

## 2011 First Special Session

**CHAPTER 9—H.F.No. 25**

*An act relating to state government; establishing the health and human services budget; making changes to children and family services, Department of Health, miscellaneous provisions, health licensing and fees, human services licensing, health care, and continuing care; redesigning service delivery; making changes to chemical and mental health; modifying fee schedules; modifying program eligibility requirements; authorizing rulemaking; imposing criminal penalties; requiring reports; appropriating money for the Departments of Health and Human Services and other health-related boards and councils; amending Minnesota Statutes 2010, sections 13.461, subdivision 24a; 62E.14, by adding a subdivision; 62J.04, subdivisions 3, 9; 62J.17, subdivision 4a; 62J.495, by adding subdivisions; 62J.692; 62Q.32; 62U.04, subdivisions 3, 9; 62U.06, subdivision 2; 103I.101, subdivision 6; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 103I.525, subdivision 2; 103I.531, subdivision 2; 103I.535, subdivision 2; 103I.541, subdivision 2c; 119B.011, subdivision 13; 119B.035, subdivision 4; 119B.09, subdivision 10, by adding subdivisions; 119B.125, by adding a subdivision; 119B.13, subdivisions 1, 1a, 7; 144.1464, subdivision 1; 144.1501, subdivision 1; 144.98, subdivisions 2a, 7, by adding subdivisions; 144A.102; 144A.61, by adding a subdivision; 144E.123; 145A.17, subdivision 3; 148.07, subdivision 1; 148.108, by adding a subdivision; 148.191, subdivision 2; 148.212, subdivision 1; 148.231; 148B.17; 148B.33, subdivision 2; 148B.52; 150A.091, subdivisions 2, 3, 4, 5, 8, by adding a subdivision; 151.07; 151.101; 151.102, by adding a subdivision; 151.12; 151.13, subdivision 1; 151.19; 151.25; 151.47, subdivision 1; 151.48; 152.12, subdivision 3; 157.15, by adding a subdivision; 157.20, by adding a subdivision; 245A.03, subdivision 7, as amended; 245A.10, subdivisions 1, 3, 4, by adding subdivisions; 245A.11, subdivision 2b; 245A.14, subdivision 4; 245A.143, subdivision 1; 245C.03, by adding a subdivision; 245C.10, by adding subdivisions; 246B.10; 253B.212; 254B.03, subdivision 4; 254B.04, by adding a subdivision; 254B.06, subdivision 2; 256.01, subdivisions 14b, 24, 29, by adding subdivisions; 256.969, subdivisions 2, 2b, by adding a subdivision; 256B.02, by adding a subdivision; 256B.03, by adding subdivisions; 256B.04, subdivision 18, by adding subdivisions; 256B.05, by adding a subdivision; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8b, 8c, 8e, 13e, 13h, 17, 17a, 18, 19a, 25, 31, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.064, subdivision 2; 256B.0641, subdivision 1; 256B.0652, subdivision 6; 256B.0659, subdivisions 11, 28; 256B.0751, subdivision 4, by adding a subdivision; 256B.0911, subdivisions 1a, 3a, 3c, 4a; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 5, 10; 256B.0943, by adding a subdivision; 256B.0945, subdivision 4; 256B.14, by adding a subdivision; 256B.19, subdivision 1e; 256B.196, subdivisions 2, 3, 5; 256B.199; 256B.431, subdivisions 2r, 2t, 32; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.438, subdivisions 1, 3, 4, by adding a subdivision; 256B.441, subdivisions*

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50a, 55a, by adding subdivisions; 256B.49, subdivisions 12, 14, 15, 16a, by adding a subdivision; 256B.5012, by adding subdivisions; 256B.69, subdivisions 5a, 5c, 28, by adding subdivisions; 256B.76, subdivisions 1, 2, 4; 256B.766; 256D.05, subdivision 1; 256D.06, subdivision 2; 256D.09, subdivision 6; 256D.46, subdivision 1; 256D.49, subdivision 3; 256E.35, subdivisions 5, 6; 256I.03, by adding a subdivision; 256I.05, subdivision 1a; 256J.20, subdivision 3; 256J.38, subdivision 1; 256J.49, subdivision 13; 256L.02, subdivision 3; 256L.03, subdivision 5; 256L.04, subdivisions 1, 10; 256L.05, subdivision 3a, by adding a subdivision; 256L.09, subdivision 2; 256L.11, subdivisions 6, 7; 256L.12, subdivision 9; 256L.15, subdivision 1; 256M.01; 256M.10, subdivision 2; 256M.20, subdivisions 1, 2, 3; 256M.30; 256M.40; 256M.50; 256M.60, subdivision 1; 256M.70, subdivision 2; 256M.80; 295.52, by adding a subdivision; 297F.10, subdivision 1; 393.07, subdivisions 10, 10a; 402A.10, subdivisions 4, 5; 402A.15; 402A.18; 402A.20; 518A.51; Laws 2009, chapter 79, article 5, sections 17, as amended; 18, as amended; 22, as amended; article 8, sections 4, as amended; 51, as amended; article 13, section 3, subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17, as amended; Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 62U; 148; 151; 214; 256; 256B; 256L; 402A; repealing Minnesota Statutes 2010, sections 13.4967, subdivision 3; 62J.07, subdivisions 1, 2, 3; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 144.1499; 245A.10, subdivision 5; 256.979, subdivisions 5, 6, 7, 10; 256.9791; 256B.057, subdivision 2c; 256B.69, subdivision 9b; 256L.07, subdivision 7; 256M.10, subdivision 5; 256M.60, subdivision 2; 256M.70, subdivision 1; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b, 12b, 13, 14, 15; 295.51, subdivisions 1, 1a; 295.52, subdivisions 1, 1a, 2, 3, 4, 4a, 5, 6, 7; 295.53, subdivisions 1, 2, 3, 4a; 295.54; 295.55; 295.56; 295.57; 295.58; 295.581; 295.582; 295.59; 402A.30; 402A.45; Laws 2008, chapter 358, article 3, sections 8; 9; Laws 2009, chapter 79, article 5, section 62; Minnesota Rules, parts 3400.0130, subpart 8; 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, 23; 4651.0110, subparts 2, 2a, 3, 4, 5; 4651.0120; 4651.0130; 4651.0140; 4651.0150; 9500.1243, subpart 3; 9500.1261, subparts 3, items D, E, 4, 5.

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

**ARTICLE 1****CHILDREN AND FAMILY SERVICES**

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

Subd. 13. **Family.** "Family" means parents, stepparents, guardians and their spouses, or other eligible relative caregivers and their spouses, and their blood related dependent children and adoptive siblings under the age of 18 years living in the same home including children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who

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

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

Sec. 2. Minnesota Statutes 2010, section 119B.035, subdivision 4, is amended to read:

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to ~~90~~ 68 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

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

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

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

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

Sec. 3. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

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

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

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

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

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

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

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Sec. 4. Minnesota Statutes 2010, section 119B.09, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2010, section 119B.125, is amended by adding a subdivision to read:

Subd. 1b. **Training required.** (a) Effective November 1, 2011, prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the county. The training documentation must have valid effective dates as of the date the registration request is submitted to the county and the training must have been provided by an individual approved to provide first aid and CPR instruction.

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

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

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

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

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Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~July 1, 2006~~ October 31, 2011, the maximum rate paid for child care assistance in any county or multicounty region under the child care fund shall be the rate for like-care arrangements in the county effective ~~January July 1, 2006, increased~~ decreased by ~~six~~ 2.5 percent.

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

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

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

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

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

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

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

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

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

**EFFECTIVE DATE.** Paragraph (d) is effective April 16, 2012. Paragraph (e) is effective September 3, 2012.

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

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

(b) The maximum rate paid to legal nonlicensed family child care providers must be ~~80~~ 68 percent of the county maximum hourly rate for licensed family child care providers.

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In counties where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by ~~0.80~~ 0.68. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

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

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

EFFECTIVE DATE. This section is effective April 16, 2012, except the amendment changing 80 to 68 and 0.80 to 0.68 is effective October 31, 2011.

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

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

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

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

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

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

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

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

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

Subd. 2. **Prohibited purchases.** EBT debit cardholders in programs listed under subdivision 1 are prohibited from using the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in section 340A.101, subdivision 2. It is unlawful for an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic beverages with the cardholder's EBT card. Any unlawful use under this subdivision shall constitute fraud and result in disqualification from the program under section 256.98, subdivision 8.

**EFFECTIVE DATE.** Subdivision 1 is effective June 1, 2012.

Sec. 11. Minnesota Statutes 2010, section 256D.05, subdivision 1, is amended to read:

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

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than ~~30~~ 45 days and which prevents the person from obtaining or retaining employment;

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

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

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

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

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

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

(8) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

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

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

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services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;

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

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

~~(13)~~ (12) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day;

~~(14)~~ (13) a person over age 18 whose primary language is not English and who is attending high school at least half time; or

~~(15)~~ (14) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.

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

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

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

Sec. 12. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:

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

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

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

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

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

Sec. 13. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

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

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

Sec. 14. Minnesota Statutes 2010, section 256E.35, subdivision 5, is amended to read:

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256E.35, subdivision 6, is amended to read:

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

The fiscal agent must ensure the household's custodial account contains the applicable matching funds to match the balance in the household's account, including

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interest, on at least a quarterly basis and at the time of an approved withdrawal. ~~Matches must be provided as follows:~~

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

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

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

Sec. 16. Minnesota Statutes 2010, section 256I.03, is amended by adding a subdivision to read:

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

Sec. 17. Minnesota Statutes 2010, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed \$426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the GRH fund to county

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human service agencies for beds permanently removed from the GRH census under a plan submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

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

(d) Counties must not negotiate supplementary service rates with providers of group residential housing that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises.

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

Sec. 18. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 19. Minnesota Statutes 2010, section 256J.49, subdivision 13, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2010, section 256M.01, is amended to read:

**256M.01 CITATION.**

Sections 256M.01 to 256M.80 may be cited as the "~~Children and Community Services~~ Vulnerable Children and Adults Act." This act establishes a fund to address the

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needs of vulnerable children, adolescents, and adults within each county in accordance with a service plan entered into by the board of county commissioners of each county and the commissioner. ~~The service plan shall specify the outcomes to be achieved, the general strategies to be employed, and the respective state and county roles. The service plan shall be reviewed and updated every two years, or sooner if both the state and the county deem it necessary.~~

Sec. 21. Minnesota Statutes 2010, section 256M.10, subdivision 2, is amended to read:

Subd. 2. ~~Children and community~~ **Vulnerable children and adults services.**  
 (a) ~~"Children and community~~ **Vulnerable children and adults services**" means services provided or arranged for by county boards for vulnerable children, adolescents and other individuals in transition from childhood to adulthood, under chapter 260C, and sections 626.556 and 626.5561, and adults under section 626.557 who experience dependency, abuse, or neglect, poverty, disability, chronic health conditions, or other factors, including ethnicity and race, that may result in poor outcomes or disparities, as well as services for family members to support those individuals. These services may be provided by professionals or nonprofessionals, including the person's natural supports in the community. For the purpose of this chapter, "vulnerable children" means children and adolescents.

(b) ~~Children and community~~ **Vulnerable children and adults** services do not include services under the public assistance programs known as the Minnesota family investment program, Minnesota supplemental aid, medical assistance, general assistance, general assistance medical care, MinnesotaCare, or community health services.

Sec. 22. Minnesota Statutes 2010, section 256M.20, subdivision 1, is amended to read:

Subdivision 1. **General supervision.** Each year the commissioner shall allocate funds to each county with an approved service plan according to section 256M.40 and service plans under section 256M.30. The funds shall be used to address the needs of vulnerable children, adolescents, and adults. The commissioner, in consultation with counties, shall provide technical assistance and evaluate county performance in achieving outcomes.

Sec. 23. Minnesota Statutes 2010, section 256M.20, subdivision 2, is amended to read:

Subd. 2. **Additional duties.** The commissioner shall:

(1) provide necessary information and assistance to each county for establishing baselines and desired improvements on ~~mental health,~~ safety, permanency, and well-being for vulnerable children and adolescents adults;

(2) provide training, technical assistance, and other supports to each county board to assist in needs assessment, planning, implementation, and monitoring of outcomes and service quality;

(3) use data collection, evaluation of service outcomes, and the review and approval of county service plans to supervise county performance in the delivery of ~~children and community~~ services;

(4) specify requirements for reports, including fiscal reports to account for funds distributed;

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(5) request waivers from federal programs as necessary to implement this section; and

(6) have authority under sections 14.055 and 14.056 to grant a variance to existing state rules as needed to eliminate barriers to achieving desired outcomes.

Sec. 24. Minnesota Statutes 2010, section 256M.20, subdivision 3, is amended to read:

Subd. 3. **Sanctions.** The commissioner shall establish and maintain a monitoring program designed to reduce the possibility of noncompliance with federal laws ~~and federal~~, regulations, and performance standards that may result in federal fiscal sanctions. If a county is not complying with federal law or federal regulation and the noncompliance may result in federal fiscal sanctions, the commissioner may withhold a portion of the county's share of state and federal funds for that program. The amount withheld must be equal to the percentage difference between the level of compliance maintained by the county and the level of compliance required by the federal regulations, multiplied by the county's share of state and federal funds for the program. The state and federal funds may be withheld until the county is found to be in compliance with all federal laws or federal regulations applicable to the program. If a county remains out of compliance for more than six consecutive months, the commissioner may reallocate the withheld funds to counties that are in compliance with the federal regulations.

Sec. 25. Minnesota Statutes 2010, section 256M.30, is amended to read:

**256M.30 SERVICE PLAN.**

Subdivision 1. **Service plan submitted to commissioner.** Effective January 1, 2004, and ~~each two-year period thereafter~~ 2012, each county must have a ~~biennial~~ service plan approved by the commissioner in order to receive funds. Counties may submit multicounty or regional service plans. Plans must be updated as needed to reflect current county policy and procedures regarding requirements and use of funds under this chapter.

Subd. 2. **Contents.** The service plan shall be completed in a form prescribed by the commissioner. The plan must include:

(1) a statement of the needs of the vulnerable children, ~~adolescents~~, and adults who experience the conditions defined in section 256M.10, subdivision 2, paragraph (a), and strengths and resources available in the community to address those needs;

(2) strategies the county will pursue to achieve the performance targets. Strategies must include specification of how funds under this section and other community resources will be used to achieve desired performance targets;

(3) a description of the county's process to solicit public input and a summary of that input;

(4) ~~beginning with the service plans submitted for the period from January 1, 2006, through December 31, 2007,~~ performance targets on statewide indicators for each county to measure outcomes of ~~children's mental health, and child~~ vulnerable children and adult's safety, permanency, and well-being. The commissioner shall consult with counties and other stakeholders to develop these indicators and collect baseline data to inform the establishment of individual county performance targets for the ~~2006-2007~~ 2012-2013 biennium and subsequent ~~plans~~ years; and

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(5) a budget for services to be provided with funds under this section. ~~The county must budget at least 40 percent of funds appropriated under sections 256M.01 to 256M.80 for services to ensure the mental health, safety, permanency, and well-being of children from low-income families. The commissioner may reduce the portion of child and community services funds that must be budgeted by a county for services to children in low-income families if:~~

~~(i) the incidence of children in low-income families within the county's population is significantly below the statewide median, or~~

~~(ii) the county has successfully achieved past performance targets for children's mental health, and child safety, permanency, and well-being and its proposed service plan is judged by the commissioner to provide an adequate level of service to the population with less funding.~~

~~Subd. 3. **Continuity of services.** In developing the plan required under this section, a county shall endeavor, within the limits of funds available, to consider the continuing need for services and programs for children and persons with disabilities that were funded by the former children's services and community service grants.~~

Subd. 4. **Information.** The commissioner shall provide each county with information and technical assistance needed to complete the service plan, including: information on ~~children's mental health, and child and adult~~ safety, permanency, and well-being in the county; comparisons with other counties; baseline performance on outcome measures; and promising program practices.

Subd. 5. **Timelines.** The ~~preliminary~~ service plan must be submitted to the commissioner by October 15, ~~2003, and October 15 of every two years thereafter~~ 2011.

Subd. 6. **Public comment.** The county board must determine how citizens in the county will participate in the development of the service plan and provide opportunities for such participation. The county must allow a period of no less than 30 days prior to the submission of the plan to the commissioner to solicit comments from the public on the contents of the plan.

Subd. 7. **Commissioner's responsibilities.** The commissioner must, ~~within 60 days of receiving each county service plan,~~ inform the county if the service plan has been approved. If the service plan is not approved, the commissioner must inform the county of any revisions needed for approval.

Sec. 26. Minnesota Statutes 2010, section 256M.40, is amended to read:

**256M.40 CHILDREN AND COMMUNITY SERVICES GRANT ALLOCATION.**

Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated ~~for children and community services grants under this chapter~~ to each county board on a calendar year basis in an amount determined according to the formula in paragraphs (a) to ~~(c)~~ (e).

~~(a) For July 1, 2003, through December 31, 2003, the commissioner shall allocate funds to each county equal to that county's allocation for the grants under section 256M.10, subdivision 5, for calendar year 2003 less payments made on or before June 30, 2003.~~

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~~(b) For calendar year 2004 and 2005, the commissioner shall allocate available funds to each county in proportion to that county's share of the calendar year 2003 allocations for the grants under section 256M.10, subdivision 5.~~

~~(c) For calendar year 2006 and each calendar year thereafter, the commissioner shall allocate available funds to each county in proportion to that county's share in the preceding calendar year.~~

(a) For calendar years 2011 and 2012, the commissioner shall allocate available funds to each county in proportion to that county's share in calendar year 2010.

(b) For calendar year 2013, the commissioner shall allocate available funds to each county as follows:

(1) 75 percent must be distributed on the basis of the county share in calendar year 2012;

(2) five percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) ten percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, and in the county as determined by the most recent data of the commissioner; and

(4) ten percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

(c) For calendar year 2014, the commissioner shall allocate available funds to each county as follows:

(1) 50 percent must be distributed on the basis of the county share in calendar year 2012;

(2) Ten percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) 20 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner; and

(4) 20 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

(d) For calendar year 2015, the commissioner shall allocate available funds to each county as follows:

(1) 25 percent must be distributed on the basis of the county share in calendar year 2012;

(2) 15 percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(3) 30 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner; and

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(4) 30 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

(e) For calendar year 2016 and each calendar year thereafter, the commissioner shall allocate available funds to each county as follows:

(1) 20 percent must be distributed on the basis of the number of persons residing in the county as determined by the most recent data of the state demographer;

(2) 40 percent must be distributed on the basis of the number of vulnerable children that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the county as determined by the most recent data of the commissioner; and

(3) 40 percent must be distributed on the basis of the number of vulnerable adults that are subjects of reports under section 626.557 in the county as determined by the most recent data of the commissioner.

Subd. 3. **Payments.** Calendar year allocations under subdivision 1 shall be paid to counties on or before July 10 of each year.

