisions of Minnesota Statutes, chapter
383.7 254B, for chemical dependency services
383.8 provided during the period July 1, 2009,
383.9 to December 31, 2010, and reimbursed by
383.10 medical assistance at the enhanced federal
383.11 matching rate provided under the American
383.12 Recovery and Reinvestment Act of 2009, the
383.13 county share is 30 percent of the nonfederal
383.14 share.

383.15 **(h) Chemical Dependency Nonentitlement**		
383.16 **Grants**	1,729,000	1,729,000

383.17 **Base Adjustment.** The general fund base is
383.18 decreased by $3,000 in each of fiscal years
383.19 2012 and 2013.

383.20 **(i) Other Continuing Care Grants**	18,272,000	13,139,000

383.21 **Base Adjustment.** The general fund base is
383.22 increased by $7,028,000 in fiscal year 2012
383.23 and increased by $8,243,000 in fiscal year
383.24 2013.

383.25 **Technology Grants.** $650,000 in fiscal
383.26 year 2010 and $1,000,000 in fiscal year
383.27 2011 are for technology grants, case
383.28 consultation, evaluation, and consumer
383.29 information grants related to developing and
383.30 supporting alternatives to shift-staff foster
383.31 care residential service models.

383.32 **Other Continuing Care Grants; HIV**
383.33 **Grants.** Money appropriated for the HIV

384.1 drug and insurance grant program in fiscal
384.2 year 2010 may be used in either year of the
384.3 biennium.

384.4 Subd. 9. **Continuing Care Management**

	Appropriations by Fund	
384.6 General	24,927,000	25,314,000
384.7 State Government 384.8 Special Revenue	875,000	125,000
384.9 Lottery Prize	157,000	157,000

384.10 **Quality Assurance Commission.** Effective
384.11 July 1, 2009, state funding for the quality
384.12 assurance commission under Minnesota
384.13 Statutes, section 256B.0951, is canceled.

384.14 **County Maintenance of Effort.** $350,000 in
384.15 fiscal year 2010 is from the general fund for
384.16 the State-County Results Accountability and
384.17 Service Delivery Reform under Minnesota
384.18 Statutes, chapter 402A.

384.19 **Base Adjustment.** The general fund base is
384.20 decreased $2,697,000 in fiscal year 2012 and
384.21 $2,791,000 in fiscal year 2013.

384.22 Subd. 10. **State-Operated Services** 258,794,000 266,191,000

384.23 The amounts that may be spent from the
384.24 appropriation for each purpose are as follows:

384.25 **Transfer Authority Related to**
384.26 **State-Operated Services.** Money
384.27 appropriated to finance state-operated
384.28 services may be transferred between the
384.29 fiscal years of the biennium with the approval
384.30 of the commissioner of finance.

384.31 **County Past Due Receivables.** The
384.32 commissioner is authorized to withhold

385.1 county federal administrative reimbursement
385.2 when the county of financial responsibility
385.3 for cost-of-care payments due the state
385.4 under Minnesota Statutes, section 246.54
385.5 or 253B.045, is 90 days past due. The
385.6 commissioner shall deposit the withheld
385.7 federal administrative earnings for the county
385.8 into the general fund to settle the claims with
385.9 the county of financial responsibility. The
385.10 process for withholding funds is governed by
385.11 Minnesota Statutes, section 256.017.

385.12 **Forecast and Census Data.** The
385.13 commissioner shall include census data and
385.14 fiscal projections for state-operated services
385.15 and Minnesota sex offender services with the
385.16 November and February budget forecasts.
385.17 Notwithstanding any contrary provision in
385.18 this article, this paragraph shall not expire.

385.19 **(a) Adult Mental Health Services**	107,702,000	107,201,000

385.20 **Appropriation Limitation.** No part of
385.21 the appropriation in this article to the
385.22 commissioner for mental health treatment
385.23 services provided by state-operated services
385.24 shall be used for the Minnesota sex offender
385.25 program.

385.26 **Community Behavioral Health Hospitals.**
385.27 Under Minnesota Statutes, section 246.51,
385.28 subdivision 1, a determination order for the
385.29 clients served in a community behavioral
385.30 health hospital operated by the commissioner
385.31 of human services is only required when
385.32 a client's third-party coverage has been
385.33 exhausted.

386.1 **Base Adjustment.** The general fund base is
386.2 decreased by $500,000 for fiscal year 2012
386.3 and by $500,000 for fiscal year 2013.

386.4 **(b) Minnesota Sex Offender Services**

386.5 Appropriations by Fund

386.6 General	38,348,000	67,503,000
386.7 Federal Fund	26,495,000	0

386.8 **Use of Federal Stabilization Funds.** Of
386.9 this appropriation, $26,495,000 in fiscal year
386.10 2010 is from the fiscal stabilization account
386.11 in the federal fund to the commissioner.
386.12 This appropriation must not be used for
386.13 any activity or service for which federal
386.14 reimbursement is claimed. This is a onetime
386.15 appropriation.

386.16 **(c) Minnesota Security Hospital and METO**
386.17 **Services**

386.18 Appropriations by Fund

386.19 General	230,000,000	83,735,000
386.20 Federal Fund	83,504,000	0

386.21 **Minnesota Security Hospital.** For the
386.22 purposes of enhancing the safety of
386.23 the public, improving supervision, and
386.24 enhancing community-based mental health
386.25 treatment, state-operated services may
386.26 establish additional community capacity
386.27 for providing treatment and supervision
386.28 of clients who have been ordered into a
386.29 less restrictive alternative of care from the
386.30 state-operated services transitional services

387.1 program consistent with Minnesota Statutes,
387.2 section 246.014.

387.3 **Use of Federal Stabilization Funds.**
387.4 $83,505,000 in fiscal year 2010 is
387.5 appropriated from the fiscal stabilization
387.6 account in the federal fund to the
387.7 commissioner. This appropriation must not
387.8 be used for any activity or service for which
387.9 federal reimbursement is claimed. This is a
387.10 onetime appropriation.

387.11 Sec. 4. **COMMISSIONER OF HEALTH**

387.12 Subdivision 1. **Total Appropriation** **$** **165,717,000** **$** **161,841,000**

387.13 Appropriations by Fund

		2010	2011
387.14		2010	2011
387.15	General	69,366,000	63,884,000
387.16	State Government		
387.17	Special Revenue	45,415,000	45,415,000
387.18	Health Care Access	39,203,000	40,809,000
387.19	Federal TANF	11,733,000	11,733,000

387.20 Subd. 2. **Community and Family Health**
387.21 **Promotion**

387.22 Appropriations by Fund

387.23	General	44,814,000	39,671,000
387.24	State Government		
387.25	Special Revenue	1,033,000	1,304,000
387.26	Federal TANF	11,733,000	11,733,000
387.27	Health Care Access	21,642,000	28,719,000

387.28 **Newborn Screening Fee.** Of the general
387.29 fund appropriation, $300,000 in fiscal year
387.30 2011 is to the commissioner for the purpose

388.1 of providing support services to families as
388.2 required under Minnesota Statutes, section
388.3 144.966, subdivision 3a. $74,000 of this
388.4 appropriation in fiscal year 2011 and $51,000
388.5 of this appropriation in subsequent fiscal
388.6 years may be used by the commissioner
388.7 for administrative costs associated with
388.8 increasing the fee, contract administration,
388.9 program oversight, and provide follow-up to
388.10 families who need assistance beyond those
388.11 available through the contractor.