Sec. 27. Minnesota Statutes 2010, section 256M.50, is amended to read:

**256M.50 FEDERAL ~~CHILDREN AND COMMUNITY SERVICES~~ GRANT ALLOCATION.**

In federal fiscal year ~~2004~~ 2012 and subsequent years, money for social services received from the federal government to reimburse counties for social service expenditures according to Title XX of the Social Security Act shall be allocated to each county according to section 256M.40, except for funds allocated for administrative purposes and migrant day care. Title XX funds must not be used for any expenditures prohibited by section 2005 of the Social Security Act and all federal certification requirements under title XX must be met by counties receiving title XX funds under this chapter.

Sec. 28. Minnesota Statutes 2010, section 256M.60, subdivision 1, is amended to read:

Subdivision 1. **Responsibilities.** The county board of each county shall be responsible for administration and funding of ~~children and community~~ services as defined in section 256M.10, subdivision 1. Each county board shall singly or in combination with other county boards use funds available to the county under Laws 2003, First Special Session chapter 14, to carry out these responsibilities. ~~The county board shall coordinate and facilitate the effective use of formal and informal helping systems to best support and nurture children, adolescents, and adults within the county who experience dependency, abuse, neglect, poverty, disability, chronic health conditions, or other factors, including ethnicity and race, that may result in poor outcomes or disparities, as well as services for family members to support such individuals. This includes assisting individuals to function at the highest level of ability while maintaining family and community relationships to the greatest extent possible.~~

Sec. 29. Minnesota Statutes 2010, section 256M.70, subdivision 2, is amended to read:

Subd. 2. **Identification of services to be provided.** If a county has made reasonable efforts to provide services according to the service plan under section 256M.30, but funds appropriated for purposes of sections 256M.01 to 256M.80 are insufficient, then the

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county may limit services that do not meet the following criteria while giving the highest funding priority to clauses (1); and (2); ~~and (3)~~:

- (1) services needed to protect individuals from maltreatment, abuse, and neglect;
- (2) emergency and crisis services needed to protect clients from physical, emotional, or psychological harm;
- (3) services that maintain a person in the person's home or least restrictive setting;
- (4) assessment of persons applying for services and referral to appropriate services when necessary; and
- (5) public guardianship services; and
- ~~(6) case management for persons with developmental disabilities, children with serious emotional disturbances, and adults with serious and persistent mental illness; and~~
- ~~(7) fulfilling licensing responsibilities delegated to the county by the commissioner under section 245A.16.~~

Sec. 30. Minnesota Statutes 2010, section 256M.80, is amended to read:

**256M.80 PROGRAM EVALUATION.**

Subdivision 1. **County evaluation.** Each county shall submit to the commissioner data from the past calendar year on the outcomes and performance indicators in the service plan. The commissioner shall prescribe standard methods to be used by the counties in providing the data. The data shall be submitted no later than March 1 of each year; ~~beginning with March 1, 2005.~~

Subd. 2. **Statewide evaluation.** Six months after the end of the first full calendar year and annually thereafter, the commissioner shall ~~prepare a report on~~ make public the counties' progress in improving the outcomes of vulnerable children; ~~adolescents~~; and adults related to ~~mental health~~; safety, permanency, and well-being. ~~This report shall be disseminated throughout the state.~~

Sec. 31. Minnesota Statutes 2010, section 393.07, subdivision 10a, is amended to read:

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

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

- ~~(1) a manual Authorization to Participate (ATP) card; or~~
- ~~(2) the immediate issuance of food stamp coupons~~ benefits.

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

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Sec. 32. Minnesota Statutes 2010, section 518A.51, is amended to read:

**518A.51 FEES FOR IV-D SERVICES.**

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

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

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

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

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

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

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

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

(g) Federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e) retained by the commissioner of human

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services shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established under paragraph (i). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

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

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

(j) The nonfederal share of the cost recovery fee revenue must be retained by the commissioner and distributed as follows:

(1) one-half of the revenue must be transferred to the child support system special revenue account to support the state's administration of the child support enforcement program and its federally mandated automated system;

(2) an additional portion of the revenue must be transferred to the child support system special revenue account for expenditures necessary to administer the fees; and

(3) the remaining portion of the revenue must be distributed to the counties to aid the counties in funding their child support enforcement programs.

(k) The nonfederal share of the federal collections fees must be distributed to the counties to aid them in funding their child support enforcement programs.

(l) The commissioner of human services shall distribute quarterly any of the funds dedicated to the counties under paragraphs (j) and (k) using the methodology specified in section 256.979, subdivision 11. The funds received by the counties must be reinvested in the child support enforcement program and the counties must not reduce the funding of their child support programs by the amount of the funding distributed.

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

**Sec. 33. [256.9871] REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES, GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.**

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

**Sec. 34. MINNESOTA EBT BUSINESS TASK FORCE.**

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

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(1) two members of the Minnesota house of representatives appointed by the speaker of the house;

(2) two members of the Minnesota senate appointed by the senate majority leader;

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

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

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

Subd. 2. **Duties.** The Minnesota EBT Business Task Force shall create a workable strategy to eliminate the purchase of tobacco and alcoholic beverages by recipients of the general assistance program and Minnesota supplemental aid program under Minnesota Statutes, chapter 256D, and programs under Minnesota Statutes, chapter 256J, using EBT cards. The task force will consider cost to the state, feasibility of execution at retail, and ease of use and privacy for EBT cardholders.

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

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

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10; and 256.9791, are repealed effective retroactively from July 1, 2011.

(b) Minnesota Statutes 2010, sections 256M.10, subdivision 5; 256M.60, subdivision 2; and 256M.70, subdivision 1, are repealed.

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

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

## ARTICLE 2

### DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2010, section 62J.04, subdivision 3, is amended to read:

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

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

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

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

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

(5) undertake health planning responsibilities;

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

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

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

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

Sec. 2. Minnesota Statutes 2010, section 62J.17, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2010, section 62J.692, is amended to read:

**62J.692 MEDICAL EDUCATION.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

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

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

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

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

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

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

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

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

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

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

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

~~(1) \$1,475,000 to the University of Minnesota Medical Center-Fairview;~~

~~(2) \$2,075,000 to the University of Minnesota School of Dentistry, and~~

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

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

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

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with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) voluntary contributions by employers or other entities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 9. **Review of eligible providers.** The commissioner and the Medical Education and Research Costs Advisory Committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of

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the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the Legislative Commission on Health Care Access.

Sec. 4. **[62U.15] ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.**

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

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

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

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

- (1) earlier identification of Alzheimer's and other dementias;
- (2) improved support of family caregivers; and
- (3) improved collaboration between medical care management and community-based supports.

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

Sec. 5. Minnesota Statutes 2010, section 103I.101, subdivision 6, is amended to read:

**Subd. 6. Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~\$215~~ \$235 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

Sec. 6. Minnesota Statutes 2010, section 103I.208, subdivision 1, is amended to read:

**Subdivision 1. Well notification fee.** The well notification fee to be paid by a property owner is:

- (1) for a new water supply well, ~~\$215~~ \$235, which includes the state core function fee;

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(2) for a well sealing, ~~\$50~~ \$65 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~\$50~~ \$65; and

(3) for construction of a dewatering well, ~~\$215~~ \$235, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of ~~\$1,075~~ \$1,175 for the dewatering wells recorded on the notification.

Sec. 7. Minnesota Statutes 2010, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, \$175 annually;

(2) for construction of a monitoring well, ~~\$215~~ \$235, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, \$175 annually;

(4) for a monitoring well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit, \$50 annually. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a board of health or community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

(5) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~\$215~~ \$235, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is \$175 per site regardless of the number of monitoring wells located on site;

(6) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~\$215~~ \$235, which includes the state core function fee;

(7) for a vertical heat exchanger with less than ten tons of heating/cooling capacity, ~~\$215~~ \$235;

(8) for a vertical heat exchanger with ten to 50 tons of heating/cooling capacity, ~~\$425~~ \$475;

(9) for a vertical heat exchanger with greater than 50 tons of heating/cooling capacity, ~~\$650~~ \$700;

(10) for a dewatering well that is unsealed under a maintenance permit, \$175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for \$875 annually for dewatering wells recorded on the permit; and

(11) for an elevator boring, ~~\$215~~ \$235 for each boring.

Sec. 8. Minnesota Statutes 2010, section 103I.235, subdivision 1, is amended to read:

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Subdivision 1. **Disclosure of wells to buyer.** (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable. In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based on the information provided on the disclosure statement required by this section or based on other available information.

(h) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 272.115, or any deed or other instrument of conveyance dated after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required information. The county

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recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~\$45~~ \$50 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~\$37.50~~ \$42.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(i) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(j) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(k) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

Sec. 9. Minnesota Statutes 2010, section 103I.525, subdivision 2, is amended to read:

Subd. 2. **Certification ~~application~~ fee.** (a) The application fee for certification as a representative of a well contractor is \$75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a well contractor is \$75. The commissioner may not renew a certification until the renewal fee is paid.

Sec. 10. Minnesota Statutes 2010, section 103I.531, subdivision 2, is amended to read:

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Subd. 2. **Certification application fee.** (a) The application fee for certification as a representative of a limited well/boring contractor is \$75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a limited well/boring contractor is \$75. The commissioner may not renew a certification until the renewal fee is paid.

Sec. 11. Minnesota Statutes 2010, section 103I.535, subdivision 2, is amended to read:

Subd. 2. **Certification application fee.** (a) The application fee for certification as a representative of an elevator boring contractor is \$75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of an elevator boring contractor is \$75. The commissioner may not renew a certification until the renewal fee is paid.

Sec. 12. Minnesota Statutes 2010, section 103I.541, subdivision 2c, is amended to read:

Subd. 2c. **Certification application fee.** (a) The application fee for certification as a representative of a monitoring well contractor is \$75. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a monitoring well contractor is \$75. The commissioner may not renew a certification until the renewal fee is paid.

Sec. 13. Minnesota Statutes 2010, section 144.1464, subdivision 1, is amended to read:

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants, within available appropriations, to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and postsecondary summer health care intern program. The purpose of the program is to expose interested secondary and postsecondary pupils to various careers within the health care profession.

Sec. 14. Minnesota Statutes 2010, section 144.1501, subdivision 1, is amended to read:

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

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

(c) "Designated rural area" means:

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

~~(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).~~ an area defined as a small rural area or isolated rural area according to the four category classifications of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Subd. 9. Exemption from national standards for proficiency testing frequency.** (a) Effective January 1, 2012, a laboratory applying for or requesting accreditation under the exemption in subdivision 8 must obtain an acceptable proficiency test result for each of the laboratory's accredited or requested fields of testing. The laboratory must analyze proficiency samples selected from one of two annual proficiency testing studies scheduled by the commissioner.

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

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

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

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

(d) The commissioner may require a laboratory to analyze additional proficiency testing samples beyond what is required in this subdivision if information available to the commissioner indicates that the laboratory's analysis for the field of testing does not meet the requirements for accreditation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Collection and maintenance.** A licensee shall collect and provide prehospital care data to the board in a manner prescribed by the board. At a minimum,

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the data must include items identified by the board that are part of the National Uniform Emergency Medical Services Data Set. A licensee shall maintain prehospital care data for every response.

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

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

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

Subd. 5. **Working group.** By October 1, 2011, the board must convene a working group composed of six members, three of which must be appointed by the board and three of which must be appointed by the Minnesota Ambulance Association, to redesign the board's policies related to collection of data from licenses. The issues to be considered include, but are not limited to, the following: user-friendly reporting requirements; data sets; improved accuracy of reported information; appropriate use of information gathered through the reporting system; and methods for minimizing the financial impact of data reporting on licenses, particularly for rural volunteer services. The working group must report its findings and recommendations to the board no later than July 1, 2012.

Sec. 22. Minnesota Statutes 2010, section 145A.17, subdivision 3, is amended to read:

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

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

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

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

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

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

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

(5) provide youth development programs when appropriate;

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

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

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

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

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

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

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

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

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services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services.

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

Sec. 23. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision to read:

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

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to applications for licensure submitted on or after that date.

Sec. 24. Minnesota Statutes 2010, section 157.20, is amended by adding a subdivision to read:

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

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

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

Sec. 25. Minnesota Statutes 2010, section 297F.10, subdivision 1, is amended to read:

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

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

(2) ~~\$8,553,000 for fiscal year 2006 and \$8,550,000 for fiscal year years 2007 and each year thereafter~~ through fiscal year 2011 and \$3,937,000 each year thereafter must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4; and

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

Sec. 26. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

(a) The commissioner of health, in consultation with the commissioner of human services, shall evaluate and recommend options for reorganizing health and human services regulatory responsibilities in both agencies to provide better efficiency and operational cost savings while maintaining the protection of the health, safety, and welfare of the public. Regulatory responsibilities that are to be evaluated are those found in Minnesota Statutes, chapters 62D, 62N, 62R, 62T, 144A, 144D, 144G, 146A, 146B, 149A, 153A, 245A, 245B, and 245C, and sections 62Q.19, 144.058, 144.0722, 144.50, 144.651, 148.511, 148.6401, 148.995, 256B.692, 626.556, and 626.557.

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

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

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

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

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

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

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

Sec. 27. **MINNESOTA TASK FORCE ON PREMATURITY.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) a review of the potential improvements in health status related to the use of health care homes to provide and coordinate pregnancy-related services; and

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

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

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

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

**Sec. 28. NURSING HOME REGULATORY EFFICIENCY.**

The commissioner of health must work with long-term care providers, provider associations, and consumer advocates to clarify for the benefit of providers, survey teams, and investigators from the office of health facility complaints all of the situations that providers must report and are required to report to the department under federal certification regulations and to the common entry point under the Minnesota Vulnerable Adults Act. The commissioner must produce decision trees, flow sheets, or other reproducible materials to guide the parties and to reduce the number of unnecessary reports.

**Sec. 29. REPEALER.**

(a) Minnesota Statutes 2010, sections 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; and 144.1499, are repealed.

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

**Sec. 30. EFFECTIVE DATE.**

This article is effective the day following final enactment.

**ARTICLE 3****MISCELLANEOUS**

Section 1. Minnesota Statutes 2010, section 245A.14, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2010, section 256B.0943, is amended by adding a subdivision to read:

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

Sec. 5. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

(7) "long-term care spouse" means the spouse who is receiving long-term care services in a long-term care facility or home and community based services pursuant

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to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913.

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

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

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

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

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

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

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

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

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be adjusted, the county or tribal agency shall mail a written notice to the community spouse 30 days in advance of the effective date of the change in the amount of the contribution.

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

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

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

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

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

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

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

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

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

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

(3) When the county or tribal agency receives a request for a variance, written notice of a grant or denial of the variance shall be mailed to the spouse within 30 calendar days after the county or tribal agency receives the financial information required in this clause. The granting of a variance will necessitate a written agreement between the spouse and the county or tribal agency with regard to the specific terms of the variance. The variance will not become effective until the written agreement is signed by the spouse. If the county or tribal agency denies in whole or in part the request for a variance, the denial notice shall set forth in writing the reasons for the denial that address the specific hardship and right to appeal.

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

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

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

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

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

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

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**Sec. 6. NONEMERGENCY MEDICAL TRANSPORTATION SINGLE ADMINISTRATIVE STRUCTURE PROPOSAL.**

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

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

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

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

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

(4) establish a standardized billing process;

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

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

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

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

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

(d) The commissioner shall establish the nonemergency medical transportation advisory council to assist the commissioner in developing a single administrative structure for providing nonemergency medical transportation services. The council shall include, but not be limited to:

(1) one representative each from the Departments of Human Services and Transportation;

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

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

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

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

**ARTICLE 4****DEPARTMENT OF HUMAN SERVICES LICENSING**

Section 1. Minnesota Statutes 2010, section 245A.10, subdivision 1, is amended to read:

Subdivision 1. **Application or license fee required, programs exempt from fee.** (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation of applications and inspection of programs which are licensed under this chapter.

(b) Except as provided under subdivision 2, no application or license fee shall be charged for child foster care, adult foster care, or family and group family child care or state-operated programs, unless the state-operated program is an intermediate care facility for persons with developmental disabilities (ICF/MR).

Sec. 2. Minnesota Statutes 2010, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a \$500 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to ~~(3)~~ (4), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide residential-based habilitation services to persons with developmental disabilities under chapter 245B, an applicant shall submit an application for each county in which the services will be provided. Upon licensure, the license holder may provide services to persons in that county plus no more than three persons at any one time in each of up to ten additional counties. A license holder in one county may not provide services under the home and community-based waiver for persons with developmental disabilities to more than three people in a second county without holding a separate license for that second county. Applicants or licensees providing services under this clause to not more than three persons remain subject to the inspection fees established in section 245A.10, subdivision 2, for each location. The license issued by the commissioner must state the name of each additional county where services are being provided to persons with developmental disabilities. A license holder must notify the

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commissioner before making any changes that would alter the license information listed under section 245A.04, subdivision 7, paragraph (a), including any additional counties where persons with developmental disabilities are being served.

(2) For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities under chapter 245B, an applicant shall submit a single application to provide services statewide.

(3) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

(4) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

Sec. 3. Minnesota Statutes 2010, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) ~~Child care centers and programs with a licensed capacity~~ shall pay an annual nonrefundable license ~~or certification~~ fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee	<del>Other Program</del> License Fee
1 to 24 persons	<del>\$225</del> \$200	\$400
25 to 49 persons	<del>\$340</del> \$300	\$600
50 to 74 persons	<del>\$450</del> \$400	\$800
75 to 99 persons	<del>\$565</del> \$500	\$1,000
100 to 124 persons	<del>\$675</del> \$600	\$1,200
125 to 149 persons	<del>\$900</del> \$700	\$1,400
150 to 174 persons	<del>\$1,050</del> \$800	\$1,600
175 to 199 persons	<del>\$1,200</del> \$900	\$1,800
	<del>\$1,350</del>	
200 to 224 persons	\$1,000	\$2,000
	<del>\$1,500</del>	
225 or more persons	\$1,100	\$2,500

(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall ~~be assessed a~~ pay an annual nonrefundable license fee based on the following schedule ~~in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community.~~

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$800</u>
<u>25 to 49 persons</u>	<u>\$1,000</u>
<u>50 to 74 persons</u>	<u>\$1,200</u>
<u>75 to 99 persons</u>	<u>\$1,400</u>

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<u>100 to 124 persons</u>	<u>\$1,600</u>
<u>125 to 149 persons</u>	<u>\$1,800</u>
<u>150 or more persons</u>	<u>\$2,000</u>

Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

(c) When a day training and habilitation program serving persons with developmental disabilities or related conditions seeks a single license allowed under section 245B.07, subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed capacity for each location.

(d) A program licensed to provide supported employment services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$650.

(e) A program licensed to provide crisis respite services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$700.

(f) A program licensed to provide semi-independent living services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$700.

(g) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients served on the first day of July of the current license year.

(h) A residential program certified by the Department of Health as an intermediate care facility for persons with developmental disabilities (ICF/MR) and a noncertified residential program licensed to provide health or rehabilitative services for persons with developmental disabilities shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$535</u>
<u>25 to 49 persons</u>	<u>\$735</u>
<u>50 or more persons</u>	<u>\$935</u>

(i) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$600</u>
<u>25 to 49 persons</u>	<u>\$800</u>

<u>50 to 74 persons</u>	<u>\$1,000</u>
<u>75 to 99 persons</u>	<u>\$1,200</u>
<u>100 or more persons</u>	<u>\$1,400</u>

(j) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$760</u>
<u>25 to 49 persons</u>	<u>\$960</u>
<u>50 or more persons</u>	<u>\$1,160</u>

(k) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$1,000</u>
<u>25 to 49 persons</u>	<u>\$1,100</u>
<u>50 to 74 persons</u>	<u>\$1,200</u>
<u>75 to 99 persons</u>	<u>\$1,300</u>
<u>100 or more persons</u>	<u>\$1,400</u>

(l) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$2,525</u>
<u>25 or more persons</u>	<u>\$2,725</u>

(m) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$450</u>
<u>25 to 49 persons</u>	<u>\$650</u>
<u>50 to 74 persons</u>	<u>\$850</u>
<u>75 to 99 persons</u>	<u>\$1,050</u>
<u>100 or more persons</u>	<u>\$1,250</u>

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(n) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

(o) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

(p) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

<u>Licensed Capacity</u>	<u>License Fee</u>
<u>1 to 24 persons</u>	<u>\$500</u>
<u>25 to 49 persons</u>	<u>\$700</u>
<u>50 to 74 persons</u>	<u>\$900</u>
<u>75 to 99 persons</u>	<u>\$1,100</u>
<u>100 or more persons</u>	<u>\$1,300</u>

(q) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

(r) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 4. Minnesota Statutes 2010, section 245A.10, is amended by adding a subdivision to read:

Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding section 16A.1285, subdivision 2, related to activities for which the commissioner charges a fee, the commissioner must plan to fully recover direct expenditures for licensing activities under this chapter over a five-year period. The commissioner may have anticipated expenditures in excess of anticipated revenues in a biennium by using surplus revenues accumulated in previous bienniums.

Sec. 5. Minnesota Statutes 2010, section 245A.10, is amended by adding a subdivision to read:

Subd. 8. **Deposit of license fees.** A human services licensing account is created in the state government special revenue fund. Fees collected under subdivisions 3 and 4 must be deposited in the human services licensing account and are annually appropriated to the commissioner for licensing activities authorized under this chapter.

Sec. 6. Minnesota Statutes 2010, section 245A.11, subdivision 2b, is amended to read:

Subd. 2b. **Adult foster care; family adult day services.** An adult foster care license holder licensed under the conditions in subdivision 2a may also provide family

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adult day care for adults ~~age 55~~ age 18 or over if no persons in the adult foster or family adult day services program have a serious and persistent mental illness or a developmental disability. Family adult day services provided in a licensed adult foster care setting must be provided as specified under section 245A.143. Authorization to provide family adult day services in the adult foster care setting shall be printed on the license certificate by the commissioner. Adult foster care homes licensed under this section and family adult day services licensed under section 245A.143 shall not be subject to licensure by the commissioner of health under the provisions of chapter 144, 144A, 157, or any other law requiring facility licensure by the commissioner of health. A separate license is not required to provide family adult day services in a licensed adult foster care home.

Sec. 7. Minnesota Statutes 2010, section 245A.143, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) The licensing standards in this section must be met to obtain and maintain a license to provide family adult day services. For the purposes of this section, family adult day services means a program operating fewer than 24 hours per day that provides functionally impaired adults, ~~none of which are under age 55, have serious or persistent mental illness, or have developmental disabilities,~~ age 18 or older with an individualized and coordinated set of services including health services, social services, and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care.

(b) A family adult day services license shall only be issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

(c) An adult foster care license holder may provide family adult day services under the license holder's adult foster care license if the license holder meets the requirements of this section.

~~(d) When an applicant or license holder submits an application for initial licensure or relicensure for both adult foster care and family adult day services, the county agency shall process the request as a single application and shall conduct concurrent routine licensing inspections.~~

~~(e) Adult foster care license holders providing family adult day services under their foster care license on March 30, 2004, shall be permitted to continue providing these services with no additional requirements until their adult foster care license is due for renewal. At the time of relicensure, an adult foster care license holder may continue to provide family adult day services upon demonstration of compliance with this section. Adult foster care license holders who provide only family adult day services on August 1, 2004, may apply for a license under this section instead of an adult foster care license.~~

Sec. 8. Minnesota Statutes 2010, section 245C.10, is amended by adding a subdivision to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care and family child care, through a fee of no more than \$20 per study charged to the license holder. The fees

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collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 9. Minnesota Statutes 2010, section 256B.49, subdivision 16a, is amended to read:

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the traumatic brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

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(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

(f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

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

Sec. 10. **REPEALER.**

Minnesota Statutes 2010, section 245A.10, subdivision 5, is repealed.

## ARTICLE 5

### HEALTH-RELATED LICENSING

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

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

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

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Subd. 4. **Animal chiropractic.** (a) Animal chiropractic registration fee is \$125.

(b) Animal chiropractic registration renewal fee is \$75.

(c) Animal chiropractic inactive renewal fee is \$25.

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

Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine, license, and renew the license of duly qualified applicants. It shall hold examinations at least once in each year at such time and place as it may determine. It shall by rule adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for registration and renewal of registration as defined in section 148.231. It shall maintain a record of all persons licensed by the board to practice professional or practical nursing and all registered nurses who hold Minnesota licensure and registration and are certified as advanced practice registered nurses. It shall cause the prosecution of all persons violating sections 148.171 to 148.285 and have power to incur such necessary expense therefor. It shall register public health nurses who meet educational and other requirements established by the board by rule, including payment of a fee. ~~Prior to the adoption of rules, the board shall use the same procedures used by the Department of Health to certify public health nurses.~~ It shall have power to issue subpoenas, and to compel the attendance of witnesses and the production of all necessary documents and other evidentiary material. Any board member may administer oaths to witnesses, or take their affirmation. It shall keep a record of all its proceedings.

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

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

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

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

Subdivision 1. **Issuance.** Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation

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or disciplinary action, nor disqualified for any other reason, under the following circumstances:

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

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

~~(c) (b) The applicant for licensure by endorsement under section 148.211, subdivision 2, or for reregistration under section 148.231, subdivision 5, is currently registered in a formal, structured refresher course or its equivalent for nurses that includes clinical practice.~~

~~(d) The applicant for licensure by examination under section 148.211, subdivision 1, who graduated from a nursing program in a country other than the United States or Canada has completed all requirements for licensure except registering for and taking the nurse licensure examination for the first time in the United States. The permit holder must practice professional nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days, whichever occurs first.~~

Sec. 5. Minnesota Statutes 2010, section 148.231, is amended to read:

**148.231 REGISTRATION; FAILURE TO REGISTER; REREGISTRATION; VERIFICATION.**

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

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

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

Subd. 5. **Reregistration.** A person whose registration has lapsed desiring to resume practice shall make application for reregistration, submit satisfactory evidence of

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compliance with the procedures and requirements established by the board, and pay the ~~registration~~ reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, ~~the registration certificate~~ shall be issued to the person who shall immediately be placed on the practicing list as a registered nurse or licensed practical nurse.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2010, section 148B.17, is amended to read:

**148B.17 FEES.**

Subdivision. 1. **Fees; Board of Marriage and Family Therapy.** ~~Each board shall by rule establish~~ The board's fees, including late fees, for licenses and renewals are established so that the total fees collected by the board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.1285. Fees must be credited to ~~accounts~~ the board's account in the state government special revenue fund.

Subd. 2. **Licensure and application fees.** Nonrefundable licensure and application fees charged by the board are as follows:

(1) application fee for national examination is \$220;

(2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is \$110;

(3) initial LMFT license fee is prorated, but cannot exceed \$125;

(4) annual renewal fee for LMFT license is \$125;

(5) late fee for initial Licensed Associate Marriage and Family Therapist LAMFT license renewal is \$50;

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

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

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

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

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

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

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

(1) sponsor application fee for approval of a continuing education course is \$60;

(2) fee for license verification by mail is \$10;

(3) duplicate license fee is \$25;

(4) duplicate renewal card fee is \$10;

(5) fee for licensee mailing list is \$60;

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(6) fee for a rule book is \$10; and

(7) fees as authorized by section 148B.175, subdivision 6, clause (7).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) dentist, \$140;

(2) full faculty dentist, \$140;

~~(2)~~ (3) limited faculty dentist, \$140;

~~(3)~~ (4) resident dentist or dental provider, \$55;

(5) advanced dental therapist, \$100;

~~(4)~~ (6) dental therapist, \$100;

~~(5)~~ (7) dental hygienist, \$55;

~~(6)~~ (8) licensed dental assistant, \$55; and

~~(7)~~ (9) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, \$15.

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

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

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

(2) dental therapist, \$10 times the number of months of the initial term;

(3) dental hygienist, \$5 times the number of months of the initial term;

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

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

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

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

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

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

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

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

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

(2) dental therapist, \$180;

(3) dental hygienist, \$118;

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

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

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

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

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

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

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

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

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

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

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

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

(3) pharmacy intern, \$30;

(4) pharmacy technician, \$30;

(5) pharmacy, \$190;

(6) drug wholesaler, legend drugs only, \$200;

(7) drug wholesaler, legend and nonlegend drugs, \$200;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;

(9) drug wholesaler, medical gases, \$150;

(10) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;

(11) drug manufacturer, legend drugs only, \$200;

(12) drug manufacturer, legend and nonlegend drugs, \$200;

(13) drug manufacturer, nonlegend or veterinary legend drugs, \$175;

(14) drug manufacturer, medical gases, \$150;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;

(16) medical gas distributor, \$75;

(17) controlled substance researcher, \$50; and

(18) pharmacy professional corporation, \$100.

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

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

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

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

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

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

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

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

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

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

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

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

**151.07 MEETINGS; EXAMINATION FEE.**

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

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

**151.101 INTERNSHIP.**

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

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

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

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

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

**151.12 RECIPROCITY; LICENSURE.**

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

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

Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist shall pay to the board a the annual renewal fee to be fixed by it specified in section 151.065. The board may promulgate by rule a charge to be assessed for the delinquent payment of a fee; the late fee specified in section 151.065 if the renewal fee and application are not received by the board prior to the date specified by the board. It shall

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be unlawful for any person licensed as a pharmacist who refuses or fails to pay ~~such~~ any applicable renewal or late fee to practice pharmacy in this state. Every certificate and license shall expire at the time therein prescribed.

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

**151.19 REGISTRATION; FEES.**

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

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

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

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

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

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

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

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

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

Subd. 3. **Sale of federally restricted medical gases.** The board shall require and provide for the annual registration of every person or establishment not licensed as a

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

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

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

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

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

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

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

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

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

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

(1) adequate storage conditions and facilities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 28. **[214.107] HEALTH-RELATED LICENSING BOARDS ADMINISTRATIVE SERVICES UNIT.**

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

Subd. 2. Authority. The administrative services unit shall act as an agent of the boards.

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

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

Sec. 29. **REGISTRATION AND LICENSE RENEWALS; HEALTH-RELATED LICENSING BOARDS.**

For licenses and registrations due to be renewed between July 1, 2011, and the day following final enactment of this section, no health-related licensing board, as defined in Minnesota Statutes, section 214.01, subdivision 2, shall assess a late fee or initiate disciplinary action against a licensee or registrant for failure to timely renew a valid license or registration if the renewal application is submitted to the proper licensing board by July 31, 2011.

Sec. 30. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

## ARTICLE 6

### HEALTH CARE

Section 1. Minnesota Statutes 2010, section 13.461, subdivision 24a, is amended to read:

Subd. 24a. **Managed care plans.** Data provided to the commissioner of human services by managed care plans relating to contracts and provider payment rates are classified under section 256B.69, subdivisions 9a and ~~9b~~ 9c.

Sec. 2. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision to read:

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

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

Sec. 3. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

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

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

Subd. 7. **Authority to administer Minnesota electronic health record incentives program.** The commissioner of human services shall administer an electronic health record incentives program according to section 4201 of the American Recovery and Reinvestment Act, Public Law 111-5 and Code of Federal Regulations, title 42, part 495.

Sec. 5. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 8. **Definitions.** For purposes of subdivisions 7 to 11, the following terms have the meanings given.

(a) "Certified electronic health record technology" has the same meaning as defined in Code of Federal Regulations, title 42, part 495.4.

(b) "Commissioner" means the commissioner of the Department of Human Services.

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(c) "National Level Repository" or "NLR" has the same meaning as defined in Code of Federal Regulations, title 42, part 495.

(d) "SMHP" means the state Medicaid health information technology plan.

(e) "MEIP" means the Minnesota electronic health record incentive program in this section.

(f) "Pediatrician" means a physician who is certified by either the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

Sec. 6. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 9. **Registration, application, and payment processing.** (a) Eligible providers and eligible hospitals must successfully complete the NLR registration process defined by the Centers for Medicare and Medicaid Services before applying for the Minnesota electronic health record incentives program.

(b) The commissioner shall collect any improper payments made under the Minnesota electronic health record incentives program.

(c) Eligible providers and eligible hospitals enrolled in the Minnesota electronic health record incentives program must retain all records supporting eligibility for a minimum of six years.

(d) The commissioner shall determine the allowable methodology options to be used by eligible providers and eligible hospitals for purposes of attesting to and calculating their Medicaid patient volume per Code of Federal Regulations, title 42, part 495.306.

(e) Minnesota electronic health record incentives program payments must be processed and paid to the tax identification number designated by the eligible provider or eligible hospital.

(f) The payment mechanism for Minnesota electronic health record incentives program payments must be determined by the commissioner.

(g) The commissioner shall determine the 12-month period selected by the state as referenced in Code of Federal Regulations, title 42, part 495.310(g)(1)(i)(B).

Sec. 7. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 10. **Audits.** The commissioner is authorized to audit an eligible provider or eligible hospital that applies for an incentive payment through the Minnesota electronic health record incentives program, both before and after payment determination. The commissioner is authorized to use state and federal laws, regulations, and circulars to develop the department's audit criteria.

Sec. 8. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 11. **Provider appeals.** An eligible provider or eligible hospital who has received notification of an adverse action related to the Minnesota electronic health record incentives program may appeal the action pursuant to subdivision 8.

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Sec. 9. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 12. **MEIP appeals.** An eligible provider or eligible hospital who has received notice of an appealable issue related to the Minnesota electronic health record incentives program may appeal the action in accordance with procedures in this section.

Sec. 10. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 13. **Definitions.** For purposes of subdivisions 12 to 15, the following terms have the meanings given.

(a) "Provider" means an eligible provider or eligible hospital for purposes of the Minnesota electronic health record incentives program.

(b) "Appealable issue" means one or more of the following issues related to the Minnesota electronic health record incentives program:

(1) incentive payments;

(2) incentive payment amounts;

(3) provider eligibility determination; or

(4) demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives.

Sec. 11. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 14. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal. The appeal must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the notice of action regarding the appealable issue. The notice of appeal must specify:

(1) the appealable issues;

(2) each disputed item;

(3) the reason for the dispute;

(4) the total dollar amount in dispute;

(5) the computation that the provider believes is correct;

(6) the authority relied upon for each disputed item;

(7) the name and address of the person or firm with whom contacts may be made regarding the appeal; and

(8) other information required by the commissioner.

Sec. 12. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 15. **Appeals review process.** (a) Upon receipt of an appeal notice satisfying subdivision 14, the commissioner shall review the appeal and issue a written appeal determination on each appealed item with 90 days. Upon mutual agreement, the

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commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect upon the date of issuance specified in the determination.

(b) In reviewing the appeal, the commissioner may request additional written or oral information from the provider.

(c) The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the commissioner prior to the issuance of the appeal determination within 30 days of the date the appeal was received by the commissioner. The provider must request an in-person conference in writing, separate from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

(d) For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The commissioner shall refer any contested case demand to the Office of the Attorney General.

(e) A contested case hearing must be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the Minnesota electronic health record incentives program eligibility determination is incorrect.

(f) Regardless of any appeal, the Minnesota electronic health record incentives program eligibility determination must remain in effect until final resolution of the appeal.

(g) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

Sec. 13. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

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

Sec. 14. Minnesota Statutes 2010, section 62Q.32, is amended to read:

**62Q.32 LOCAL OMBUDSPERSON.**

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

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

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

Sec. 15. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) the reason for the delay;

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** (a) ~~By no later than 12 months after the commissioner publishes the information in subdivision 3, paragraph (c).~~ For product renewals or for

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new products that are offered, after 12 months have elapsed from publication by the commissioner of the information in subdivision 3, paragraph (e):

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

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

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

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

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

Sec. 17. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:

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

Sec. 18. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

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

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

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

Sec. 19. Minnesota Statutes 2010, section 256.969, subdivision 2, is amended to read:

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, including the system used by the Medicare

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program to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on program eligibility or hospital peer group. Relative values shall be recalculated when the base year is changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may extend the time period forward to obtain sufficiently valid information to establish relative values. Relative value determinations shall not include property cost data, Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and recalculate relative values and case mix indices to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register and a 30-day comment period. The commissioner shall recategorize the diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013, reflected in subdivision 2b. The first recategorization shall occur January 1, 2013, and shall occur every two years after. When rates are not rebased under subdivision 2b, the commissioner may establish relative values and case mix indices based on charge data and may update the base year to the most recent data available.

Sec. 20. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

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

Sec. 21. Minnesota Statutes 2010, section 256.969, is amended by adding a subdivision to read:

Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment for fee for service admissions occurring on or after September 1, 2011, through June 30, 2015, made to hospitals for inpatient services before third-party liability and spenddown,

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is reduced ten percent from the current statutory rates. Facilities defined under subdivision 16, long-term hospitals as determined under the Medicare program, children's hospitals whose inpatients are predominantly under 18 years of age, and payments under managed care are excluded from this paragraph.

(b) Effective for admissions occurring during calendar year 2010 and each year after, the commissioner shall calculate a regional readmission rate for admissions to all hospitals occurring within 30 days of a previous discharge. The commissioner may adjust the readmission rate taking into account factors such as the medical relationship, complicating conditions, and sequencing of treatment between the initial admission and subsequent readmissions.

(c) Effective for payments to all hospitals on or after July 1, 2013, through June 30, 2015, the reduction in paragraph (a) is reduced one percentage point for every percentage point reduction in the overall readmissions rate between the two previous calendar years to a maximum of five percent.

Sec. 22. Minnesota Statutes 2010, section 256B.02, is amended by adding a subdivision to read:

Subd. 16. **Termination; terminate.** "Termination" or "terminate" for a provider means a state Medicaid program, state children's health insurance program, or Medicare program has taken an action to revoke the provider's billing privileges, the provider has exhausted all appeal rights or the timeline for appeal has expired, there is no expectation by the provider, Medicaid program, state children's health insurance program, or Medicare program that the revocation is temporary, the provider will be required to reenroll to reinstate billing privileges, and the termination occurred for cause, including fraud, integrity, or quality.