388.12 **Support Services for Families With**
388.13 **Children Who are Deaf or Have Hearing**
388.14 **Loss.** Of the general fund amount, $16,000
388.15 in fiscal year 2010 and $284,000 in fiscal
388.16 year 2011 is for support services to families
388.17 with children who are deaf or have hearing
388.18 loss. Of this amount, in fiscal year 2011,
388.19 $223,000 is for grants and the balance is for
388.20 administrative costs. Base funding in fiscal
388.21 years 2012 and 2013 is $300,000 each year.
388.22 Of this amount, $241,000 each year is for
388.23 grants and the balance is for administrative
388.24 costs.

388.25 **Funding Usage.** Up to 75 percent of the
388.26 fiscal year 2012 appropriation for local public
388.27 health grants may be used to fund calendar
388.28 year 2011 allocations for this program. The
388.29 general fund reduction of $5,193,000 in
388.30 fiscal year 2011 for local public health grants
388.31 is onetime and the base funding for local
388.32 public health grants for fiscal year 2012 is
388.33 increased by $5,193,000.

388.34 **Colorectal Screening.** $88,000 in fiscal year
388.35 2010 and $62,000 in fiscal year 2011 are

389.1 for grants to the Hennepin County Medical
389.2 Center and MeritCare Bemidji for colorectal
389.3 screening demonstration projects.

389.4 **Feasibility Pilot Project for Cancer**
389.5 **Surveillance.** Of the general fund
389.6 appropriation for fiscal year 2010, $100,000
389.7 is to the commissioner to provide grant
389.8 funding to cover the cost of one full-time
389.9 equivalent position at the Hennepin County
389.10 Medical Center to carry out the feasibility
389.11 pilot project.

389.12 **American Recovery and Reinvestment**
389.13 **Act Funds.** Federal funds received by the
389.14 commissioner for WIC program management
389.15 information systems from the American
389.16 Recovery and Reinvestment Act of 2009,
389.17 Public Law 111-5, are appropriated to the
389.18 commissioner for the purpose of the grant.

389.19 **TANF Appropriations.** (1) $1,156,000 of
389.20 the TANF funds are appropriated each year to
389.21 the commissioner for family planning grants
389.22 under Minnesota Statutes, section 145.925.

389.23 (2) $3,579,000 of the TANF funds are
389.24 appropriated each year to the commissioner
389.25 for home visiting and nutritional services
389.26 listed under Minnesota Statutes, section
389.27 145.882, subdivision 7, clauses (6) and (7).
389.28 Funds must be distributed to community
389.29 health boards according to Minnesota
389.30 Statutes, section 145A.131, subdivision 1.

389.31 (3) $2,000,000 of the TANF funds are
389.32 appropriated each year to the commissioner
389.33 for decreasing racial and ethnic disparities
389.34 in infant mortality rates under Minnesota
389.35 Statutes, section 145.928, subdivision 7.

390.1 (4) $4,998,000 of the TANF funds are
390.2 appropriated each year to the commissioner
390.3 for the family home visiting grant program
390.4 according to Minnesota Statutes, section
390.5 145A.17. $4,000,000 of the funding must
390.6 be distributed to community health boards
390.7 according to Minnesota Statutes, section
390.8 145A.131, subdivision 1. $998,000 of
390.9 the funding must be distributed to tribal
390.10 governments based on Minnesota Statutes,
390.11 section 145A.14, subdivision 2a. The
390.12 commissioner may use five percent of
390.13 the funds appropriated each fiscal year to
390.14 conduct the ongoing evaluations required
390.15 under Minnesota Statutes, section 145A.17,
390.16 subdivision 7, and may use ten percent of
390.17 the funds appropriated each fiscal year to
390.18 provide training and technical assistance as
390.19 required under Minnesota Statutes, section
390.20 145A.17, subdivisions 4 and 5.

390.21 **Base Adjustment.** The general fund base
390.22 is increased by $10,302,000 for fiscal year
390.23 2012 and increased by $5,109,000 for fiscal
390.24 year 2013. The health care access fund base
390.25 is reduced to $1,719,000 for both fiscal years
390.26 2012 and 2013.

390.27 **TANF Carryforward.** Any unexpended
390.28 balance of the TANF appropriation in the
390.29 first year of the biennium does not cancel but
390.30 is available for the second year.

390.31 Subd. 3. **Policy Quality and Compliance**

390.32 Appropriations by Fund

390.33	General	7,491,000	7,242,000

State Government Special Revenue	14,173,000	14,173,000
Health Care Access	17,561,000	12,090,000

Community-Based Health Care Demonstration Project. Notwithstanding the provisions of Laws 2007, chapter 147, article 19, section 3, subdivision 6, paragraph (e), base level funding to the commissioner for the demonstration project grant described in Minnesota Statutes, section 62Q.80, subdivision 1a, shall be zero for fiscal years 2011 and 2012.

Medical Education and Research Cost Federal Compliance. Notwithstanding Laws 2008, chapter 363, article 18, section 4, subdivision 3, the base level funding for the commissioner to distribute to the Mayo Clinic for transitional funding while federal compliance changes are made to the medical education and research cost funding distribution formula shall be $0 for fiscal years 2010 and 2011.

Autism Clinical Research. The commissioner, in partnership with a Minnesota research institution, shall apply for funds available for research grants under the American Recovery and Reinvestment Act (ARRA) of 2009 in order to expand research and treatment of autism spectrum disorders.

Health Information Technology. (a) Of the health care access fund appropriation, $4,000,000 is to fund the revolving loan account under Minnesota Statutes, section

392.1 62J.496. This appropriation must not be
392.2 expended unless it is matched with federal
392.3 funding under the federal Health Information
392.4 Technology for Economic and Clinical
392.5 Health (HITECH) Act. This appropriation
392.6 must not be included in the agency's base
392.7 budget for the fiscal year beginning July 1,
392.8 2012.

392.9 (b) On or before June 30, 2013, $1,200,000
392.10 shall be transferred from the revolving loan
392.11 account under Minnesota Statutes, section
392.12 62J.496, to the health care access fund.
392.13 This is a onetime transfer and must not be
392.14 included in the agency's base budget for the
392.15 fiscal year beginning July 1, 2014.

392.16 **Base Adjustment.** The general fund
392.17 base is $8,243,000 in fiscal year 2012 and
392.18 $8,243,000 in fiscal year 2013. The health
392.19 care access fund base is $10,950,000 in fiscal
392.20 year 2012 and $6,816,000 in fiscal year 2013.