Sec. 23. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision to read:

Subd. 4. **Prohibition on payments to providers outside of the United States.** Payments for medical assistance must not be made:

(1) for services delivered or items supplied outside of the United States; or

(2) to a provider, financial institution, or entity located outside of the United States.

Sec. 24. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision to read:

Subd. 5. **Ordering or referring providers.** Claims for payments for supplies or services that are based on an order or referral of a provider must include the ordering or referring provider's national provider identifier (NPI). Claims for supplies or services ordered or referred by a vendor who is not enrolled in medical assistance are not covered.

Sec. 25. Minnesota Statutes 2010, section 256B.04, subdivision 18, is amended to read:

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

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

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

Sec. 26. Minnesota Statutes 2010, section 256B.04, is amended by adding a subdivision to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the Minnesota Department of Human Services permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

Sec. 27. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or

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nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

- (1) admitted for lawful permanent residence according to United States Code, title 8;
- (2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;
- (3) granted asylum according to United States Code, title 8, section 1158;
- (4) granted withholding of deportation according to United States Code, title 8, section 1253(h);
- (5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);
- (6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);
- (7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
- (8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or
- (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

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

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

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

- (i) refugees admitted to the United States according to United States Code, title 8, section 1157;
- (ii) persons granted asylum according to United States Code, title 8, section 1158;
- (iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);
- (iv) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) dialysis;

(ix) chemotherapy or therapeutic radiation services;

(x) rehabilitation services;

(xi) physical, occupational, or speech therapy;

(xii) transportation services;

(xiii) case management;

(xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xv) dental services;

(xvi) hospice care;

(xvii) audiology services and hearing aids;

(xviii) podiatry services;

(xix) chiropractic services;

(xx) immunizations;

(xxi) vision services and eyeglasses;

(xxii) waiver services;

(xxiii) individualized education programs; or

(xxiv) chemical dependency treatment.

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present as designated in paragraph (c) and who in the United States as defined in Code of Federal Regulations, title 8, section 103.12, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations,

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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.

~~(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)~~ (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

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

Sec. 28. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3g. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

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(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

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

Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **Physical therapy.** (a) Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities, (2) 20 modality sessions, and (3) three evaluations or reevaluations. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

**EFFECTIVE DATE.** The amendment to paragraph (a) is effective January 1, 2012. The amendment to paragraph (b) is effective March 1, 2012.

Sec. 30. Minnesota Statutes 2010, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** (a) Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 120 units of any combination of approved CPT codes, and (2) two evaluations or reevaluations. Services provided by an occupational therapy assistant shall be reimbursed

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at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

**EFFECTIVE DATE.** The amendment to paragraph (a) is effective January 1, 2012. The amendment to paragraph (b) is effective March 1, 2012.

Sec. 31. Minnesota Statutes 2010, section 256B.0625, subdivision 8b, is amended to read:

Subd. 8b. **Speech-language pathology and audiology services.** (a) Medical assistance covers speech-language pathology and related services, including specialized maintenance therapy. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Authorization by the commissioner is required to provide medically necessary speech-language pathology services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 50 treatment sessions with any combination of approved CPT codes, and (2) one evaluation.

(c) Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed at the same rate as services performed by a speech-language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.

**EFFECTIVE DATE.** The amendment to paragraph (a) is effective January 1, 2012. The amendment to paragraph (b) is effective March 1, 2012.

Sec. 32. Minnesota Statutes 2010, section 256B.0625, subdivision 8c, is amended to read:

Subd. 8c. **Care management; rehabilitation services.** ~~(a) Effective July 1, 1999, onetime thresholds shall replace annual thresholds for provision of rehabilitation services described in subdivisions 8, 8a, and 8b. The onetime thresholds will be the same in amount and description as the thresholds prescribed by the Department of Human Services health care programs provider manual for calendar year 1997, except they will not be renewed annually, and they will include sensory skills and cognitive training skills.~~

~~(b)~~ (a) A care management approach for authorization of rehabilitation services beyond the threshold described in subdivisions 8, 8a, and 8b shall be instituted in conjunction with the onetime thresholds. The care management approach shall require the provider and the department rehabilitation reviewer to work together directly through written communication, or telephone communication when appropriate, to establish a medically necessary care management plan. Authorization for rehabilitation services shall include approval for up to ~~12~~ six months of services at a time without additional documentation from the provider during the extended period, when the rehabilitation services are medically necessary due to an ongoing health condition.

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~~(c)~~ (b) The commissioner shall implement an expedited five-day turnaround time to review authorization requests for recipients who need emergency rehabilitation services and who have exhausted their onetime threshold limit for those services.

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

Sec. 33. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to read:

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater number of visits is obtained.

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

Sec. 34. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

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

Sec. 35. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs ~~plus a fixed dispensing fee, or the maximum allowable cost set by the federal government or~~ by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. ~~Effective July 1, 2009, The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers~~

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in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be ~~on the basis of~~ the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or ~~the amount established for Medicare by the~~ 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider or the wholesale acquisition cost.

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

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consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

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

Sec. 36. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

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

- (1) performing or obtaining necessary assessments of the patient's health status;
- (2) formulating a medication treatment plan;
- (3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
- (4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
- (5) documenting the care delivered and communicating essential information to the patient's other primary care providers;
- (6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;
- (7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and
- (8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

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

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

- (1) have a valid license issued under chapter 151;
- (2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of

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

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, ~~excluding including~~ long-term care ~~and settings~~, group homes, ~~if the service is ordered by the provider-directed care coordination team and facilities providing assisted living services, but excluding skilled nursing facilities;~~ and

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

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

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

Sec. 37. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to read:

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

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- (1) an ambulance, as defined in section 144E.001, subdivision 2;
- (2) special transportation; or
- (3) common carrier including, but not limited to, bus, taxicab, other commercial carrier, or private automobile.

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

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

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

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

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

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

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

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

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

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

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

(e) Effective for services provided on or after September 1, 2011, nonemergency transportation rates, including special transportation, taxi, and other commercial carriers,

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are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 38. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after September 1, 2011, ambulance services payment rates are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 39. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to read:

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers ~~costs~~ of the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Sec. 40. Minnesota Statutes 2010, section 256B.0625, subdivision 25, is amended to read:

Subd. 25. **Prior authorization required.** (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service is not subject to administrative appeal.

(b) The commissioner shall implement a modernized electronic system for providers to request prior authorization. The modernized electronic system must include at least the following functionalities:

(1) authorizations are recipient-centric, not provider-centric;

(2) adequate flexibility to support authorizations for an episode of care, continuous drug therapy, or for individual onetime services and allows an ordering and a rendering provider to both submit information into one request;

(3) allows providers to review previous authorization requests and determine where a submitted request is within the authorization process;

(4) supports automated workflows that allow providers to securely submit medical information that can be accessed by medical and pharmacy review vendors as well as department staff; and

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(5) supports development of automated clinical algorithms that can verify information and provide responses in real time.

(c) The system described in paragraph (b) shall be completed by March 1, 2012. All authorization requests submitted on and after March 1, 2012, or upon completion of the modernized authorization system, whichever is later, must be submitted electronically by providers, except requests for drugs dispensed by an outpatient pharmacy, services that are provided outside of the state and surrounding local trade area, and services included on a service agreement.

Sec. 41. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party payer. A good faith effort is established by supplying with the authorization request to the commissioner the following:

(1) a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

(2) the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available for the service.

(c) Authorization is not required if a third-party payer has made payment that is equal to or greater than 60 percent of the maximum payment amount for the service allowed under medical assistance.

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

Sec. 42. Minnesota Statutes 2010, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

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(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

Sec. 43. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to read:

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

~~(b) Until the volume of systems purchased increases to allow a discount price, the commissioner shall reimburse augmentative and alternative communication manufacturers and vendors at the manufacturer's suggested retail price for augmentative and alternative communication systems and related components. The commissioner shall separately reimburse providers for purchasing and integrating individual communication systems which are unavailable as a package from an augmentative and alternative communication vendor. Augmentative and alternative communication systems must be paid the lower of the:~~

~~(1) submitted charge; or~~

~~(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or~~

~~(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.~~

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(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

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

Sec. 44. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Payment for noncovered services.** (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescription drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service.

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

Sec. 45. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56. **Medical service coordination.** (a) Medical assistance covers in-reach community-based service coordination that is performed in a hospital emergency department as an eligible procedure under a state healthcare program or private insurance for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four

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consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(b) Reimbursement must be made in 15-minute increments under current Medicaid mental health social work reimbursement methodology and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. A frequent user who is participating in care coordination within a health care home framework is ineligible for reimbursement under this subdivision. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

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

Sec. 46. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare. Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

Sec. 47. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 48. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 59. **Services provided by advanced dental therapists and dental therapists.** Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

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

Sec. 49. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. ~~Co-payments~~ Cost-sharing. (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing for all recipients, effective for services provided on or after ~~October 1, 2003, and before January 1, 2009~~ September 1, 2011:

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

(2) \$3 for eyeglasses;

(3) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to \$20 upon federal approval; ~~and~~

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

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

~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:~~

~~(1) \$3.50 for nonemergency visits to a hospital-based emergency room;~~

~~(2) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(3)~~ (6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly ~~co-payments~~ cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on ~~co-payments~~ cost-sharing.

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

Sec. 50. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

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- (2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;
- (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;
- (4) recipients receiving hospice care;
- (5) 100 percent federally funded services provided by an Indian health service;
- (6) emergency services;
- (7) family planning services;
- (8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and
- (9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

**EFFECTIVE DATE.** This section is effective September 1, 2011, for services provided on a fee-for-service basis and January 1, 2012, for services provided by a managed care plan or county-based purchasing plan.

Sec. 51. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the \$12 per month maximum ~~or the \$7 per month maximum effective January 1, 2009~~, for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent ~~co-payment~~ cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

**EFFECTIVE DATE.** This section is effective September 1, 2011, for services provided on a fee-for-service basis, and January 1, 2012, for services provided by a managed care plan or county-based purchasing plan.

Sec. 52. Minnesota Statutes 2010, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility,

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after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) ~~Except for a nursing home or convalescent care facility,~~ when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner may shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) ~~the commissioner receives reliable evidence of fraud or willful misrepresentation by the vendor,~~ determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

~~(2)~~ (3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

~~(3)~~ (4) identify the types of claims to which the withholding applies; and

~~(4)~~ (5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud ~~or willful misrepresentation~~ by the vendor, or after legal proceedings relating to the alleged fraud ~~or willful misrepresentation~~ are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner ~~may~~ shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

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(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program; ~~and~~

~~(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.~~

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

Sec. 53. Minnesota Statutes 2010, section 256B.0641, subdivision 1, is amended to read:

Subdivision 1. **Recovery procedures; sources.** Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government;

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner; ~~and~~

(3) a medical assistance vendor is liable for the overpayment amount owed by a long-term care provider if the vendors or their owners are under common control or ownership; and

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(4) in order to collect past due obligations to the department, the commissioner shall make any necessary adjustments to payments to a provider or vendor that has the same tax identification number as is assigned to a provider or vendor with past due obligations.

Sec. 54. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to read:

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner of health shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

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

Sec. 55. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waived services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and health care home.

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

Sec. 56. Minnesota Statutes 2010, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic

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intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin ~~Faculty Associates~~ County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

(d) The commissioner shall inform ~~Hennepin County and Ramsey County~~ the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (c), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

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(e) The payments in paragraphs (a) to (c) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

Sec. 57. Minnesota Statutes 2010, section 256B.196, subdivision 3, is amended to read:

Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner under subdivision 2, Hennepin County and Ramsey County shall make periodic intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs (a) ~~to (c)~~ and (b). All of the intergovernmental transfers made by Hennepin County shall be used to match federal payments to Hennepin County Medical Center under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Hennepin Faculty Associates County Medical Center under subdivision 2, paragraph (b), ~~and to Metropolitan Health Plan~~ under subdivision 2, paragraph (c). All of the intergovernmental transfers made by Ramsey County shall be used to match federal payments to Regions Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group under subdivision 2, paragraph (b), ~~and to HealthPartners~~ under subdivision 2, paragraph (c).

Sec. 58. Minnesota Statutes 2010, section 256B.196, subdivision 5, is amended to read:

Subd. 5. **Recession period.** Each type of intergovernmental transfer in subdivision 2, paragraphs (a) to (d), for payment periods from October 1, 2008, through ~~December 31, 2010~~ June 30, 2013, is voluntary on the part of Hennepin and Ramsey Counties, meaning that the transfer must be agreed to, in writing, by the counties prior to any payments being issued. One agreement on each type of transfer shall cover the entire recession period.

Sec. 59. **[256B.198] PAYMENTS FOR NONHOSPITAL-BASED GOVERNMENTAL HEALTH CENTERS.**

(a) The commissioner may make payments to nonhospital-based health centers operated by a governmental entity for the difference between the expenditures incurred by the health center for patients eligible for medical assistance, and the payments to the health center for medical assistance permitted elsewhere under this chapter.

(b) The nonfederal share of payments authorized under paragraph (a) shall be provided through certified public expenditures authorized under section 256B.199, paragraph (b).

(c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total cost of care demonstration project, Hennepin County may receive federal matching funds for certified public expenditures under paragraph (a), if the county participates in a total cost of care demonstration project under sections 256B.0755 and 256B.0756, or another total cost of care demonstration project approved by the commissioner, and the county exceeds the minimum performance threshold established by the commissioner for the demonstration project. The value of the federal matching funds for the certified public expenditures allocated to Hennepin County shall be equal to the value of savings achieved above the minimum performance threshold. The same proportion of federal matching funds for certified public expenditure allocated to Hennepin County based on savings achieved under the demonstration project shall continue after the demonstration project and must continue to be paid to Hennepin County each year thereafter.

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(d) Beginning July 1, 2014, or no earlier than 12 months after the initial allocation under paragraph (c) if a portion of the federal matching funds for certified public expenditure remains with the state, the commissioner shall annually determine if the savings from county's total cost of care demonstration project exceeded the savings from the previous year and allocate federal matching funds for certified public expenditures to Hennepin County equal to the amount of savings achieved above the amount achieved in the previous year. The proportion of federal matching funds for certified public expenditure allocated to Hennepin County shall be paid to Hennepin County each year thereafter, until no federal matching funds for certified public expenditures under paragraph (a) remain with the state.

(e) Nothing under this subdivision precludes Hennepin County from receiving an additional gain-sharing payment or relieves the county from paying a downside risk-sharing payment to the state under the demonstration project under section 256B.0755.

Sec. 60. Minnesota Statutes 2010, section 256B.199, is amended to read:

**256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). Effective September 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (e).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

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(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

(e) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program according to the requirements and conditions of paragraph (c). A hospital may elect on an annual basis to not be a disproportionate share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 256.969, subdivision 9, paragraph (b).

Sec. 61. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692

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for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year until the final performance target is reached.

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

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for ~~state health care program enrollees for calendar year 2009~~ medical assistance and MinnesotaCare enrollees for calendar year 2011. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. ~~The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold in this paragraph does not apply to county-based purchasing plans.~~

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each

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year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved.

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

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

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved.

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

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

(k) 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.

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

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

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

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

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

Sec. 62. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under this section.

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(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. ~~Effective July 1, 2009, and thereafter, The transfers required by amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts otherwise required to be transferred specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the transfers amount specified under paragraph (a), clause (1).~~

(c) Beginning ~~July~~ September 1, 2009 ~~2011~~, of the ~~amounts~~ amount in paragraph (a), the commissioner shall transfer \$21,714,000 each fiscal year to the medical education and research fund. ~~The balance of the transfers under paragraph (a) shall be transferred to the medical education and research fund no earlier than July 1 of the following fiscal year.~~

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund \$23,936,000 in fiscal years 2012 and 2013 and \$36,744,000 in fiscal year 2014 and thereafter.

Sec. 63. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to

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providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

Sec. 64. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.**

(a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

~~Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.~~

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in

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developing program specifications for these services. The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2008 2012, the commissioner may expand contracting under this subdivision to all shall enroll persons with disabilities not otherwise required to enroll in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this subdivision.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

- (1) implementation efforts;
- (2) consumer protections; and
- (3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, in which case at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 65. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

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(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum.

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Sec. 66. Minnesota Statutes 2010, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

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(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

Sec. 67. Minnesota Statutes 2010, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

Sec. 68. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements

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to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

(5) a dental clinic ~~associated with an oral health or dental education program owned and~~ operated by the University of Minnesota or ~~an institution within~~ the Minnesota State Colleges and Universities system.

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

(d) Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.

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

Sec. 69. Minnesota Statutes 2010, section 256B.766, is amended to read:

**256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

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(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, anesthesia services, and hospice services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Sec. 70. **[256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment and implementation.** The commissioner of human services shall contract with a Minnesota-based academic or clinical research institution or institutions specializing in providing complementary and alternative medicine education and clinical services to establish and implement a five-year demonstration project in conjunction with federally qualified health centers or federally qualified health center "look-alikes" as defined in section 145.9269, to improve the quality and cost-effectiveness of care provided under medical assistance to enrollees with neck and back problems. The demonstration project must maximize the use of complementary and alternative medicine-oriented primary care providers, including but not limited to physicians and chiropractors. The demonstration project must be designed to significantly improve physical and mental health for enrollees who present with neck and back problems while decreasing medical treatment costs. The commissioner, in consultation with the commissioner of health, shall deliver services through the demonstration project beginning January 1, 2012, or upon federal approval, whichever is later.

Subd. 2. **RFP and project criteria.** The commissioner shall develop and issue a request for proposal (RFP) for the demonstration project. The RFP must require the

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academic or clinical research institution or institutions selected to demonstrate a proven track record over at least five years of conducting high-quality, federally funded clinical research. The RFP shall specify the state costs directly related to the requirements of this section and shall require that the selected institution pay those costs to the state. The institution and the federally qualified health centers and federally qualified health center "look-alikes" shall also:

(1) provide patient education, provider education, and enrollment training components on health and lifestyle issues in order to promote enrollee responsibility for health care decisions, enhance productivity, prepare enrollees to reenter the workforce, and reduce future health care expenditures;

(2) use high-quality and cost-effective integrated disease management that includes the best practices of traditional and complementary and alternative medicine;

(3) incorporate holistic medical care, appropriate nutrition, exercise, medications, and conflict resolution techniques;

(4) include a provider education component that makes use of professional organizations representing chiropractors, nurses, and other primary care providers and provides appropriate educational materials and activities in order to improve the integration of traditional medical care with licensed chiropractic services and other alternative health care services and achieve program enrollment objectives; and

(5) provide to the commissioner the information and data necessary for the commissioner to prepare the annual reports required under subdivision 6.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the commissioner from current enrollees in the prepaid medical assistance program who have, or are determined to be at significant risk of developing, neck and back problems. Participation in the demonstration project shall be voluntary. The commissioner shall seek to enroll, over the term of the demonstration project, ten percent of current and future medical assistance enrollees who have, or are determined to be at significant risk of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic or clinical research institution or institutions selected, federally qualified health centers, and federally qualified health center "look-alikes" to fund all costs of the demonstration project. Amounts received under subdivision 2 are appropriated to the commissioner for the purposes of this section.