392.21 Subd. 4. **Health Protection**

392.22 Appropriations by Fund

392.23	General	9,871,000	9,780,000
392.24	State Government		
392.25	Special Revenue	30,209,000	30,209,000

392.26 **Base Adjustment.** The general fund base is
392.27 reduced by $50,000 in each of fiscal years
392.28 2012 and 2013.

392.29 **Health Protection Appropriations.** (a)
392.30 $163,000 each year is for the lead abatement
392.31 grant program.

392.32 (b) $100,000 each year is for emergency
392.33 preparedness and response activities.

393.1 (c) $50,000 each year is for tuberculosis
393.2 prevention and control. This is a onetime
393.3 appropriation.

393.4 **American Recovery and Reinvestment**
393.5 **Act Funds.** Federal funds received
393.6 by the commissioner for immunization
393.7 operations from the American Recovery
393.8 and Reinvestment Act of 2009, Public Law
393.9 111-5, are appropriated to the commissioner
393.10 for the purposes of the grant.

393.11	Subd. 5. **Administrative Support Services**		7,190,000	7,190,000
393.12	Sec. 5. **HEALTH-RELATED BOARDS**			
393.13	Subdivision 1. **Total Appropriation**	**$**	**15,017,000 $**	**14,831,000**

393.14 This appropriation is from the state
393.15 government special revenue fund.

393.16 **Transfer.** In fiscal year 2010, $6,000,000
393.17 shall be transferred from the state government
393.18 special revenue fund to the general fund.

393.19 The amounts that may be spent for each
393.20 purpose are specified in the following
393.21 subdivisions.

393.22	Subd. 2. **Board of Chiropractic Examiners**	447,000	447,000
393.23	Subd. 3. **Board of Dentistry**	1,009,000	1,009,000
393.24 393.25	Subd. 4. **Board of Dietetic and Nutrition Practice**	105,000	105,000
393.26 393.27	Subd. 5. **Board of Marriage and Family Therapy**	137,000	137,000
393.28	Subd. 6. **Board of Medical Practice**	3,674,000	3,674,000
393.29	Subd. 7. **Board of Nursing**	4,217,000	4,219,000

394.1 Subd. 8. **Board of Nursing Home** 394.2 **Administrators**	1,146,000	958,000

394.3 **Administrative Services Unit - Operating**
394.4 **Costs.** Of this appropriation, $524,000
394.5 in fiscal year 2010 and $526,000 in
394.6 fiscal year 2011 are for operating costs
394.7 of the administrative services unit. The
394.8 administrative services unit may receive
394.9 and expend reimbursements for services
394.10 performed by other agencies.

394.11 **Administrative Services Unit - Retirement**
394.12 **Costs.** Of this appropriation in fiscal year
394.13 2010, $201,000 is for onetime retirement
394.14 costs in the health-related boards. This
394.15 funding may be transferred to the health
394.16 boards incurring those costs for their
394.17 payment. These funds are available either
394.18 year of the biennium.

394.19 **Administrative Services Unit - Volunteer**
394.20 **Health Care Provider Program.** Of this
394.21 appropriation, $79,000 in fiscal year 2010
394.22 and $89,000 in fiscal year 2011 are to pay
394.23 for medical professional liability coverage
394.24 required under Minnesota Statutes, section
394.25 214.40.

394.26 **Administrative Services Unit - Contested**
394.27 **Cases and Other Legal Proceedings.** Of
394.28 this appropriation, $200,000 in fiscal year
394.29 2010 and $200,000 in fiscal year 2011
394.30 are for costs of contested case hearings
394.31 and other unanticipated costs of legal
394.32 proceedings involving health-related
394.33 boards funded under this section. Upon
394.34 certification of a health-related board to the

395.1 administrative services unit that the costs
395.2 will be incurred and that there is insufficient
395.3 money available to pay for the costs out of
395.4 money currently available to that board, the
395.5 administrative services unit is authorized
395.6 to transfer money from this appropriation
395.7 to the board for payment of those costs
395.8 with the approval of the commissioner of
395.9 finance. This appropriation does not cancel.
395.10 Any unencumbered and unspent balances
395.11 remain available for these expenditures in
395.12 subsequent fiscal years.

395.13	Subd. 9. **Board of Optometry**		101,000	101,000
395.14	Subd. 10. **Board of Pharmacy**		1,413,000	1,413,000
395.15	Subd. 11. **Board of Physical Therapy**		295,000	295,000
395.16	Subd. 12. **Board of Podiatry**		56,000	56,000
395.17	Subd. 13. **Board of Psychology**		806,000	806,000
395.18	Subd. 14. **Board of Social Work**		1,022,000	1,022,000
395.19	Subd. 15. **Board of Veterinary Medicine**		195,000	195,000
395.20 395.21	Subd. 16. **Board of Behavioral Health and Therapy**		394,000	394,000
395.22 395.23	Sec. 6. **EMERGENCY MEDICAL SERVICES BOARD**	$	**4,378,000**	$ **3,828,000**

395.24 Appropriations by Fund

		2010	2011
395.25		2010	2011
395.26	General	3,674,000	3,124,000
395.27 395.28	State Government Special Revenue	704,000	704 ,000

395.29 **Longevity Award and Incentive Program.**
395.30 Of the general fund appropriation, $700,000

396.1 in fiscal year 2010 and $700,000 in fiscal year
396.2 2011 are to the board for the Cooper/Sams
396.3 volunteer ambulance program, under
396.4 Minnesota Statutes, section 144E.40.

396.5 **Transfer.** In fiscal year 2010, $6,182,000
396.6 is transferred from the Cooper/Sams
396.7 volunteer ambulance trust, established under
396.8 Minnesota Statutes, section 144E.42, to the
396.9 general fund.

396.10 **Health Professional Services Program.**
396.11 $704,000 in fiscal year 2010 and $704,000 in
396.12 fiscal year 2011 from the state government
396.13 special revenue fund are for the health
396.14 professional services program.

396.15 **Comprehensive Advanced Life-Support**
396.16 **Educational (CALS) Program.** $100,000 in
396.17 the first year from the Cooper/Sams volunteer
396.18 ambulance trust is for the comprehensive
396.19 advanced life-support educational (CALS)
396.20 program established under Minnesota
396.21 Statutes, section 144E.37. This appropriation
396.22 is to extend availability and affordability
396.23 of the CALS program for rural emergency
396.24 medical personnel and to assist hospital staff
396.25 in attaining the credentialing levels necessary
396.26 for implementation of the statewide trauma
396.27 system.

396.28 Sec. 7. **DEPARTMENT OF VETERANS**
396.29 **AFFAIRS** **$ 200,000 $ 0**

396.30 **Veterans Paramedic Apprenticeship**
396.31 **Program.** Of this appropriation, $200,000
396.32 in the first year is from the Cooper/Sams
396.33 volunteer ambulance trust for transfer
396.34 to the commissioner of veterans affairs

397.1 for a grant to the Minnesota Ambulance
397.2 Association to implement a veterans
397.3 paramedic apprenticeship program to
397.4 reintegrate returning military medics into
397.5 Minnesota's workforce in the field of
397.6 paramedic and emergency services, thereby
397.7 guaranteeing returning military medics
397.8 gainful employment with livable wages and
397.9 benefits. This appropriation is available until
397.10 expended.

397.11 Sec. 8. **DEPARTMENT OF PUBLIC SAFETY** **$** **250,000** **$** **0**

397.12 **Medical Response Unit Reimbursement**
397.13 **Pilot Program.** (a) $250,000 in the first
397.14 year is from the Cooper/Sams volunteer
397.15 ambulance trust for a transfer to the
397.16 Department of Public Safety for a medical
397.17 response unit reimbursement pilot program.
397.18 Of this appropriation, $75,000 is for
397.19 administrative costs to the Department of
397.20 Public Safety, including providing contract
397.21 staff support and technical assistance to the
397.22 pilot program partners if necessary.

397.23 (b) Of the amount in paragraph (a), $175,000
397.24 is to be used to provide a predetermined
397.25 reimbursement amount to the participating
397.26 medical response units. The Department
397.27 of Public Safety or its contract designee
397.28 will develop an agreement with the medical
397.29 response units outlining reimbursement and
397.30 program requirements to include HIPAA
397.31 compliance while participating in the pilot
397.32 program.

397.33 Sec. 9. **COUNCIL ON DISABILITY** **$** **524,000** **$** **524,000**

398.1 Sec. 10. **OMBUDSMAN FOR MENTAL**
398.2 **HEALTH AND DEVELOPMENTAL**
398.3 **DISABILITIES** | **$** | **1,655,000** | **$** | **1,655,000**

398.4 Sec. 11. **OMBUDSPERSON FOR FAMILIES** | **$** | **265,000** | **$** | **265,000**

398.5 Sec. 12. Laws 2007, chapter 147, article 19, section 3, subdivision 4, as amended
398.6 by Laws 2008, chapter 277, article 5, section 1; and Laws 2008, chapter 363, article
398.7 18, section 7, is amended to read:

398.8 Subd. 4. **Children and Economic Assistance**
398.9 **Grants**

398.10 The amounts that may be spent from this
398.11 appropriation for each purpose are as follows:

398.12 (a) **MFIP/DWP Grants**

398.13 Appropriations by Fund

398.14 General	62,069,000	62,405,000
398.15 Federal TANF	75,904,000	80,841,000

398.16 (b) **Support Services Grants**

398.17 Appropriations by Fund

398.18 General	8,715,000	8,715,000
398.19 Federal TANF	113,429,000	115,902,000

398.20 **TANF Prior Appropriation Cancellation.**
398.21 Notwithstanding Laws 2001, First Special
398.22 Session chapter 9, article 17, section
398.23 2, subdivision 11, paragraph (b), any
398.24 unexpended TANF funds appropriated to the
398.25 commissioner to contract with the Board of
398.26 Trustees of Minnesota State Colleges and
398.27 Universities, to provide tuition waivers to
398.28 employees of health care and human service

399.1 providers that are members of qualifying
399.2 consortia operating under Minnesota
399.3 Statutes, sections 116L.10 to 116L.15, must
399.4 cancel at the end of fiscal year 2007.

399.5 **MFIP Pilot Program.** Of the TANF
399.6 appropriation, $100,000 in fiscal year 2008
399.7 and $750,000 in fiscal year 2009 are for a
399.8 grant to the Stearns-Benton Employment and
399.9 Training Council for the Workforce U pilot
399.10 program. Base level funding for this program
399.11 shall be $750,000 in 2010 and $0 in 2011.

399.12 **Supported Work.** (1) Of the TANF
399.13 appropriation, $5,468,000 in fiscal year 2008
399.14 is for supported work for MFIP participants,
399.15 to be allocated to counties and tribes based
399.16 on the criteria under clauses (2) and (3), and
399.17 is available until expended. Paid transitional
399.18 work experience and other supported
399.19 employment under this rider provides
399.20 a continuum of employment assistance,
399.21 including outreach and recruitment,
399.22 program orientation and intake, testing and
399.23 assessment, job development and marketing,
399.24 preworksite training, supported worksite
399.25 experience, job coaching, and postplacement
399.26 follow-up, in addition to extensive case
399.27 management and referral services. *** (The**
399.28 **preceding text "and $7,291,000 in fiscal**
399.29 **year 2009" was indicated as vetoed by the**
399.30 **governor.)**

399.31 (2) A county or tribe is eligible to receive an
399.32 allocation under this rider if:

399.33 (i) the county or tribe is not meeting the
399.34 federal work participation rate;

400.1 (ii) the county or tribe has participants who
400.2 are required to perform work activities under
400.3 Minnesota Statutes, chapter 256J, but are not
400.4 meeting hourly work requirements; and

400.5 (iii) the county or tribe has assessed
400.6 participants who have completed six weeks
400.7 of job search or are required to perform
400.8 work activities and are not meeting the
400.9 hourly requirements, and the county or tribe
400.10 has determined that the participant would
400.11 benefit from working in a supported work
400.12 environment.

400.13 (3) A county or tribe may also be eligible for
400.14 funds in order to contract for supplemental
400.15 hours of paid work at the participant's child's
400.16 place of education, child care location, or the
400.17 child's physical or mental health treatment
400.18 facility or office. This grant to counties and
400.19 tribes is specifically for MFIP participants
400.20 who need to work up to five hours more
400.21 per week in order to meet the hourly work
400.22 requirement, and the participant's employer
400.23 cannot or will not offer more hours to the
400.24 participant.

400.25 **Work Study.** Of the TANF appropriation,
400.26 $750,000 each year are to the commissioner
400.27 to contract with the Minnesota Office of
400.28 Higher Education for the biennium beginning
400.29 July 1, 2007, for work study grants under
400.30 Minnesota Statutes, section 136A.233,
400.31 specifically for low-income individuals who
400.32 receive assistance under Minnesota Statutes,
400.33 chapter 256J, and for grants to opportunities
400.34 industrialization centers. *** (The preceding
400.35 text beginning "Work Study. Of the TANF**

401.1 **appropriation," was indicated as vetoed**
401.2 **by the governor.)**

401.3 **Integrated Service Projects.** $2,500,000
401.4 in fiscal year 2008 and $2,500,000 in fiscal
401.5 year 2009 are appropriated from the TANF
401.6 fund to the commissioner to continue to
401.7 fund the existing integrated services projects
401.8 for MFIP families, and if funding allows,
401.9 additional similar projects.

401.10 **Base Adjustment.** The TANF base for fiscal
401.11 year 2010 is $115,902,000 and for fiscal year
401.12 2011 is $115,152,000.