Subd. 6. **Annual reports.** The commissioner, beginning December 15, 2012, and each December 15 thereafter through December 15, 2015, shall report annually to the legislature on the functional and mental improvements of the populations served by the demonstration project, patient satisfaction, and the cost-effectiveness of the program. The reports must also include data on hospital admissions, days in hospital, rates of outpatient surgery and other services, and drug utilization. The report, due December 15, 2015, must include recommendations on whether the demonstration project should be continued and expanded.

Sec. 71. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

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Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Sec. 72. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 73. **[256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

**Subdivision 1. Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

**Subd. 2. Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) An enrollee must select a health plan within three calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria.

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

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(1) provide coverage for mental health and chemical dependency treatment services; and

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

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

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

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

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

<u>19-29</u>	<u>\$125</u>
<u>30-34</u>	<u>\$135</u>
<u>35-39</u>	<u>\$140</u>
<u>40-44</u>	<u>\$175</u>
<u>45-49</u>	<u>\$215</u>
<u>50-54</u>	<u>\$295</u>
<u>55-59</u>	<u>\$345</u>
<u>60+</u>	<u>\$360</u>

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

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and

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cost-effective method of referring eligible applicants to professional insurance agent associations.

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

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

Sec. 74. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) ~~Beginning July 1, 2010, or upon federal approval, whichever is later,~~ Parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.

~~(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.~~

(f) [Reserved.]

Sec. 75. Minnesota Statutes 2010, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** Eligibility for MinnesotaCare is limited to citizens or nationals of the United States, qualified noncitizens, and other persons residing lawfully in the United States as ~~described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j) defined in Code of Federal Regulations, title 8, section 103.12.~~ Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who

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are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

Sec. 76. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

(d) For children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the first period of renewal begins the month the enrollee turns 21 years of age.

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

Sec. 77. Minnesota Statutes 2010, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

Sec. 78. Minnesota Statutes 2010, section 256L.09, subdivision 2, is amended to read:

Subd. 2. **Residency requirement.** ~~(a) To be eligible for health coverage under the MinnesotaCare program, adults without children must be permanent residents of Minnesota.~~

~~(b)~~ To be eligible for health coverage under the MinnesotaCare program, pregnant women, individuals, and families, ~~and with~~ children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval.

**EFFECTIVE DATE.** This section is effective the day following final enactment or upon federal approval of federal financial participation for adults without children,

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whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 79. Minnesota Statutes 2010, section 256L.11, subdivision 6, is amended to read:

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the \$10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

Sec. 80. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with

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the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 81. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

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

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year, until the final performance target is reached.

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

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The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year ~~2009~~ medical assistance and MinnesotaCare enrollees for calendar year 2011. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. ~~The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.~~

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year, until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved.

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

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

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this

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performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

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

Sec. 82. Minnesota Statutes 2010, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months. ~~This paragraph expires June 30, 2010. If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this provision will expire on the date when it is no longer subject to section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes of that date.~~

Sec. 83. Minnesota Statutes 2010, section 295.52, is amended by adding a subdivision to read:

Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year, beginning in 2011, the commissioner of management and budget shall determine the projected balance in the health care access fund for the biennium.

(b) If the commissioner of management and budget determines that the projected balance in the health care access fund for the biennium reflects a ratio of revenues to expenditures and transfers greater than 125 percent, and if the actual cash balance in the fund is adequate, as determined by the commissioner of management and budget, the commissioner, in consultation with the commissioner of revenue, shall reduce the tax rates levied under subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient to reduce the structural balance in the fund. The rate may be reduced to the extent that the projected revenues for the biennium do not exceed 125 percent of expenditures and transfers. The new rate shall be rounded to the nearest one-tenth of one percent. The rate reduction under this paragraph expires at the end of each calendar year and is subject to an annual redetermination by the commissioner of management and budget.

(c) For purposes of the analysis defined in paragraph (b), the commissioner of management and budget shall include projected revenues, notwithstanding the repeal of the tax imposed under this section effective January 1, 2020.

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Sec. 84. Laws 2009, chapter 79, article 5, section 17, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 9, is amended to read:

**EFFECTIVE DATE.** This section is effective ~~January 1, 2011~~ October 1, 2019, or upon federal approval and on the date when it is no longer subject to the maintenance of effort requirements of section 5001 of Public Law 111-5 the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. The commissioner of human services shall notify the revisor of statutes of that date.

Sec. 85. Laws 2009, chapter 79, article 5, section 18, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 10, is amended to read:

**EFFECTIVE DATE.** This section is effective ~~upon federal approval and on the date when it is no longer subject to the maintenance of effort requirements of section 5001 of Public Law 111-5~~ January 1, 2014, or upon the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 86. Laws 2009, chapter 79, article 5, section 22, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 11, is amended to read:

**EFFECTIVE DATE.** This section is effective for periods of ineligibility established on or after January 1, ~~2011~~ 2014, ~~unless it is in violation of section 5001 of Public Law 111-5. If it is in violation of that section, then it shall be effective on the date when it is no longer subject to maintenance of effort requirements of section 5001 of Public Law 111-5 or upon the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148.~~ The commissioner of human services shall notify the revisor of statutes of that date.

Sec. 87. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 12, is amended to read:

**EFFECTIVE DATE.** The section is effective ~~July 1, 2011~~ January 1, 2014, or upon the date it is no longer subject to the maintenance effort requirement in Public Law 111-148.

Sec. 88. Laws 2009, chapter 173, article 1, section 17, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 13, is amended to read:

**EFFECTIVE DATE.** This section is effective for pooled trust accounts established on or after January 1, ~~2011~~ 2014, ~~unless it is in violation of section 5001 of Public Law 111-5 or upon the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. If it is in violation of that section, then it shall be effective on the date when it is no longer subject to maintenance of effort requirements of section 5001 of Public Law 111-5.~~ The commissioner of human services shall notify the revisor of statutes of that date.

Sec. 89. **PLAN TO COORDINATE CARE FOR CHILDREN WITH HIGH-COST MENTAL HEALTH CONDITIONS.**

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The commissioner of human services shall develop and submit to the legislature by January 15, 2012, a plan to provide care coordination to medical assistance and MinnesotaCare enrollees who are children with high-cost mental health conditions. For purposes of this section, a child has a "high-cost mental health condition" if mental health and medical expenses over the past year totalled \$100,000 or more. For purposes of this section, "care coordination" means collaboration between an advanced practice nurse and primary care physicians and specialists to manage care; development of mental health management plans for recurrent mental health issues; oversight and coordination of all aspects of care in partnership with families; organization of medical, treatment, and therapy information into a summary of critical information; coordination and appropriate sequencing of evaluations and multiple appointments; information and assistance with accessing resources; and telephone triage for behavior or other problems.

Sec. 90. **REGULATORY SIMPLIFICATION AND REDUCTION OF PROVIDER REPORTING AND DATA SUBMITTAL REQUIREMENTS.**

Subdivision 1. **Regulatory simplification and report reduction work group.** The commissioner of management and budget shall convene a regulatory simplification and report reduction work group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittal requirements for health care providers or group purchasers related to health care costs, quality, utilization, access, or patient encounters or related to provider or group purchaser, monitoring, finances, and regulation. For purposes of this section, the term "health care providers or group purchasers" has the meaning provided in Minnesota Statutes, section 62J.03, subdivisions 6 and 8, except that it also includes nursing homes.

Subd. 2. **Plan development and other duties.** (a) The commissioner of management and budget, in consultation with the work group, shall develop a plan for regulatory simplification and report reduction activities of the commissioners of health, human services, and commerce that considers collection and regulation of the following in a coordinated manner:

- (1) encounter data;
- (2) group purchaser provider network data;
- (3) financial reporting;
- (4) reporting and documentation requirements relating to member communications and marketing materials;
- (5) state regulation and oversight of group purchasers;
- (6) requirements and procedures for denial, termination, or reduction of services and member appeals and grievances; and
- (7) state performance improvement projects, requirements, and procedures.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, shall present to the legislature by February 15, 2012, proposals to implement their recommendations.

Subd. 3. **New reporting and other duties.** (a) The commissioner of management and budget, in consultation with the work group and the commissioners of health, human services, and commerce, shall develop criteria to be used by the commissioners in

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determining whether to establish new reporting and data submittal requirements. These criteria must support the establishment of new reporting and data submittal requirements only:

(1) if required by a federal agency or state statute;

(2) if needed for a state regulatory audit or corrective action plan;

(3) if needed to monitor or protect public health;

(4) if needed to manage the cost and quality of Minnesota's public health insurance programs; or

(5) if a review and analysis by the commissioner of the relevant agency has documented the necessity, importance, and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, may propose to the legislature new provider and group purchaser reporting and data submittal requirements to take effect on or after July 1, 2012. These proposals shall include an analysis of the extent to which the requirements meet the criteria developed under paragraph (a).

**Sec. 91. SPECIALIZED MAINTENANCE THERAPY.**

The commissioner of human services shall evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with serious and persistent mental illness who are at risk of hospitalization will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by December 15, 2011.

**Sec. 92. REDUCING HOSPITALIZATION RATES.**

The commissioner of human services, by January 15, 2012, shall present recommendations to the legislature to reduce hospitalization rates for state health care program enrollees who are children with high-cost medical conditions.

**Sec. 93. MEDICAID FRAUD PREVENTION AND DETECTION.**

Subdivision 1. **Request for proposals.** By December 31, 2011, the commissioner of human services shall issue a request for proposals to prevent and detect Medicaid fraud and mispayment. The request for proposals shall require the vendor to provide data analytics capabilities, including, but not limited to, predictive modeling techniques and other forms of advanced analytics, technical assistance, claims review, and medical record and documentation investigations, to detect and investigate improper payments both before and after payments are made.

Subd. 2. **Proof of concept phase.** The selected vendor, at no cost to the state, shall be required to apply its analytics and investigations on a subset of data provided by the commissioner to demonstrate the direct recoveries of the solution.

Subd. 3. **Data confidentiality.** Data provided by the commissioner to the vendor under this section must maintain the confidentiality of the information.

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Subd. 4. **Full implementation phase.** The request for proposal must require the commissioner to implement the recommendations provided by the vendor if the work done under the requirements of subdivision 2 provides recoveries directly related to the investigations to the state. After full implementation, the vendor shall be paid from recoveries directly attributable to the work done by the vendor, according to the terms and performance measures negotiated in the contract.

Subd. 5. **Selection of vendor.** The commissioner of human services shall select a vendor from the responses to the request for proposal by January 31, 2012.

Subd. 6. **Progress report.** The commissioner shall provide a report describing the progress made under this section to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over the Department of Human Services by June 15, 2012. The report shall provide a dynamic scoring analysis of the work described in the report.

**Sec. 94. CAPITATION PAYMENT DELAY.**

The commissioner shall delay \$135,000,000 of the medical assistance and MinnesotaCare capitation payment to managed care plans and county-based purchasing plans due in May 2013 and the payment due in April 2013 for special needs basic care until July 1, 2013. The payment shall be made no earlier than July 1, 2013, and no later than July 31, 2013.

The commissioner shall delay \$135,000,000 of the medical assistance and MinnesotaCare capitation payment to managed care plans and county-based purchasing plans due in the second quarter of calendar year 2015 and the April 2015 payment for special needs basic care until July 1, 2015. The payment shall be made no earlier than July 1, 2015, and no later than July 31, 2015.

**Sec. 95. MINNESOTA AUTISM SPECTRUM DISORDER TASK FORCE.**

Subdivision 1. **Members.** (a) The Autism Spectrum Disorder Task Force is composed of 19 members, appointed as follows:

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

(2) two members of the house of representatives, one from the majority party, appointed by the speaker of the house, and one from the minority party, appointed by the minority leader;

(3) two members who are family members of individuals with autism spectrum disorder (ASD), one of whom shall be appointed by the majority leader of the senate, and one of whom shall be appointed by the speaker of the house;

(4) one member appointed by the Minnesota chapter of the American Academy of Pediatrics who is a developmental behavioral pediatrician;

(5) one member appointed by the Minnesota Academy of Family Physicians who is a family practice physician;

(6) one member appointed by the Minnesota Psychological Association who is a neuropsychologist;

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(7) one member appointed by the majority leader of the senate who represents a minority autism community;

(8) one member representing the directors of public school student support services;

(9) one member appointed by the Minnesota Council of Health Plans;

(10) three members who represent autism advocacy groups, two of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the majority leader of the senate; and

(11) one member appointed by each of the respective commissioners of the following departments: education, employment and economic development, health, and human services.

(b) Appointments must be made by September 1, 2011. The senate member appointed by the majority leader of the senate shall convene the first meeting of the task force no later than October 1, 2011. The task force shall elect a chair from among members at the first meeting. The task force shall meet at least six times per year.

Subd. 2. **Duties.** (a) The task force shall develop an autism spectrum disorder statewide strategic plan that focuses on improving awareness, early diagnosis, and intervention and on ensuring delivery of treatment and services for individuals diagnosed with an autism spectrum disorder, including the coordination and accessibility of cost-effective treatments and services throughout the individual's lifetime.

(b) The task force shall coordinate with existing efforts relating to autism spectrum disorders at the Departments of Education, Employment and Economic Development, Health, and Human Services and at the University of Minnesota and other agencies and organizations as the task force deems appropriate.

Subd. 3. **Report.** The task force shall submit its strategic plan to the legislature by January 15, 2013. The task force shall continue to provide assistance with the implementation of the strategic plan, as approved by the legislature, and shall submit a progress report by January 15, 2014, and by January 15, 2015, on the status of implementation of the strategic plan, including any draft legislation necessary for implementation.

Subd. 4. **Expiration.** The task force expires June 30, 2015, unless extended by law.

**Sec. 96. COMPETITIVE BIDDING PILOT.**

For managed care contracts effective January 1, 2012, the commissioner of human services is required to establish a competitive price bidding pilot for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The pilot must allow a minimum of two managed care organizations to serve the metropolitan area. The pilot shall expire after two full calendar years on December 31, 2013. The commissioner of human service shall conduct an evaluation of the pilot to determine the cost-effectiveness and impacts to provider access at the end of the two-year period.

**Sec. 97. REPEALER.**

Subdivision 1. **Legislative Oversight Commission.** Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, are repealed.

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Subd. 2. **Children formerly under medical assistance.** Minnesota Statutes 2010, section 256L.07, subdivision 7, exempting eligibility for children formerly under medical assistance, is repealed retroactively from October 1, 2008, and federal approval is no longer necessary.

Subd. 3. **Extending medical assistance.** Minnesota Statutes 2010, section 256B.057, subdivision 2c, (extended medical assistance for certain children) is repealed.

Subd. 4. Minnesota Statutes 2010, section 256B.69, subdivision 9b, is repealed.

Subd. 5. The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9, (renewal rolling month and premium grace month) are repealed.

Subd. 6. **MinnesotaCare provider taxes.** Minnesota Statutes 2010, sections 13.4967, subdivision 3; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b, 12b, 13, 14, and 15; 295.51, subdivisions 1 and 1a; 295.52, subdivisions 1, 1a, 2, 3, 4, 4a, 5, 6, and 7; 295.53, subdivisions 1, 2, 3, and 4a; 295.54; 295.55; 295.56; 295.57; 295.58; 295.581; 295.582; and 295.59, are repealed effective for gross revenues received after December 31, 2019.

Subd. 7. **Renewal of medical assistance eligibility.** The amendment in Laws 2009, chapter 79, article 5, section 62, is repealed retroactively from July 1, 2009.

Sec. 98. **EFFECTIVE DATE.**

This article is effective the day following final enactment unless another effective date is specified in this article.

## ARTICLE 7

### CONTINUING CARE

Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 7, as amended by Laws 2011, chapter 86, section 4, is amended to read:

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

- (1) foster care settings that are required to be registered under chapter 144D;
- (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);
- (3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;
- (4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division, and the department shall immediately decrease the licensed capacity for the home. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

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Sec. 2. Minnesota Statutes 2010, section 256.01, subdivision 24, is amended to read:

Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability Linkage Line, ~~to serve as Minnesota's neutral access point for statewide consumer disability information, referral, and assistance system for people with disabilities and chronic illnesses that.~~ The Disability Linkage Line shall:

- (1) deliver information and assistance based on national and state standards;
- ~~(1) provides~~ (2) provide information about state and federal eligibility requirements, benefits, and service options;
- (3) provide benefits and options counseling;
- ~~(2) makes~~ (4) make referrals to appropriate support entities;
- ~~(3) delivers information and assistance based on national and state standards;~~
- ~~(4) assists~~ (5) educate people ~~to~~ on their options so they can make well-informed decisions ~~choices; and~~
- ~~(5) supports~~ (6) help support the timely resolution of service access and benefit issues;
- (7) inform people of their long-term community services and supports;
- (8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; and
- (9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org.

Sec. 3. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, ~~paragraph (j);~~ and 256B.055, subdivision 12, the commissioner shall review all medical evidence submitted by county agencies with a referral and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

- (1) the number of applications to the state medical review team that were denied, approved, or withdrawn;
- (2) the average length of time from receipt of the application to a decision;

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(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief appeals referee.

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

Subd. 20. **Money Follows the Person Rebalancing demonstration project.** In accordance with federal law governing Money Follows the Person Rebalancing funds, amounts equal to the value of enhanced federal funding resulting from the operation of the demonstration project grant must be transferred from the medical assistance account in the general fund to an account in the special revenue fund. Funds in the special revenue fund account do not cancel and are appropriated to the commissioner to carry out the goals of the Money Follows the Person Rebalancing demonstration project as required under the approved federal plan for the use of the funds, and may be transferred to the medical assistance account if applicable.

Sec. 5. Minnesota Statutes 2010, section 256B.05, is amended by adding a subdivision to read:

Subd. 5. **Obligation of local agency to process medical assistance applications within established timelines.** The local agency must act on an application for medical assistance within ten working days of receipt of all information needed to act on the application but no later than required under Minnesota Rules, part 9505.0090, subparts 2 and 3.

Sec. 6. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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- (1) household goods and personal effects are not considered;
  - (2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;
  - (3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;
  - (4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; and
  - (5) ~~effective upon federal approval~~, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph ~~(c)~~ (d).
- (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

**EFFECTIVE DATE.** This section is effective January 1, 2014.

Sec. 7. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

- (1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;
- (2) is at least 16 but less than 65 years of age;
- (3) meets the asset limits in paragraph ~~(c)~~ (d); and
- (4) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than \$65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

~~(b)~~ (c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

- (1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, ~~may retain eligibility for up to four calendar months~~; or

(2) ~~effective January 1, 2004~~, loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other

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eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

~~(c)~~ (d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed \$20,000, excluding:

- (1) all assets excluded under section 256B.056;
- (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; ~~and~~
- (3) medical expense accounts set up through the person's employer; and
- (4) spousal assets, including spouse's share of jointly held assets.

~~(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.~~

~~(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.~~

~~(e)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. (e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under section 256.01, subdivision 18b.~~

(1) An enrollee must pay the greater of a \$65 premium or the premium shall be calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

~~(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a \$35 premium or the premium calculated in clause (1).~~

~~(3) Effective November 1, 2003, All enrollees who receive unearned income must pay one-half of one five percent of unearned income in addition to the premium amount, except as provided under section 256.01, subdivision 18b.~~

~~(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).~~

~~(5)~~ (4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

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(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.

(k) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

**EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). ~~Beginning July 1, 2011, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in at least two activities of daily living as defined in section 256B.0659.~~ Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school.

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Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0656. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0656. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 9. Minnesota Statutes 2010, section 256B.0652, subdivision 6, is amended to read:

Subd. 6. **Authorization; personal care assistance and qualified professional.**

(a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in subdivision 11 and section 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for recipients with dependencies in two or more activities of daily living:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) presence of complex health-related needs as defined in section 256B.0659; and

(3) presence of Level I behavior as defined in section 256B.0659.

(c) For purposes meeting the criteria in paragraph (b), the methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

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(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659, subdivision 4, paragraph (d).

(d) Effective July 1, 2011, the home care rating for recipients who have a dependency in one activity of daily living or Level I behavior shall equal no more than two units per day. Recipients with this home care rating are not subject to the methodology in paragraph (c) and are not eligible for more than two units per day.

(e) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

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(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 275 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) ~~Effective January 1, 2010,~~ Persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

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

Sec. 11. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.**  
(a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

- (1) employee files, including:
  - (i) applications for employment;
  - (ii) background study requests and results;
  - (iii) orientation records about the agency policies;
  - (iv) trainings completed with demonstration of competence;
  - (v) supervisory visits;

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- (vi) evaluations of employment; and
- (vii) signature on fraud statement;
- (2) recipient files, including:
  - (i) demographics;
  - (ii) emergency contact information and emergency backup plan;
  - (iii) personal care assistance service plan;
  - (iv) personal care assistance care plan;
  - (v) month-to-month service use plan;
  - (vi) all communication records;
  - (vii) start of service information, including the written agreement with recipient; and
  - (viii) date the home care bill of rights was given to the recipient;
- (3) agency policy manual, including:
  - (i) policies for employment and termination;
  - (ii) grievance policies with resolution of consumer grievances;
  - (iii) staff and consumer safety;
  - (iv) staff misconduct; and
  - (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;
- (4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; ~~and~~
- (5) agency marketing and advertising materials and documentation of marketing activities and costs; and
- (6) for each personal care assistant, whether or not the personal care assistant is providing care to a relative as defined in subdivision 11.
- (b) The commissioner may assess a fine of up to \$500 on provider agencies that do not consistently comply with the requirements of this subdivision.

Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to read:

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

- (a) "Long-term care consultation services" means:
  - (1) assistance in identifying services needed to maintain an individual in the most inclusive environment;
  - (2) providing recommendations on cost-effective community services that are available to the individual;
  - (3) development of an individual's person-centered community support plan;
  - (4) providing information regarding eligibility for Minnesota health care programs;

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(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated screening to determine the need for an institutional level of care under subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as ~~defined under section 144.0724, subdivision 11, determined under section 256B.0911, subdivision 4a, paragraph (d), or 256B.092,~~ service eligibility including state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support plan development with appropriate referrals, including the option for consumer-directed community supports;

(8) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(9) assistance to transition people back to community settings after facility admission.

(b) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(c) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 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 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.

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(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual, and alternatives to residential settings, including, but not limited to, foster care settings that are not the primary residence of the license holder. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.

(f) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to the services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The team must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

(4) the person's freedom to accept or reject the recommendations of the team;

(5) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(6) the long-term care consultant's decision regarding the person's need for institutional level of care as determined under criteria established in section 144.0724, subdivision 11, or 256B.092; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more

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than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Transition to Consultation for housing with services.** (a) ~~Housing with services establishments offering or providing assisted living under chapter 144G shall inform all prospective residents of the availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident. The purpose of transitional long-term care consultation for registered housing with services is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation,~~ Prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) ~~Transitional consultation~~ Registered housing with services establishments shall inform all prospective residents of the availability of long-term care consultation and the need to receive and verify the consultation prior to signing a lease or contract. Long-term care consultation for registered housing with services are is provided as determined by the commissioner of human services in partnership with county long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. ~~The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation.~~ The service is delivered under a partnership between lead agencies as defined in subdivision 1a, paragraph (d), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

(1) ~~the consultation must be provided by a qualified professional as determined by the commissioner~~ shall be performed in a manner that provides objective and complete information;

(2) the consultation must include a review of the prospective resident's reasons for considering ~~assisted living housing with services,~~ the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or ~~assisted living housing with services~~ settings that may meet the prospective resident's needs; ~~and~~

(3) the prospective resident shall be informed of the availability of ~~long-term care consultation services described in subdivision 3a that are available~~ a face-to-face visit at no charge to the prospective resident to assist the prospective resident in assessment and

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planning to meet the prospective resident's long-term care needs. ~~The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals who are at highest risk of nursing facility placement or as needed for determining eligibility; and~~

(4) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

(c) Housing with services establishments registered under chapter 144D shall:

(1) inform all prospective residents of the availability of and contact information for consultation services under this subdivision;

(2) except for individuals seeking lease-only arrangements in subsidized housing settings, receive a copy of the verification of counseling prior to executing a lease or service contract with the prospective resident, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements; and

(3) retain a copy of the verification of counseling as part of the resident's file.

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

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to read:

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

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(c) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria ~~established~~ developed by the commissioner, and in section ~~144.0724, subdivision 11, and~~ 256B.092, using forms developed by the commissioner. Effective no sooner than on or after July 1, 2012, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4a, paragraph (d), but for the provision of services under the alternative care program. ~~Effective January 1, 2011, this determination must be made according to the criteria established in section 144.0724, subdivision 11;~~

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding \$500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or

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will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) only one dependency up to two dependencies in bathing, dressing, grooming, or walking, or (iii) a dependency score of less than three if eating is the only dependency and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed ~~\$600~~ \$593 per month for all new participants enrolled in the program on or after July 1, ~~2009~~ 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

- (i) the appointment of a representative payee;
- (ii) automatic payment from a financial account;
- (iii) the establishment of greater family involvement in the financial management of payments; or
- (iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

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(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 17. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waived services to an individual elderly waiver client except for individuals described in paragraph (b) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by ~~the greater of any legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment.

(b) The monthly limit for the cost of waived services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with:

(1) no dependencies in activities of daily living; or

(2) ~~only one dependency up to two dependencies~~ in bathing, dressing, grooming, or walking, or (3) ~~a dependency score of less than three if eating is the only dependency, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911~~

~~shall be the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A \$1,750 per month effective on October July 1, 2008 2011, per month for all new participants enrolled in the program on or after July 1, 2009 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).~~

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waived services exceeds the monthly limit established in paragraph (a) or

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(b), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a) or (b).

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waived services, a monthly conversion budget limit for the cost of elderly waived services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be based on the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident residents~~ in the nursing facility where the resident elderly waiver applicant currently resides ~~multiplied~~. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365 and, divided by 12, less and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion rate may budget limit shall be adjusted by the greater of any subsequent legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates annually as described in subdivision 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the ~~conversion rate limit is equal to the nursing facility rate per diem used to calculate the monthly conversion budget limit must be~~ reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waived services, including ~~extended medical~~ specialized supplies and equipment and environmental ~~modifications and accessibility~~ adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The

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lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

~~(f)~~ (f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in

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each recipient's customized living service plan. The lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

- (1) intermittent assistance with toileting, positioning, or transferring;
- (2) cognitive or behavioral issues;
- (3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after ~~January~~ July 1, 2011, and all other participants at their first reassessment after ~~January~~ July 1, 2011, dependency in at least ~~two~~ three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

- (1) licensed corporate adult foster homes; or

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(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h ~~for the contract period beginning October 1, 2009~~. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

Sec. 23. **[256B.097] STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.**

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans

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receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including traumatic brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

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

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of the commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

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(e) The commissioner shall seek a federal waiver by July 1, 2012 to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first two years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota; and

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

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(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

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(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types

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of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

**EFFECTIVE DATE.** (a) Subdivisions 1 to 6 are effective July 1, 2011.

(b) The jurisdictions of the regional quality councils in subdivision 4 must be defined, with implementation dates, by July 1, 2012. During the biennium beginning July 1, 2011, the Quality Assurance Commission shall continue to implement the alternative licensing system under this section.

Sec. 24. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning January October 1, 2011, participating local government governmental entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d) (e). Payments of the nonfederal share shall be made monthly submitted to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph (d). Payments for each month beginning in January 2011 through September 2015 shall be due by the 15th day of the following month prior to payment to the nursing facility for that month's services. If any provider participating governmental entity obligated to pay an amount under this subdivision is more than two months delinquent in the does not make timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a. shall revoke participation under this subdivision and end payments determined under section 256B.441, subdivision 55a, to the participating nursing facility effective on the first day of the month for which timely payment was not received. In the event of revocation, the nursing facility may not bill, collect, or retain the amount allowed in section 256B.441, subdivision 55a, from private-pay residents for days of service on or after the first day of the month following the month in which the revocation occurred.

Sec. 25. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to read:

Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

(b) For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the commissioner shall limit payment for leave days in a nursing facility to 60 percent of that nursing facility's total payment rate for the involved resident.

(c) For services rendered on or after July 1, 2011, for facilities reimbursed under this chapter, the commissioner shall limit payment for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident, and

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shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415.

Sec. 26. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003, for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Sec. 27. Minnesota Statutes 2010, section 256B.431, subdivision 32, is amended to read:

Subd. 32. **Payment during first ~~90~~ 30 days.** ~~(a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 paid days after admission shall be:~~

~~(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class;~~

~~(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class;~~

~~(3) beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and~~

~~(4) payments under this paragraph apply to admissions occurring on or after July 1, 2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.~~

~~(b)~~ For rate years beginning on or after July 1, ~~2003~~ 2011, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section shall be:

(1) for the first 30 calendar days after admission, the rate shall be 120 percent of the facility's medical assistance rate for each RUG class;

(2) beginning with the 31st calendar day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(3) payments under this paragraph apply to admissions occurring on or after July 1, ~~2003~~ 2011.

~~(c)~~ ~~Effective January 1, 2004,~~ (b) The enhanced rates under this subdivision shall not be allowed if a resident has resided during the previous 30 calendar days in:

(1) the same nursing facility;

(2) a nursing facility owned or operated by a related party; or

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(3) a nursing facility or part of a facility that closed or was in the process of closing.

Sec. 28. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, October 1, 2011, and October 1, 2012. ~~this paragraph shall apply only to the property-related payment rate; except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided.~~ For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

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(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 29. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

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(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(g) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(h) Beginning July 16, 2011, the commissioner shall no longer accept applications for planned closure rate adjustments under subdivision 3.

Sec. 30. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities. Effective January 1, 2012, resident reimbursement classifications shall be established according to the 48 group, resource utilization groups, RUG-IV model under section 144.0724.

Sec. 31. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid

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Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

Sec. 32. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

Sec. 33. Minnesota Statutes 2010, section 256B.438, is amended by adding a subdivision to read:

Subd. 8. **Rate determination upon transition to RUG-IV payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

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(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

Sec. 34. Minnesota Statutes 2010, section 256B.441, subdivision 50a, is amended to read:

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Sec. 35. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to read:

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Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between ~~January~~ October 1, 2011, and ~~September 30, 2015~~ the day before the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local ~~government~~ governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other ~~RUG's levels~~ RUGs shall be computed as provided under subdivision 54.

~~(b)~~ For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGs shall be computed under subdivision 54. The rate increase allowed in this paragraph shall take effect only upon federal approval.

~~(c)~~ Rates determined under this subdivision shall take effect beginning ~~January~~ October 1, 2011, based on cost reports for the ~~rate reporting~~ year ending September 30, ~~2009~~ 2010, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

~~(c)~~ (d) ~~Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by September 30, 2010. Participation under this subdivision is irrevocable. If paragraph (a) does not result in a rate greater than what would have been provided without application of this subdivision, a facility's rates shall be calculated as otherwise provided and no payment by the local government entity shall be required under paragraph (d)~~ August 31, 2011, or by June 30 of any subsequent year.

~~(d)~~ (e) ~~For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under ~~subdivision 54~~, paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.~~

~~(e)~~ (f) ~~The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.~~

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Sec. 36. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 61. **Rate increase for low-rate facilities.** Effective October 1, 2011, operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased for a resource utilization group rate with a weight of 1.00 by up to 2.45 percent, but not to exceed for the same resource utilization group weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's operating payment rate on the preceding September 30.

Sec. 37. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under ~~sections 144.0724, subdivision 11, and section 256B.0911~~; or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 39. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

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(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

**EFFECTIVE DATE.** Paragraph (f) is effective July 1, 2013.

Sec. 40. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waived services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist

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in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

~~(b)~~ (e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or traumatic brain injury waived services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing, unless provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), and the licensed capacity shall be reduced accordingly. If the adult foster home becomes no longer viable due to these transfers, the county agency, with the

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assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by June 30, 2012.

**EFFECTIVE DATE.** Paragraphs (b), (c), and (d) are effective July 1, 2013.

Sec. 41. Minnesota Statutes 2010, section 256B.49, is amended by adding a subdivision to read:

Subd. 23. **Community-living settings.** "Community-living settings" means a single-family home or apartment where the service recipient or their family owns or rents, as demonstrated by a lease agreement, and maintains control over the individual unit. Community-living settings are subject to the following:

- (1) individuals are not required to receive services;
- (2) individuals are not required to have a disability or specific diagnosis to live in the community-living setting;
- (3) individuals may hire service providers of their choice;
- (4) individuals may choose whether to share their household and with whom;
- (5) the home or apartment must include living, sleeping, bathing, and cooking areas;
- (6) individuals must have lockable access and egress;
- (7) individuals must be free to receive visitors and leave the settings at times and for durations of their own choosing;
- (8) leases must not reserve the right to assign units or change unit assignments; and
- (9) access to the greater community must be easily facilitated based on the individual's needs and preferences.

Sec. 42. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/DD rate increase.** Effective July 1, 2011, the commissioner shall increase the daily rate to \$138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

Sec. 43. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 10. **ICF/DD rate adjustment.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 44. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

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Subd. 11. **ICF/DD rate decrease effective July 1, 2011.** For each facility reimbursed under this section, the commissioner shall decrease operating payments equal to 1.5 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 45. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 12. **ICF/DD rate increase effective July 1, 2013.** For each facility reimbursed under this section, the commissioner shall increase operating payments equal to one-half percent of the operating payment rates in effect on June 30, 2013. For each facility, the commissioner shall apply the rate increase, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 46. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 13. **ICF/DD rate decrease effective July 1, 2012.** Notwithstanding subdivision 12, for each facility reimbursed under this section, the commissioner shall decrease operating payments equal to 1.67 percent of the operating payment rates in effect on June 30, 2012. For each facility, the commissioner shall apply the rate reduction based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

**EFFECTIVE DATE.** This section is effective July 1, 2012, if the federal approval required under section 52 has not been obtained by June 30, 2012.

Sec. 47. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 12, is amended to read:

**EFFECTIVE DATE.** The section is effective ~~July 1, 2011~~ on or after January 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21.

Sec. 48. Laws 2009, chapter 79, article 8, section 51, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 17, section 14, is amended to read:

**EFFECTIVE DATE.** This section is effective July 1, ~~2011~~ 2012, or upon federal approval, whichever is later.

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Sec. 49. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

**Subd. 8. Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

<b>(a) Aging and Adult Services Grants</b>	13,499,000	15,805,000
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**Base Adjustment.** The general fund base is increased by \$5,751,000 in fiscal year 2012 and \$6,705,000 in fiscal year 2013.

**Information and Assistance Reimbursement.** Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

**Community Service Development Grant Reduction.** Funding for community service development grants must be reduced by \$260,000 for fiscal year 2010; \$284,000 in fiscal year 2011; \$43,000 in fiscal year 2012; and \$43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

**Community Service Development Grant Community Initiative.** Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

**Senior Nutrition Use of Federal Funds.** For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by \$500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

<b>(b) Alternative Care Grants</b>	50,234,000	48,576,000
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**Base Adjustment.** The general fund base is decreased by \$3,598,000 in fiscal year 2012 and \$3,470,000 in fiscal year 2013.

**Alternative Care Transfer.** Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

**(c) Medical Assistance Grants; Long-Term Care Facilities.**

367,444,000                      419,749,000

**(d) Medical Assistance Long-Term Care Waivers and Home Care Grants**

853,567,000                      1,039,517,000

**Manage Growth in TBI and CADI Waivers.** During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

**Manage Growth in DD Waiver.** The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner

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from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

**Adjustment to Lead Agency Waiver Allocations.** Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

~~**Alternatives to Personal Care Assistance Services.** Base level funding of \$3,237,000 in fiscal year 2012 and \$4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.~~

**(e) Mental Health Grants**

Appropriations by Fund		
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

**Funding Usage.** Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

**(f) Deaf and Hard-of-Hearing Grants** 1,930,000 1,917,000

**(g) Chemical Dependency Entitlement Grants** 111,303,000 122,822,000

**Payments for Substance Abuse Treatment.** For placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

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(1) rates charged for these services on January 1, 2009; or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Rates for fiscal years 2010 and 2011 must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, the statewide aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the projected aggregate payment under the rates in effect for fiscal year 2011 excluding the rate reduction for rates that were below the average on January 1, 2009, plus a state share increase of \$3,787,000 for fiscal year 2012 and \$5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

**Chemical Dependency Special Revenue Account.** For fiscal year 2010, \$750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

**County CD Share of MA Costs for ARRA Compliance.** Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal

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share. This provision is effective the day following final enactment.

**(h) Chemical Dependency Nonentitlement Grants**

1,729,000 1,729,000

**(i) Other Continuing Care Grants**

19,201,000 17,528,000

**Base Adjustment.** The general fund base is increased by \$2,639,000 in fiscal year 2012 and increased by \$3,854,000 in fiscal year 2013.

**Technology Grants.** \$650,000 in fiscal year 2010 and \$1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

**Other Continuing Care Grants; HIV Grants.** Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

**Quality Assurance Commission.** Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

**Sec. 50. NURSING FACILITY PILOT PROJECT.**

Subdivision 1. Report. The commissioner of human services, in consultation with the commissioner of health, stakeholders, and experts, shall provide to the legislature recommendations by November 15, 2011, on how to develop a project to demonstrate a new approach to caring for certain individuals in nursing facilities.