401.13 (c) **MFIP Child Care Assistance Grants**

401.14	General	74,654,000	71,951,000

401.15 (d) **Basic Sliding Fee Child Care Assistance**
401.16 **Grants**

401.17	General	42,995,000	45,008,000

401.18 **Base Adjustment.** The general fund base
401.19 is $44,881,000 for fiscal year 2010 and
401.20 $44,852,000 for fiscal year 2011.

401.21 **At-Home Infant Care Program.** No
401.22 funding shall be allocated to or spent on
401.23 the at-home infant care program under
401.24 Minnesota Statutes, section 119B.035.

401.25 (e) **Child Care Development Grants**

401.26	General	4,390,000	6,390,000

401.27 **Prekindergarten Exploratory Projects.** Of
401.28 the general fund appropriation, $2,000,000
401.29 the first year and $4,000,000 the second

402.1 year are for grants to the city of St. Paul,
402.2 Hennepin County, and Blue Earth County to
402.3 establish scholarship demonstration projects
402.4 to be conducted in partnership with the
402.5 Minnesota Early Learning Foundation to
402.6 promote children's school readiness. This
402.7 appropriation is available until June 30, 2009.

402.8 **Child Care Services Grants.** Of this
402.9 appropriation, $250,000 each year are for
402.10 the purpose of providing child care services
402.11 grants under Minnesota Statutes, section
402.12 119B.21, subdivision 5. This appropriation
402.13 is for the 2008-2009 biennium only, and does
402.14 not increase the base funding.

402.15 **Early Childhood Professional**
402.16 **Development System.** Of this appropriation,
402.17 $250,000 each year are for purposes of the
402.18 early childhood professional development
402.19 system, which increases the quality and
402.20 continuum of professional development
402.21 opportunities for child care practitioners.
402.22 This appropriation is for the 2008-2009
402.23 biennium only, and does not increase the
402.24 base funding.

402.25 **Base Adjustment.** The general fund base
402.26 is $1,515,000 for each of fiscal years 2010
402.27 and 2011.

402.28 (f) **Child Support Enforcement Grants**

402.29	General	11,038,000	3,705,000

402.30 **Child Support Enforcement.** $7,333,000
402.31 for fiscal year 2008 is to make grants to
402.32 counties for child support enforcement
402.33 programs to make up for the loss under the

403.1 2005 federal Deficit Reduction Act of federal
403.2 matching funds for federal incentive funds
403.3 passed on to the counties by the state.

403.4 This appropriation is available until June 30,
403.5 2009.

403.6 (g) **Children's Services Grants**

403.7 Appropriations by Fund

403.8	General	63,647,000	71,147,000
403.9	Health Care Access	250,000	-0-
403.10	TANF	240,000	340,000

403.11 **Grants for Programs Serving Young**
403.12 **Parents.** Of the TANF fund appropriation,
403.13 $140,000 each year is for a grant to a program
403.14 or programs that provide comprehensive
403.15 services through a private, nonprofit agency
403.16 to young parents in Hennepin County who
403.17 have dropped out of school and are receiving
403.18 public assistance. The program administrator
403.19 shall report annually to the commissioner on
403.20 skills development, education, job training,
403.21 and job placement outcomes for program
403.22 participants.

403.23 **County Allocations for Rate Increases.**
403.24 County Children and Community Services
403.25 Act allocations shall be increased by
403.26 $197,000 effective October 1, 2007, and
403.27 $696,000 effective October 1, 2008, to help
403.28 counties pay for the rate adjustments to
403.29 day training and habilitation providers for
403.30 participants paid by county social service
403.31 funds. Notwithstanding the provisions of
403.32 Minnesota Statutes, section 256M.40, the
403.33 allocation to a county shall be based on

404.1 the county's proportion of social services
404.2 spending for day training and habilitation
404.3 services as determined in the most recent
404.4 social services expenditure and grant
404.5 reconciliation report.

404.6 **Privatized Adoption Grants.** Federal
404.7 reimbursement for privatized adoption grant
404.8 and foster care recruitment grant expenditures
404.9 is appropriated to the commissioner for
404.10 adoption grants and foster care and adoption
404.11 administrative purposes.

404.12 **Adoption Assistance Incentive Grants.**
404.13 Federal funds available during fiscal year
404.14 2008 and fiscal year 2009 for the adoption
404.15 incentive grants are appropriated to the
404.16 commissioner for these purposes.

404.17 **Adoption Assistance and Relative Custody**
404.18 **Assistance.** The commissioner may transfer
404.19 unencumbered appropriation balances for
404.20 adoption assistance and relative custody
404.21 assistance between fiscal years and between
404.22 programs.

404.23 **Children's Mental Health Grants.** Of the
404.24 general fund appropriation, $5,913,000 in
404.25 fiscal year 2008 and $6,825,000 in fiscal year
404.26 2009 are for children's mental health grants.
404.27 The purpose of these grants is to increase and
404.28 maintain the state's children's mental health
404.29 service capacity, especially for school-based
404.30 mental health services. The commissioner
404.31 shall require grantees to utilize all available
404.32 third party reimbursement sources as a
404.33 condition of using state grant funds. At
404.34 least 15 percent of these funds shall be
404.35 used to encourage efficiencies through early

405.1 intervention services. At least another 15
405.2 percent shall be used to provide respite care
405.3 services for children with severe emotional
405.4 disturbance at risk of out-of-home placement.

405.5 **Mental Health Crisis Services.** Of the
405.6 general fund appropriation, $2,528,000 in
405.7 fiscal year 2008 and $2,850,000 in fiscal year
405.8 2009 are for statewide funding of children's
405.9 mental health crisis services. Providers must
405.10 utilize all available funding streams.

405.11 **Children's Mental Health Evidence-Based**
405.12 **and Best Practices.** Of the general fund
405.13 appropriation, $375,000 in fiscal year 2008
405.14 and $750,000 in fiscal year 2009 are for
405.15 children's mental health evidence-based and
405.16 best practices including, but not limited
405.17 to: Adolescent Integrated Dual Diagnosis
405.18 Treatment services; school-based mental
405.19 health services; co-location of mental
405.20 health and physical health care, and; the
405.21 use of technological resources to better
405.22 inform diagnosis and development of
405.23 treatment plan development by mental
405.24 health professionals. The commissioner
405.25 shall require grantees to utilize all available
405.26 third-party reimbursement sources as a
405.27 condition of using state grant funds.

405.28 **Culturally Specific Mental Health**
405.29 **Treatment Grants.** Of the general fund
405.30 appropriation, $75,000 in fiscal year 2008
405.31 and $300,000 in fiscal year 2009 are for
405.32 children's mental health grants to support
405.33 increased availability of mental health
405.34 services for persons from cultural and
405.35 ethnic minorities within the state. The

406.1 commissioner shall use at least 20 percent
406.2 of these funds to help members of cultural
406.3 and ethnic minority communities to become
406.4 qualified mental health professionals and
406.5 practitioners. The commissioner shall assist
406.6 grantees to meet third-party credentialing
406.7 requirements and require them to utilize all
406.8 available third-party reimbursement sources
406.9 as a condition of using state grant funds.