Subd. 2. Contents of report. The recommendations shall address the:

(1) nature of the demonstration in terms of timing, size, qualifications to participate, participation selection criteria and postdemonstration options for the demonstration and for participating facilities;

(2) nature of needed new form of licensure;

(3) characteristics of the individuals the new model is intended to serve and comparison of these characteristics with those individuals served by existing models of care;

(4) quality standards for licensure addressing management, types and amounts of staffing, safety, infection control, care processes, quality improvement, and resident rights;

(5) characteristics of inspection process;

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- (6) funding for inspection process;
- (7) enforcement authorities;
- (8) role of Medicare;
- (9) participation in the elderly waiver program, including rate setting;
- (10) nature of any federal approval or waiver requirements and the method and timing of obtaining them;
- (11) consumer rights; and
- (12) methods and resources needed to evaluate the effectiveness of the model with regards to cost and quality.

Sec. 51. **PROVIDER RATE AND GRANT REDUCTIONS.**

(a) The commissioner of human services shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.5 percent effective July 1, 2011, through June 30, 2013, for services rendered on or after those dates. Beginning July 1, 2013, the commissioner of human services shall decrease grants, allocations, reimbursement rate individual limits, and rate limits, as applicable, by 1.0 percent for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501, except for corporate foster care and customized living services otherwise reduced in this article;

(2) home and community-based waived services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915, except for corporate foster care and customized living services otherwise reduced in this article;

(3) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49, except for corporate foster care and customized living services otherwise reduced in this article;

(4) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

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(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917 except for grants in subdivision 14, and 256B.0928;

(16) disability linkage line grants under Minnesota Statutes, section 256.01, subdivision 24;

(17) housing access grants under Minnesota Statutes, section 256B.0658;

(18) self-advocacy grants under Laws 2009, chapter 101; and

(19) technology grants under Laws 2009, chapter 79.

(c) Notwithstanding paragraph (b), clause (9), effective July 1, 2011, through June 30, 2013, payment rates shall be increased by one-half percent for day training and habilitation services under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, produced as a social service under Minnesota Statutes, section 256M.60.

(d) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a three percent reduction for the specified services for the period of January 1, 2012, through June 30, 2012, and a 1.5 percent reduction for those services on and after July 1, 2012. The commissioner of human services shall make adjustments as necessary and consistent with paragraph (a).

**Sec. 52. IMPLEMENT NURSING HOME LEVEL OF CARE CRITERIA.**

The commissioner shall seek any necessary federal approval in order to implement the changes to the level of care criteria in Minnesota Statutes, section 144.0724, subdivision 11, on July 1, 2012.

**Sec. 53. [256B.021] MEDICAL ASSISTANCE REFORM WAIVER.**

Subdivision 1. **Intent.** It is the intent of the legislature to reform components of the medical assistance program for seniors and people with disabilities or other complex needs, and medical assistance enrollees in general, in order to achieve better outcomes,

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such as community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs, including other state agencies' services.

Subd. 2. **Proposal.** The commissioner shall develop a proposal to the United States Department of Health and Human Services, which shall include any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, and any other federal authority that may be necessary for the projects specified in subdivision 4. The commissioner shall ensure all projects are budget neutral or result in savings to the state budget, considering cost changes across all divisions and other agencies that are affected.

Subd. 3. **Legislative proposals; rules.** The commissioner shall report to the members of the legislative committees having jurisdiction over human services issues by January 15, 2012, regarding the progress of this waiver, and make recommendations regarding any legislative changes necessary to accomplish the projects in subdivision 4.

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with Minnesota Statutes, sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under Minnesota Statutes, section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in Minnesota Statutes, section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, consistent with Minnesota Statutes, section 256L.17, subdivision 2, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with Minnesota Statutes, section 256B.056, subdivision 3c, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition

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but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

- (1) coordination with health care homes or health care coordinators;
- (2) assessment for wellness, housing needs, employment, planning, and goal setting;
- (3) training services;
- (4) job placement services;
- (5) career counseling;
- (6) benefit counseling;
- (7) worker supports and coaching;
- (8) assessment of workplace accommodations;
- (9) transitional housing services; and
- (10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

- (1) provide people less expensive alternatives to medical assistance services;
- (2) offer more flexible and updated community support services under the Medicaid state plan;
- (3) provide an individual budget and increased opportunity for self-direction;
- (4) strengthen family and caregiver support services;
- (5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;
- (6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;
- (7) target access to residential care for those with higher needs;
- (8) develop capacity within the community for crisis intervention and prevention;
- (9) redesign case management;
- (10) offer life planning services for families to plan for the future of their child with a disability;
- (11) enhance self-advocacy and life planning for people with disabilities;
- (12) improve information and assistance to inform long-term care decisions; and
- (13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels

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of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in Minnesota Statutes, section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

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(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

Subd. 5. **Federal funds.** The commissioner is authorized to accept and expend federal funds that support the purposes of this section.

**Sec. 54. CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

(a) Notwithstanding any other rate reduction in this article, the commissioner of human services shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2012, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease, and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waived services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

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(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a 2.34 percent reduction for the specified services for the period of January 1, 2013, through June 30, 2013, and a 1.67 percent reduction for those services on and after July 1, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

**EFFECTIVE DATE.** This section is effective July 1, 2012, if the federal approval required under section 52 has not been obtained by June 30, 2012.

**ARTICLE 8****CHEMICAL AND MENTAL HEALTH**

Section 1. Minnesota Statutes 2010, section 246B.10, is amended to read:

**246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county. A county's payment must be made from the county's own sources of revenue and payments must equal ~~ten~~ 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day, that the civilly committed sex offender spends at the facility. If payments received by the state under this chapter exceed ~~90~~ 75 percent of the cost of care, the county is responsible for paying the state the remaining amount. The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

**EFFECTIVE DATE.** This section is effective for all individuals who are civilly committed to the Minnesota sex offender program on or after August 1, 2011.

Sec. 2. Minnesota Statutes 2010, section 253B.212, is amended to read:

**253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS; WHITE EARTH BAND OF OJIBWE.**

Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake Band of Chippewa Indians.** The commissioner of human services may contract with

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and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the Red Lake Band of Chippewa Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service may not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

**Subd. 1a. Cost of care; commitment by tribal court order; White Earth Band of Ojibwe Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the White Earth Band of Ojibwe Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The tribe may also contract directly with the commissioner for treatment of those members of the White Earth Band who have been committed by tribal court order to the White Earth Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and the White Earth Band shall not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

**Subd. 2. Effect given to tribal commitment order.** When, under an agreement entered into pursuant to ~~subdivision 1~~ subdivisions 1 or 1a, the Indian Health Service applies to a regional center for admission of a person committed to the jurisdiction of the health service by the tribal court as a person who is mentally ill, developmentally disabled, or chemically dependent, the commissioner may treat the patient with the consent of the Indian Health Service.

A person admitted to a regional center pursuant to this section has all the rights accorded by section 253B.03. In addition, treatment reports, prepared in accordance with the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health Service within 60 days of commencement of the patient's stay at the facility. A subsequent treatment report shall be filed with the Indian Health Service within six months of the patient's admission to the facility or prior to discharge, whichever comes first. Provisional discharge or transfer of the patient may be authorized by the head of the treatment facility only with the consent of the Indian Health Service. Discharge from the facility to the Indian Health Service may be authorized by the head of the treatment facility after notice to and consultation with the Indian Health Service.

Sec. 3. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

**Subd. 4. Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~16.14~~ 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~16.14~~ 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of

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payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

**EFFECTIVE DATE.** This section is effective for claims processed beginning July 1, 2011.

Sec. 4. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision to read:

**Subd. 2a. Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, and recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

Sec. 5. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

**Subd. 2. Allocation of collections.** The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate ~~83.86~~ 77.05 percent of patient payments and third-party payments to the special revenue account and ~~16.14~~ 22.95 percent to the county financially responsible for the patient.

**EFFECTIVE DATE.** This section is effective for claims processed beginning July 1, 2011.

Sec. 6. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to read:

**Subd. 41. Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county or an American Indian tribe through a residential facility, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

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

Sec. 7. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to read:

**Subd. 4. Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in

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bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

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

**Sec. 8. COMMUNITY MENTAL HEALTH SERVICES; USE OF BEHAVIORAL HEALTH HOSPITALS.**

The commissioner shall issue a written report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by December 31, 2011, on how the community behavioral health hospital facilities will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The commissioner must consult with the regional planning work groups for adult mental health and must include the recommendations of the work groups in the legislative report. The report must address future use of community behavioral health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65 percent licensed bed occupancy rate, and using the facilities for another purpose that will meet the mental health needs of residents of the region. The regional planning work groups shall work with the commissioner to prioritize the needs of their regions. These priorities, by region, must be included in the commissioner's report to the legislature.

**Sec. 9. [245.4863] INTEGRATED DUAL DIAGNOSIS TREATMENT.**

(a) The commissioner shall require individuals who perform chemical dependency assessments or mental health diagnostic assessments to use screening tools approved by the commissioner in order to identify whether an individual who is the subject of the assessment screens positive for co-occurring mental health or chemical dependency disorders. Screening for co-occurring disorders must begin no later than December 31, 2011.

(b) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(c) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

**Sec. 10. REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.**

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The commissioner shall issue a report to the legislative committees with jurisdiction over health and human services finance no later than December 31, 2011, which provides the number of employees in management positions at the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital at St. Peter and the ratio of management to direct-care staff for each facility.

**ARTICLE 9****REDESIGNING SERVICE DELIVERY**

Section 1. Minnesota Statutes 2010, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 18 years of age who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

- (1) be one of the existing tribes with reservation land in Minnesota;
- (2) have a tribal court with jurisdiction over child custody proceedings;
- (3) have a substantial number of children for whom determinations of maltreatment have occurred;
- (4) have capacity to respond to reports of abuse and neglect under section 626.556;
- (5) provide a wide range of services to families in need of child welfare services; and
- (6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

- (1) assessment and prevention of child abuse and neglect;

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- (2) family preservation;
- (3) facilitative, supportive, and reunification services;
- (4) out-of-home placement for children removed from the home for child protective purposes; and
- (5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

- (1) the child must be receiving child protective services;
- (2) the child must be in foster care; or
- (3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal,

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definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 2. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a confirmation letter to the enrollee from the prepaid health plan that explains that the enrollee may change the request at any time;

(2) the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device if the materials contain enrollee data that is individually identifiable;

(3) the enrollee is provided a customer service number on the enrollee's membership card that may be called to request a paper version of the materials provided in an alternative format; and

(4) the materials provided in an alternative format meets all other requirements of the commissioner regarding content, size of the typeface, and any required time frames for distribution. "Required time frames for distribution" must permit sufficient time for prepaid health plans to distribute materials in alternative formats upon receipt of enrollees' requests for the materials.

(c) A prepaid health plan may provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. The commissioner or local agency, as applicable, shall inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. If the potential enrollee requests an alternative format of the prepaid health plan's primary care network list, a record of that request shall be retained by the commissioner or local agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary care network list to the commissioner and to local agencies within its service area to accommodate potential enrollee requests for paper versions of the primary care network list.

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(d) A prepaid health plan may provide in an alternative format materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions of paragraphs (b), (c), and (e), are met for persons who are eligible for enrollment in managed care.

(e) The commissioner shall seek any federal Medicaid waivers within 90 days after the effective date of this subdivision that are necessary to provide alternative formats of required material to enrollees of prepaid health plans as authorized under this subdivision.

(f) The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to determine how materials required to be made available to enrollees under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with a prepaid health plan may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

Sec. 3. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than \$35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(f) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

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Sec. 4. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of nursing homes, regional treatment centers, and licensed residential facilities with negotiated rates shall not have overpayments recovered from their personal needs allowance.

Sec. 5. Minnesota Statutes 2010, section 256J.38, subdivision 1, is amended to read:

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

- (1) reconstruct each affected budget month and corresponding payment month;
- (2) use the policies and procedures that were in effect for the payment month; and

(3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Sec. 6. Minnesota Statutes 2010, section 393.07, subdivision 10, is amended to read:

Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local social services agency shall establish and administer the food stamp program according to rules of the commissioner of human services, the supervision of the commissioner as specified in section 256.01, and all federal laws and regulations. The commissioner of human services shall monitor food stamp program delivery on an ongoing basis to ensure that each county complies with federal laws and regulations. Program requirements to be monitored include, but are not limited to, number of applications, number of approvals,

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number of cases pending, length of time required to process each application and deliver benefits, number of applicants eligible for expedited issuance, length of time required to process and deliver expedited issuance, number of terminations and reasons for terminations, client profiles by age, household composition and income level and sources, and the use of phone certification and home visits. The commissioner shall determine the county-by-county and statewide participation rate.

(b) On July 1 of each year, the commissioner of human services shall determine a statewide and county-by-county food stamp program participation rate. The commissioner may designate a different agency to administer the food stamp program in a county if the agency administering the program fails to increase the food stamp program participation rate among families or eligible individuals, or comply with all federal laws and regulations governing the food stamp program. The commissioner shall review agency performance annually to determine compliance with this paragraph.

(c) A person who commits any of the following acts has violated section 256.98 or 609.821, or both, and is subject to both the criminal and civil penalties provided under those sections:

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willful statement or misrepresentation, or intentional concealment of a material fact, food stamps or vouchers issued according to sections 145.891 to 145.897 to which the person is not entitled or in an amount greater than that to which that person is entitled or which specify nutritional supplements to which that person is not entitled; or

(2) presents or causes to be presented, coupons or vouchers issued according to sections 145.891 to 145.897 for payment or redemption knowing them to have been received, transferred or used in a manner contrary to existing state or federal law; or

(3) willfully uses, possesses, or transfers food stamp coupons, authorization to purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner contrary to existing state or federal law, rules, or regulations; or

(4) buys or sells food stamp coupons, authorization to purchase cards, other assistance transaction devices, vouchers issued according to sections 145.891 to 145.897, or any food obtained through the redemption of vouchers issued according to sections 145.891 to 145.897 for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps, authorization to purchase cards, or other assistance transaction devices found in the possession of any person who is neither a recipient of the food stamp program nor otherwise authorized to possess and use such materials. Confiscated property shall be disposed of as the commissioner may direct and consistent with state and federal food stamp law. The confiscated property must be retained for a period of not less than 30 days to allow any affected person to appeal the confiscation under section 256.045.

~~(e) Food stamp overpayment claims which are due in whole or in part to client error shall be established by the county agency for a period of six years from the date of any resultant overpayment. Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.~~

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(f) With regard to the federal tax revenue offset program only, recovery incentives authorized by the federal food and consumer service shall be retained at the rate of 50 percent by the state agency and 50 percent by the certifying county agency.

(g) A peace officer, welfare fraud investigator, federal law enforcement official, or the commissioner of health may confiscate vouchers found in the possession of any person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise authorized to possess and use such vouchers. Confiscated property shall be disposed of as the commissioner of health may direct and consistent with state and federal law. The confiscated property must be retained for a period of not less than 30 days.

(h) The commissioner of human services may seek a waiver from the United States Department of Agriculture to allow the state to specify foods that may and may not be purchased in Minnesota with benefits funded by the federal Food Stamp Program. The commissioner shall consult with the members of the house of representatives and senate policy committees having jurisdiction over food support issues in developing the waiver. The commissioner, in consultation with the commissioners of health and education, shall develop a broad public health policy related to improved nutrition and health status. The commissioner must seek legislative approval prior to implementing the waiver.

Sec. 7. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

Subd. 4. **Essential human services or essential services.** "Essential human services" or "essential services" means assistance and services to recipients or potential recipients of public welfare and other services delivered by counties or tribes that are mandated in federal and state law that are to be available in all counties of the state.

Sec. 8. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

Subd. 5. **Service delivery authority.** "Service delivery authority" means a single county, or group consortium of counties operating by execution of a joint powers agreement under section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of the county board of commissioners to participate in the redesign under this chapter or has been assigned by the commissioner pursuant to section 402A.18. A service delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen by resolution of tribal government to participate in redesign under this chapter.

Sec. 9. Minnesota Statutes 2010, section 402A.15, is amended to read:

**402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME REFORMS.**

Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome Reforms shall develop a uniform process to establish and review performance and outcome standards for all essential human services based on the current level of resources available, and ~~to~~ shall develop appropriate reporting measures and a uniform accountability process for responding to a county's or ~~human~~ service delivery authority's failure to make adequate progress on achieving performance measures. The accountability process shall focus on the performance measures rather than inflexible implementation requirements.

(b) The steering committee shall:

(1) by November 1, 2009, establish an agreed-upon list of essential services;

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(2) by February 15, 2010, develop and recommend to the legislature a uniform, graduated process, in addition to the remedies identified in section 402A.18, for responding to a county's failure to make adequate progress on achieving performance measures; and

(3) by December 15, 2012, for each essential service, make recommendations to the legislature regarding ~~(1)~~ (i) performance measures and goals based on those measures for each essential service, ~~(2)~~ and (ii) a system for reporting on the performance measures and goals, and ~~(3) appropriate resources, including funding, needed to achieve those performance measures and goals.~~ ~~The resource recommendations shall take into consideration program demand and the unique differences of local areas in geography and the populations served. Priority shall be given to services with the greatest variation in availability and greatest administrative demands.~~ By January 15 of each year starting January 15, 2011, the steering committee shall report its recommendations to the governor and legislative committees with jurisdiction over health and human services. As part of its report, the steering committee shall, as appropriate, recommend statutory provisions, rules and requirements, and reports that should be repealed or eliminated.

(c) As far as possible, the performance measures, reporting system, and funding shall be consistent across program areas. The development of performance measures shall consider the manner in which data will be collected and performance will be reported. The steering committee shall consider state and local administrative costs related to collecting data and reporting outcomes when developing performance measures. ~~The steering committee shall correlate the performance measures and goals to available levels of resources, including state and local funding. The steering committee shall also identify and incorporate federal performance measures in its recommendations for those program areas where federal funding is contingent on meeting federal performance standards.~~ The steering committee shall take into consideration that the goal of implementing changes to program monitoring and reporting the progress toward achieving outcomes is to significantly minimize the cost of administrative requirements and to allow funds freed by reduced administrative expenditures to be used to provide additional services, allow flexibility in service design and management, and focus energies on achieving program and client outcomes.

(d) In making its recommendations, the steering committee shall consider input from the council established in section 402A.20. ~~The steering committee shall review the measurable goals established in a memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied as statewide performance outcomes.~~

(e) The steering committee shall form work groups that include persons who provide or receive essential services and representatives of organizations who advocate on behalf of those persons.

(f) By December 15, 2009, the steering committee shall establish a three-year schedule for completion of its work. The schedule shall be published on the Department of Human Services Web site and reported to the legislative committees with jurisdiction over health and human services. In addition, the commissioner shall post quarterly updates on the progress of the steering committee on the Department of Human Services Web site.

Subd. 2. **Composition.** (a) The steering committee shall include:

(1) the commissioner of human services, or designee, and two additional representatives of the department;

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(2) two county commissioners, representative of rural and urban counties, selected by the Association of Minnesota Counties;

(3) two county directors of human services, representative of rural and urban counties, selected by the Minnesota Association of County Social Service Administrators; and

(4) three clients or client advocates representing different populations receiving services from the Department of Human Services, who are appointed by the commissioner.