406.10 **Mental Health Services for Children with**
406.11 **Special Treatment Needs.** Of the general
406.12 fund appropriation, $50,000 in fiscal year
406.13 2008 and $200,000 in fiscal year 2009 are
406.14 for children's mental health grants to support
406.15 increased availability of mental health
406.16 services for children with special treatment
406.17 needs. These shall include, but not be limited
406.18 to: victims of trauma, including children
406.19 subjected to abuse or neglect, veterans and
406.20 their families, and refugee populations;
406.21 persons with complex treatment needs, such
406.22 as eating disorders; and those with low
406.23 incidence disorders.

406.24 **MFIP and Children's Mental Health**
406.25 **Pilot Project.** Of the TANF appropriation,
406.26 $100,000 in fiscal year 2008 and $200,000
406.27 in fiscal year 2009 are to fund the MFIP
406.28 and children's mental health pilot project.
406.29 Of these amounts, up to $100,000 may be
406.30 expended on evaluation of this pilot.

406.31 **Prenatal Alcohol or Drug Use.** Of the
406.32 general fund appropriation, $75,000 ~~each~~
406.33 ~~year is to award grants beginning July 1,~~
406.34 ~~2007, to programs that provide services~~
406.35 ~~under Minnesota Statutes, section 254A.171,~~

407.1 ~~in Pine, Kanabec, and Carlton Counties.~~
407.2 the second year is for a grant to A Circle
407.3 of Women for program services. This
407.4 appropriation shall become part of the base
407.5 appropriation.

407.6 **Base Adjustment.** The general fund base
407.7 is $62,572,000 in fiscal year 2010 and
407.8 $62,575,000 in fiscal year 2011.

407.9 (h) **Children and Community Services Grants**

407.10 General 101,369,000 69,208,000

407.11 **Base Adjustment.** The general fund base
407.12 is $69,274,000 in each of fiscal years 2010
407.13 and 2011.

407.14 **Targeted Case Management Temporary**
407.15 **Funding.** (a) Of the general fund
407.16 appropriation, $32,667,000 in fiscal year
407.17 2008 is transferred to the targeted case
407.18 management contingency reserve account in
407.19 the general fund to be allocated to counties
407.20 and tribes affected by reductions in targeted
407.21 case management federal Medicaid revenue
407.22 as a result of the provisions in the federal
407.23 Deficit Reduction Act of 2005, Public Law
407.24 109-171.

407.25 (b) Contingent upon (1) publication by the
407.26 federal Centers for Medicare and Medicaid
407.27 Services of final regulations implementing
407.28 the targeted case management provisions
407.29 of the federal Deficit Reduction Act of
407.30 2005, Public Law 109-171, or (2) the
407.31 issuance of a finding by the Centers for
407.32 Medicare and Medicaid Services of federal
407.33 Medicaid overpayments for targeted case

408.1 management expenditures, up to $32,667,000
408.2 is appropriated to the commissioner of human
408.3 services. Prior to distribution of funds, the
408.4 commissioner shall estimate and certify the
408.5 amount by which the federal regulations or
408.6 federal disallowance will reduce targeted
408.7 case management Medicaid revenue over the
408.8 2008-2009 biennium.

408.9 (c) Within 60 days of a contingency described
408.10 in paragraph (b), the commissioner shall
408.11 distribute the grants proportionate to each
408.12 affected county or tribe's targeted case
408.13 management federal earnings for calendar
408.14 year 2005, not to exceed the lower of (1) the
408.15 amount of the estimated reduction in federal
408.16 revenue or (2) $32,667,000.

408.17 (d) These funds are available in either year of
408.18 the biennium. Counties and tribes shall use
408.19 these funds to pay for social service-related
408.20 costs, but the funds are not subject to
408.21 provisions of the Children and Community
408.22 Services Act grant under Minnesota Statutes,
408.23 chapter 256M.

408.24 (e) This appropriation shall be available to
408.25 pay counties and tribes for expenses incurred
408.26 on or after July 1, 2007. The appropriation
408.27 shall be available until expended.

408.28 (i) **General Assistance Grants**

408.29	General	37,876,000	38,253,000

408.30 **General Assistance Standard.** The
408.31 commissioner shall set the monthly standard
408.32 of assistance for general assistance units
408.33 consisting of an adult recipient who is

409.1 childless and unmarried or living apart
409.2 from parents or a legal guardian at $203.
409.3 The commissioner may reduce this amount
409.4 according to Laws 1997, chapter 85, article
409.5 3, section 54.

409.6 **Emergency General Assistance.** The
409.7 amount appropriated for emergency general
409.8 assistance funds is limited to no more
409.9 than $7,889,812 in fiscal year 2008 and
409.10 $7,889,812 in fiscal year 2009. Funds
409.11 to counties must be allocated by the
409.12 commissioner using the allocation method
409.13 specified in Minnesota Statutes, section
409.14 256D.06.

409.15 (j) **Minnesota Supplemental Aid Grants**

409.16	General	30,505,000	30,812,000

409.17 **Emergency Minnesota Supplemental**
409.18 **Aid Funds.** The amount appropriated for
409.19 emergency Minnesota supplemental aid
409.20 funds is limited to no more than $1,100,000
409.21 in fiscal year 2008 and $1,100,000 in fiscal
409.22 year 2009. Funds to counties must be
409.23 allocated by the commissioner using the
409.24 allocation method specified in Minnesota
409.25 Statutes, section 256D.46.

409.26 (k) **Group Residential Housing Grants**

409.27	General	91,069,000	98,671,000

409.28 **People Incorporated.** Of the general fund
409.29 appropriation, $460,000 each year is to
409.30 augment community support and mental
409.31 health services provided to individuals

410.1 residing in facilities under Minnesota
410.2 Statutes, section 256I.05, subdivision 1m.

410.3 (l) **Other Children and Economic Assistance**
410.4 **Grants**

410.5	General	20,183,000	16,333,000
410.6	Federal TANF	1,500,000	1,500,000

410.7 **Base Adjustment.** The general fund base
410.8 shall be $16,033,000 in fiscal year 2010 and
410.9 $15,533,000 in fiscal year 2011. The TANF
410.10 base shall be $1,500,000 in fiscal year 2010
410.11 and $1,181,000 in fiscal year 2011.

410.12 **Homeless and Runaway Youth.** Of the
410.13 general fund appropriation, $500,000 each
410.14 year are for the Runaway and Homeless
410.15 Youth Act under Minnesota Statutes, section
410.16 256K.45. Funds shall be spent in each area
410.17 of the continuum of care to ensure that
410.18 programs are meeting the greatest need. This
410.19 is a onetime appropriation.

410.20 **Long-Term Homelessness.** Of the general
410.21 fund appropriation, $2,000,000 in fiscal year
410.22 2008 is for implementation of programs
410.23 to address long-term homelessness and is
410.24 available in either year of the biennium. This
410.25 is a onetime appropriation.

410.26 **Minnesota Community Action Grants.** (a)
410.27 Of the general fund appropriation, $250,000
410.28 each year is for the purposes of Minnesota
410.29 community action grants under Minnesota
410.30 Statutes, sections 256E.30 to 256E.32. This
410.31 is a onetime appropriation.

410.32 (b) Of the TANF appropriation, $1,500,000
410.33 each year is for community action agencies

411.1 for auto repairs, auto loans, and auto
411.2 purchase grants to individuals who are
411.3 eligible to receive benefits under Minnesota
411.4 Statutes, chapter 256J, or who have lost
411.5 eligibility for benefits under Minnesota
411.6 Statutes, chapter 256J, due to earnings in the
411.7 prior 12 months. Base level funding for this
411.8 activity shall be $1,500,000 in fiscal year
411.9 2010 and $1,181,000 in fiscal year 2011. *
411.10 **(The preceding text beginning "(b) Of the**
411.11 **TANF appropriation," was indicated as**
411.12 **vetoed by the governor.)**

411.13 (c) Money appropriated under paragraphs (a)
411.14 and (b) that is not spent in the first year does
411.15 not cancel but is available for the second
411.16 year.

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

411.18 Sec. 13. **EMERGENCY SERVICES SHELTER GRANTS FROM AMERICAN**
411.19 **RECOVERY AND REINVESTMENT ACT.**

411.20 (a) To the extent permitted under federal law, the commissioner of human services,
411.21 when determining the uses of the emergency services shelter grants provided under the
411.22 American Recovery and Reinvestment Act, shall give priority to programs that serve
411.23 the following:
411.24 (1) homeless youth;
411.25 (2) American Indian women who are victims of trafficking;
411.26 (3) high-risk adult males considered to be very likely to enter or reenter state or
411.27 county correctional programs, or chemical and mental health programs;
411.28 (4) battered women; and
411.29 (5) families affected by foreclosure.
411.30 (b) Paragraph (a) does not supersede use of ARRA funds as otherwise provided
411.31 in this act.

411.32 Sec. 14. **TRANSFERS.**

411.33 Subdivision 1. **Grants.** The commissioner of human services, with the approval
411.34 of the commissioner of finance, and after notification of the chairs of the relevant senate

412.1 budget division and house of representatives finance division committee, may transfer
412.2 unencumbered appropriation balances for the biennium ending June 30, 2011, within
412.3 fiscal years among the MFIP, general assistance, general assistance medical care, medical
412.4 assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section
412.5 119B.05, Minnesota supplemental aid, and group residential housing programs, and the
412.6 entitlement portion of the chemical dependency consolidated treatment fund, and between
412.7 fiscal years of the biennium.

412.8 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
412.9 money may be transferred within the Departments of Human Services and Health as the
412.10 commissioners consider necessary, with the advance approval of the commissioner of
412.11 finance. The commissioner shall inform the chairs of the relevant house and senate health
412.12 committees quarterly about transfers made under this provision.

412.13 Sec. 15. **2007 AND 2008 APPROPRIATION AMENDMENTS.**

412.14 (a) Notwithstanding Laws 2007, chapter 147, article 19, section 3, subdivision 4,
412.15 paragraph (g), as amended by Laws 2008, chapter 363, article 18, section 7, the TANF
412.16 fund base for the Children's Mental Health Pilots is $0 in fiscal year 2011. This paragraph
412.17 is effective retroactively from July 1, 2008.

412.18 (b) The appropriation for patient incentive programs under Laws 2007, chapter 147,
412.19 article 19, section 3, subdivision 6, paragraph (e), is canceled. This paragraph is effective
412.20 retroactively from July 1, 2007.

412.21 (c) The onetime general fund base reduction for Child Care Development Grants
412.22 under Laws 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (d), is
412.23 increased by $4,000. This paragraph is effective retroactively from July 1, 2008.

412.24 (d) The base for Children Services Grants under Laws 2008, chapter 363, article 18,
412.25 section 3, subdivision 4, paragraph (e), is decreased $1,000 in each year of the fiscal year
412.26 2010 and 2011 biennium. This paragraph is effective retroactively from July 1, 2008.

412.27 (e) Notwithstanding Laws 2008, chapter 363, article 18, section 3, subdivision 4, the
412.28 general fund base adjustment for Children and Community Services Grants under Laws
412.29 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (f), is increased by
412.30 $98,000 each year of fiscal years 2010 and 2011. This paragraph is effective retroactively
412.31 from July 1, 2008.

412.32 (f) The base for Other Continuing Care Grants under Laws 2008, chapter 363, article
412.33 18, section 3, subdivision 6, paragraph (h), is decreased by $10,000 in fiscal year 2010.
412.34 This paragraph is effective retroactively from July 1, 2008.

413.1 Sec. 16. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

413.2 The commissioners of health and human services shall not use indirect cost
413.3 allocations to pay for the operational costs of any program for which they are responsible.

413.4 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

413.5 All uncodified language contained in this article expires on June 30, 2011, unless a
413.6 different expiration date is explicit.

413.7 Sec. 18. **EFFECTIVE DATE.**

413.8 The provisions in this article are effective July 1, 2009, unless a different effective
413.9 date is specified."

413.10 Delete the title and insert:

413.11 "A bill for an act

413.12 relating to state government; making changes to health and human services;
413.13 amending provisions related to licensing, the Minnesota family investment
413.14 program, child care, adult supports; fraud prevention, state-operated services,
413.15 the Minnesota sex offender program, the Department of Health, health care
413.16 programs, chemical and mental health; continuing care programs, and public
413.17 health; establishing the State-County Results, Accountability, and Service
413.18 Delivery Redesign; making technical changes; making forecast adjustments;
413.19 requiring reports; establishing and increasing fees; appropriating money;
413.20 amending Minnesota Statutes 2008, sections 60A.092, subdivision 2; 62D.03,
413.21 subdivision 4; 62D.05, subdivision 3; 62J.495; 62J.496; 62J.497, subdivisions
413.22 1, 2, by adding subdivisions; 62J.692, subdivision 7; 103I.208, subdivision
413.23 2; 119B.09, subdivision 7; 119B.13, subdivision 6; 119B.21, subdivisions 5,
413.24 10; 119B.231, subdivisions 2, 3, 4; 144.0724, subdivisions 2, 4, 8, by adding
413.25 subdivisions; 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision
413.26 1a; 144.125, subdivision 1; 144.226, subdivision 4; 144.72, subdivisions 1, 3;
413.27 144.9501, subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions
413.28 1g, 4; 144.9508, subdivisions 2, 3, 4; 144.9512, subdivision 2; 144.966, by
413.29 adding a subdivision; 144.97, subdivisions 2, 4, 6, by adding subdivisions;
413.30 144.98, subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision
413.31 1; 144A.073, by adding a subdivision; 144A.44, subdivision 2; 144A.46,
413.32 subdivision 1; 145A.17, by adding a subdivision; 148.6445, by adding a
413.33 subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180, subdivisions 1, 2, 3, 5;
413.34 152.126, subdivisions 1, 2, 6; 153A.17; 157.15, by adding a subdivision; 157.16;
413.35 157.22; 176.011, subdivision 9; 245.462, subdivision 18; 245.470, subdivision
413.36 1; 245.4871, subdivision 27; 245.488, subdivision 1; 245A.03, by adding a
413.37 subdivision; 245A.10, subdivisions 2, 3; 245A.11, subdivision 2a, by adding
413.38 subdivisions; 245A.16, subdivisions 1, 3; 245C.03, subdivision 2; 245C.04,
413.39 subdivisions 1, 3; 245C.05, subdivision 4, by adding a subdivision; 245C.08,
413.40 subdivision 2; 245C.10, subdivision 3, by adding subdivisions; 245C.17, by
413.41 adding a subdivision; 245C.20; 245C.21, subdivision 1a; 245C.23, subdivision 2;
413.42 246.50, subdivision 5, by adding subdivisions; 246.51, by adding subdivisions;
413.43 246.511; 246.52; 246.54, subdivision 2; 246B.01, by adding subdivisions;
413.44 252.025, subdivision 7; 252.46, by adding a subdivision; 252.50, subdivision 1;
413.45 254A.02, by adding a subdivision; 254A.16, by adding a subdivision; 254B.03,
413.46 subdivisions 1, 3, by adding a subdivision; 254B.05, subdivision 1; 254B.09,
413.47 subdivision 2; 256.01, subdivision 2b, by adding subdivisions; 256.045,
413.48 subdivision 3; 256.476, subdivisions 5, 11; 256.962, subdivisions 2, 6; 256.969,
413.49 subdivisions 2b, 3a, by adding subdivisions; 256.975, subdivision 7; 256.983,

414.1 subdivision 1; 256B.04, subdivision 16; 256B.055, subdivisions 7, 12; 256B.056,
414.2 subdivisions 3c, 3d; 256B.057, by adding a subdivision; 256B.0575; 256B.0595,
414.3 subdivisions 1, 2; 256B.06, subdivisions 4, 5; 256B.0621, subdivision 2;
414.4 256B.0622, subdivision 2; 256B.0623, subdivision 5; 256B.0624, subdivisions
414.5 5, 8; 256B.0625, subdivisions 3, 3c, 6a, 7, 9, 11, 13, 13e, 13h, 17, 17a, 19a,
414.6 19c, 26, 42, 47, by adding subdivisions; 256B.0641, subdivision 3; 256B.0651;
414.7 256B.0652; 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657,
414.8 subdivisions 2, 6, 8, by adding a subdivision; 256B.08, by adding a subdivision;
414.9 256B.0911, subdivisions 1, 1a, 3, 3a, 3b, 3c, 4a, 5, 6, 7, by adding subdivisions;
414.10 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3e, 3h, 5, by adding a
414.11 subdivision; 256B.0916, subdivision 2; 256B.0917, by adding a subdivision;
414.12 256B.092, subdivision 8a, by adding subdivisions; 256B.0943, subdivisions 1,
414.13 12; 256B.0944, by adding a subdivision; 256B.0947, subdivision 1; 256B.15,
414.14 subdivisions 1, 1a, 1h, 2, by adding subdivisions; 256B.199; 256B.37,
414.15 subdivisions 1, 5; 256B.434, subdivision 4, by adding a subdivision; 256B.437,
414.16 subdivision 6; 256B.441, subdivisions 55, 58, by adding a subdivision; 256B.49,
414.17 subdivisions 12, 13, 14, 17, by adding subdivisions; 256B.501, subdivision
414.18 4a; 256B.5011, subdivision 2; 256B.5012, by adding a subdivision; 256B.69,
414.19 subdivisions 5a, 5c, 5f, 23; 256B.76, subdivision 1; 256D.03, subdivision 4;
414.20 256D.44, subdivision 5; 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05,
414.21 subdivisions 1a, 7c; 256J.08, subdivision 73a; 256J.24, subdivision 5; 256J.425,
414.22 subdivisions 2, 3; 256J.45, subdivision 3; 256J.49, subdivisions 1, 4; 256J.521,
414.23 subdivision 2; 256J.545; 256J.561, subdivisions 2, 3; 256J.57, subdivision
414.24 1; 256J.575, subdivisions 3, 4, 6, 7; 256J.621; 256J.626, subdivision 7;
414.25 256J.95, subdivisions 3, 11, 12, 13; 256L.03, by adding a subdivision; 256L.04,
414.26 subdivisions 1, 7a, 10a, by adding a subdivision; 256L.05, subdivisions 1, 3, 3a,
414.27 by adding a subdivision; 256L.07, subdivisions 1, 2, 3, by adding a subdivision;
414.28 256L.11, subdivision 1; 256L.15, subdivisions 2, 3; 256L.17, subdivisions 3, 5;
414.29 259.67, by adding a subdivision; 270A.09, by adding a subdivision; 327.14,
414.30 by adding a subdivision; 327.15; 327.16; 327.20, subdivision 1, by adding a
414.31 subdivision; 501B.89, by adding a subdivision; 519.05; 604A.33, subdivision
414.32 1; 609.232, subdivision 11; 626.556, subdivision 3c; 626.5572, subdivisions
414.33 6, 13, 21; Laws 2003, First Special Session chapter 14, article 13C, section
414.34 2, subdivision 1, as amended; Laws 2007, chapter 147, article 19, section 3,
414.35 subdivision 4, as amended; proposing coding for new law in Minnesota Statutes,
414.36 chapters 62A; 62Q; 246B; 254B; 256; 256B; proposing coding for new law as
414.37 Minnesota Statutes, chapter 402A; repealing Minnesota Statutes 2008, sections
414.38 103I.112; 144.9501, subdivision 17b; 148D.180, subdivision 8; 245C.11,
414.39 subdivisions 1, 2; 246.51, subdivision 1; 246.53, subdivision 3; 256.962,
414.40 subdivision 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6,
414.41 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092, subdivision
414.42 5a; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256I.06, subdivision
414.43 9; 256L.17, subdivision 6; 327.14, subdivisions 5, 6; Minnesota Rules, parts
414.44 4626.2015, subpart 9; 9555.6125, subpart 4, item B."

415.1 We request the adoption of this report and repassage of the bill.

415.2 House Conferees: (Signed)

415.3 ....
415.4 Thomas Huntley Paul Thissen

415.5 ....
415.6 Larry Hosch Karen Clark

415.7 ....
415.8 Jim Abeler

415.9 Senate Conferees: (Signed)

415.10 ....
415.11 Linda Berglin Tony Lourey

415.12 ....
415.13 Kathy Sheran Julie Rosen

415.14 ....
415.15 Yvonne Prettner Solon