(b) The commissioner, or designee, and a county commissioner shall serve as cochairs of the committee. The committee shall be convened within 60 days of May 15, 2009.

(c) State agency staff shall serve as informational resources and staff to the steering committee. Statewide county associations may assemble county program data as required.

~~(d) To promote information sharing and coordination between the steering committee and council, one of the county representatives from paragraph (a), clause (2), and one of the county representatives from paragraph (a), clause (3), must also serve as a representative on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).~~

Sec. 10. Minnesota Statutes 2010, section 402A.18, is amended to read:

**402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET PERFORMANCE OUTCOMES.**

Subdivision 1. **Underperforming county; specific service.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for a specific essential service, the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential service to the commissioner.

Subd. 2. **Underperforming county; more than one-half of ~~service~~ services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for more than one-half of the defined essential service services, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of ~~the specific~~ essential service services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall

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not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of ~~the specific~~ essential ~~service~~ services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of ~~the specific~~ essential ~~service~~ services to the commissioner.

Subd. 2a. **Financial responsibility of underperforming county.** A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the essential service or essential services the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:

(1) the county or service delivery authority determined by the commissioner to be deficient in achieving minimum performance outcomes has the opportunity, in coordination with the council, to develop a program outcome improvement plan. The program outcome improvement plan must be developed no later than six months from the date of the deficiency determination; and

(2) the council has conducted an assessment of the program outcome improvement plan to determine if the county or service delivery authority has made satisfactory progress toward performance outcomes and has made a recommendation about remedies to the commissioner. The review assessment and recommendation must be made to the commissioner within 12 months from the date of the deficiency determination.

Sec. 11. Minnesota Statutes 2010, section 402A.20, is amended to read:

**402A.20 COUNCIL.**

Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service Delivery Redesign Council is established. Appointed council members must be appointed by their respective agencies, associations, or governmental units by November 1, 2009. The council shall be cochaired by the commissioner of human services, or designee, and a county representative from paragraph (b), clause (4) or (5), appointed by the Association of Minnesota Counties. Recommendations of the council must be approved by a majority of the voting council members. The provisions of section 15.059 do not apply to this council, and this council does not expire.

(b) The council must consist of the following members:

(1) two legislators appointed by the speaker of the house, one from the minority and one from the majority;

(2) two legislators appointed by the Senate Rules Committee, one from the majority and one from the minority;

(3) the commissioner of human services, or designee, and three employees from the department;

(4) two county commissioners appointed by the Association of Minnesota Counties;

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(5) two county representatives appointed by the Minnesota Association of County Social Service Administrators;

(6) one representative appointed by AFSCME as a nonvoting member; and

(7) one representative appointed by the Teamsters as a nonvoting member.

(c) Administrative support to the council may be provided by the Association of Minnesota Counties and affiliates.

(d) Member agencies and associations are responsible for initial and subsequent appointments to the council.

Subd. 2. **Council duties.** The council shall:

(1) provide review of the service delivery redesign process, including proposed memoranda of understanding to establish a service delivery authority to conduct and administer experimental projects to test new methods and procedures of delivering services;

~~(2) certify, in accordance with section 402A.30, subdivision 4, the formation of a service delivery authority, including the memorandum of understanding in section 402A.30, subdivision 2, paragraph (b);~~

~~(3) ensure the consistency of the memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), with the performance standards recommended by the steering committee and enacted by the legislature;~~

~~(4)~~ (2) ensure the consistency of the memorandum of understanding, to the extent appropriate, with other memorandum of understanding entered into by other service delivery authorities;

(3) review and make recommendations on applications from a service delivery authority for waivers of statutory or rule program requirements that are needed for flexibility to determine the most cost-effective means of achieving specified measurable goals in a redesign of human services delivery;

~~(5)~~ (4) establish a process to take public input on the service delivery framework specified in the memorandum of understanding in section 402A.30, subdivision 2, paragraph (b) scope of essential services over which a service delivery authority has jurisdiction;

~~(6)~~ (5) form work groups as necessary to carry out the duties of the council under the redesign;

~~(7)~~ (6) serve as a forum for resolving conflicts among participating counties and tribes or between participating counties or tribes and the commissioner of human services, provided nothing in this section is intended to create a formal binding legal process;

~~(8)~~ (7) engage in the program improvement process established in section 402A.18, subdivision 3; and

~~(9)~~ (8) identify and recommend incentives for counties and tribes to participate in human services service delivery authorities.

Subd. 3. **Program evaluation.** By December 15, 2014, the council shall request consideration by the legislative auditor for a reevaluation under section 3.971, subdivision

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7, of those aspects of the program evaluation of human services administration reported in January 2007 affected by this chapter.

Sec. 12. [402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.

Subdivision 1. Requirements for establishing a service delivery authority.

(a) A county, tribe, or consortium of counties is eligible to establish a service delivery authority if:

(1) the county, tribe, or consortium of counties is:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more;

(iii) a consortium of four or more counties in reasonable geographic proximity without regard to population; or

(iv) one or more tribes with a total combined population of 25,000 or more.

The council may recommend that the commissioner of human services exempt a single county, tribe, or consortium of counties from the minimum population standard if the county, tribe, or consortium of counties can demonstrate that it can otherwise meet the requirements of this chapter.

(b) A service delivery authority shall:

(1) comply with current state and federal law, including any existing federal or state performance measures and performance measures under section 402A.15 when they are enacted into law, except where waivers are approved by the commissioner. Nothing in this subdivision requires the establishment of performance measures under section 402A.15 prior to a service delivery authority participating in the service delivery redesign under this chapter;

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of those services included in a proposal for a redesigned service or services and identify a single administrative agent for purposes of contact and communication with the department;

(4) identify the waivers from statutory or rule program requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals that the participating service delivery authority is expected to achieve;

(5) set forth a reasonable level of targeted reductions in overhead and administrative costs for each service delivery authority participating in the service delivery redesign;

(6) set forth the terms under which a county, tribe, or consortium of counties may withdraw from participation. In the case of withdrawal of any or all parties or the dissolution of the service delivery authority, the employees shall continue to be represented by the same exclusive representative or representatives and continue to be covered by the same collective bargaining union agreement until a new agreement is negotiated or the collective bargaining agreement term ends; and

(7) set forth a structure for managing the terms and conditions of employment of the employees as provided in section 402A.40.

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(c) Once a county, tribe, or consortium of counties establishes a service delivery authority, no county, tribe, or consortium of counties that is a member of the service delivery authority may participate as a member of any other service delivery authority. The service delivery authority may allow an additional county, a tribe, or a consortium of counties to join the service delivery authority subject to the approval of the council and the commissioner.

(d) Nothing in this chapter precludes local governments from using sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Nothing in this chapter limits the authority of a county board or tribal council to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Subd. 2. **Relief from statutory requirements.** (a) Unless otherwise identified in the memorandum of understanding, any county, tribe, or consortium of counties forming a service delivery authority is exempt from the provisions of sections 245.465; 245.4835; 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph (b); and 256M.30.

(b) This subdivision does not preclude any county, tribe, or consortium of counties forming a service delivery authority from requesting additional waivers from statutory and rule requirements to ensure greater local control and flexibility.

Subd. 3. **Duties.** The service delivery authority shall:

(1) within the scope of essential services set forth in the memorandum of understanding establishing the authority, carry out the responsibilities required of local agencies under chapter 393 and human services boards under chapter 402;

(2) manage the public resources devoted to human services and other public services delivered or purchased by the counties or tribes that are subsidized or regulated by the Department of Human Services under chapters 245 to 261;

(3) employ staff to assist in carrying out its duties;

(4) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human services functions in the event of any business interruption according to local, state, and federal emergency planning requirements;

(5) receive and expend funds received for the redesign process under the memorandum of understanding;

(6) plan and deliver services directly or through contract with other governmental, tribal, or nongovernmental providers;

(7) rent, purchase, sell, and otherwise dispose of real and personal property as necessary to carry out the redesign; and

(8) carry out any other service designated as a responsibility of a county.

Subd. 4. **Process for establishing a service delivery authority.** (a) The county, tribe, or consortium of counties meeting the requirements of section 402A.30 and proposing to establish a service delivery authority shall present to the council:

(1) in conjunction with the commissioner, a proposed memorandum of understanding meeting the requirements of subdivision 1, paragraph (b), and outlining;

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(i) the details of the proposal;

(ii) the state, tribal, and local resources, which may include, but are not limited to, funding, administrative and technology support, and other requirements necessary for the service delivery authority; and

(iii) the relief available to the service delivery authority if the resource commitments identified in item (ii) are not met; and

(2) a board resolution from the board of commissioners of each participating county stating the county's intent to participate, or in the case of a tribe, a resolution from tribal government, stating the tribe's intent to participate.

(b) After the council has considered and recommended approval of a proposed memorandum of understanding, the commissioner may finalize and execute the memorandum of understanding.

Subd. 5. **Commissioner authority to seek waivers.** The commissioner may use the authority under section 256.01, subdivision 2, paragraph (1), to grant waivers identified as part of a proposed service delivery authority under subdivision 1, paragraph (b), clause (4), except that waivers granted under this section must be approved by the council under section 402A.20 rather than the Legislative Advisory Committee.

**Sec. 13. [402A.40] TRANSITION TO NEW BARGAINING UNIT STRUCTURE.**

Subdivision 1. **Application of section.** Notwithstanding the provisions of section 179A.12 or any other law, this section governs, where contrary to other law, the initial certification and decertification, if any, of exclusive representatives for service delivery authorities. Employees of a service delivery authority are public employees under section 179A.03, subdivision 14. Service delivery authorities are public employers under section 179A.03, subdivision 15.

Subd. 2. **Existing majority.** The commissioner of the Minnesota Bureau of Mediation Services shall certify an employee organization for employees of a service delivery authority as exclusive representative for an appropriate unit upon a petition filed with the commissioner by the organization demonstrating that the petitioner is certified pursuant to section 179A.12 as the exclusive representative of a majority of the employees included within the unit as of that date. Two or more employee organizations that represent the employees in a unit may petition jointly under this subdivision, provided that any organization may withdraw from a joint certification in favor of the remaining organizations on 30 days' notice to the remaining organizations, the employer, and the commissioner, without affecting the rights and obligations of the remaining organizations or the employer. The commissioner shall make a determination on a timely petition within 45 days of its receipt.

Subd. 3. **No existing majority.** (a) If no exclusive representative is certified under subdivision 2, the commissioner shall certify an employee organization as exclusive representative for an appropriate unit established upon a petition filed by the organization within the time period provided in subdivision 2 demonstrating that the petitioner is certified under section 179A.12 as the exclusive representative of fewer than a majority of the employees included within the unit if no other employee organization so certified has filed a petition within the time period provided in subdivision 2 and a majority of the employees in the unit are represented by employee organizations under section 179A.12 on the date of the petition. Two or more employee organizations, each of which represents

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employees included in the unit may petition jointly under this paragraph, provided that any organization may withdraw from a joint certification in favor of the remaining organizations on 30 days' notice to the remaining organizations, the employer, and the commissioner without affecting the rights and obligations of the remaining organizations or the employer. The commissioner shall make a determination on a timely petition within 45 days of its receipt.

(b) If no exclusive representative is certified under paragraph (a) or subdivision 2, and an employee organization petitions the commissioner within 90 days of the creation of the service delivery authority demonstrating that a majority of the employees included within an appropriate unit wish to be represented by the petitioner, where this majority is evidenced by current dues deduction rights, signed statements from employees in counties within the service delivery authority that are not currently represented by any employee organization plainly indicating that the signatories wish to be represented for collective bargaining purposes by the petitioner rather than by any other organization, or a combination of those, the commissioner shall certify the petitioner as exclusive representative of the employees in the unit. The commissioner shall make a determination on a timely petition within 45 days of its receipt.

(c) If no exclusive representative is certified under paragraph (a) or (b) or subdivision 2, and an employee organization petitions the commissioner subsequent to the creation of the service delivery authority demonstrating that at least 30 percent of the employees included within an appropriate unit wish to be represented by the petitioner, where this 30 percent is evidenced by current dues deduction rights, signed statements from employees in counties within the service delivery authority that are not currently represented by any employee organization plainly indicating that the signatories wish to be represented for collective bargaining purposes by the petitioner rather than by any other organization, or a combination of those, the commissioner shall conduct a secret ballot election to determine the wishes of the majority. The election must be conducted within 45 days of receipt or final decision on any petitions filed pursuant to subdivision 2, whichever is later. The election is governed by section 179A.12, where not inconsistent with other provisions of this section.

Subd. 4. **Decertification.** The commissioner may not consider a petition for decertification of an exclusive representative certified under this section for one year after certification, unless section 179A.20, subdivision 6, applies.

Subd. 5. **Continuing contract.** (a) The terms and conditions of collective bargaining agreements covering the employees of service delivery authorities remain in effect until a successor agreement becomes effective or, if no employee organization petitions to represent the employees of the service delivery authority, until six months after the establishment of the service delivery authority.

(b) Any accrued leave, including but not limited to sick leave, vacation time, compensatory leave or paid time off, or severance pay benefits accumulated under policies of the previously employing county or a collective bargaining agreement between the previously employing county and an exclusive representative shall continue to apply in the newly created service delivery authority for the employees of the previously employing county. An employee who was eligible for the benefits of the Family and Medical Leave Act at the previously employing county shall continue to be eligible at the newly created service delivery authority.

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(c) If it is necessary, prior to the negotiation of a new collective bargaining agreement, to lay off an employee of a service delivery authority and if two or more employees previously performed the work, seniority based on continuous length of service with a service delivery authority member county shall be the determining factor in determining which qualified employee shall be offered the job by the service delivery authority. An employee whose work is being transferred to the service delivery authority shall have the option of being laid off.

Subd. 6. **Contract and representation responsibilities.** (a) The exclusive representatives of units of employees certified prior to the creation of the service delivery authority remain responsible for administration of their contracts and for other contractual duties and have the right to dues and fair share fee deduction and other contractual privileges and rights until a contract is agreed upon with the service delivery authority. Exclusive representatives of service delivery authority employees certified after the creation of the service delivery authority are immediately upon certification responsible for bargaining on behalf of employees within the unit. They are also responsible for administering grievances arising under previous contracts covering employees included within the unit that remain unresolved upon agreement with the service delivery authority on a contract. Where the employer does not object, these responsibilities may be varied by agreement between the outgoing and incoming exclusive representatives. All other rights and duties of representation begin upon the creation of a service delivery authority, except that exclusive representatives certified upon or after the creation of the service delivery authority shall immediately, upon certification, have the right to all employer information and all forms of access to employees within the bargaining unit which would be permitted to the current contract holder, including the rights in section 179A.07, subdivision 6. This section does not affect an existing collective bargaining contract. Incoming exclusive representatives are immediately, upon certification, responsible for bargaining on behalf of all previously unrepresented employees assigned to their units.

(b) Nothing in this section prevents an exclusive representative certified after the effective dates of these provisions from assessing fair share or dues deductions immediately upon certification if the employees were unrepresented for collective bargaining purposes before that certification.

**Sec. 14. COUNTY ELECTRONIC VERIFICATION PROCEDURES.**

The commissioner of human services shall define which public assistance program requirements may be electronically verified for the purposes of determining eligibility, and shall also define procedures for electronic verification. The commissioner of human services shall report back to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2012, with draft legislation to implement the procedures if legislation is necessary for purposes of implementation.

**Sec. 15. ALIGNMENT OF PROGRAM POLICY AND PROCEDURES.**

The commissioner of human services, in consultation with counties and other key stakeholders, shall analyze and develop recommendations to align program policy and procedures across all public assistance programs to simplify and streamline program eligibility and access. The commissioner shall report back to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2013, with draft legislation to implement the recommendations.

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Sec. 16. ALTERNATIVE STRATEGIES FOR CERTAIN REDETERMINATIONS.

The commissioner of human services shall develop and implement by July 15, 2012, a simplified process to redetermine eligibility for recipient populations in the medical assistance, Minnesota supplemental aid, food support, and group residential housing programs who are eligible based upon disability or age, and who are expected to experience minimal change in income or assets from month to month. The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 17. SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT PROCESS.

(a) The commissioner of human services shall issue a request for information for an integrated service delivery system for health care programs, food support, cash assistance, and child care. The commissioner shall determine, in consultation with partners in paragraph (c), if the products meet departments' and counties' functions. The request for information may incorporate a performance-based vendor financing option in which the vendor shares the risk of the project's success. The health care system must be developed in phases with the capacity to integrate food support, cash assistance, and child care programs as funds are available. The request for information must require that the system:

(1) streamline eligibility determinations and case processing to support statewide eligibility processing;

(2) enable interested persons to determine eligibility for each program, and to apply for programs online in a manner that the applicant will be asked only those questions relevant to the programs for which the person is applying;

(3) leverage technology that has been operational in other state environments with similar requirements; and

(4) include Web-based application, worker application processing support, and the opportunity for expansion.

(b) The commissioner shall issue a final report, including the implementation plan, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services no later than January 31, 2012.

(c) The commissioner shall partner with counties, a service delivery authority established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology, other state agencies, and service partners to develop an integrated service delivery framework, which will simplify and streamline human services eligibility and enrollment processes. The primary objectives for the simplification effort include significantly improved eligibility processing productivity resulting in reduced time for eligibility determination and enrollment, increased customer service for applicants and recipients of services, increased program integrity, and greater administrative flexibility.

(d) The commissioner, along with a county representative appointed by the Association of Minnesota Counties, shall report specific implementation progress to the legislature annually beginning May 15, 2012.

(e) The commissioner shall work with the Minnesota Association of County Social Service Administrators and the Office of Enterprise Technology to develop collaborative task forces, as necessary, to support implementation of the service delivery components

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under this paragraph. The commissioner must evaluate, develop, and include as part of the integrated eligibility and enrollment service delivery framework, the following minimum components:

(1) screening tools for applicants to determine potential eligibility as part of an online application process;

(2) the capacity to use databases to electronically verify application and renewal data as required by law;

(3) online accounts accessible by applicants and enrollees;

(4) an interactive voice response system, available statewide, that provides case information for applicants, enrollees, and authorized third parties;

(5) an electronic document management system that provides electronic transfer of all documents required for eligibility and enrollment processes; and

(6) a centralized customer contact center that applicants, enrollees, and authorized third parties can use statewide to receive program information, application assistance, and case information, report changes, make cost-sharing payments, and conduct other eligibility and enrollment transactions.

(f) Subject to a legislative appropriation, the commissioner of human services shall issue a request for proposal for the appropriate phase of an integrated service delivery system for health care programs, food support, cash assistance, and child care.

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

Sec. 18. **WHITE EARTH BAND OF OJIBWE HUMAN SERVICES PROJECT.**

(a) The commissioner of human services, in consultation with the White Earth Band of Ojibwe, shall transfer legal responsibility to the tribe for providing human services to tribal members and their families who reside on or off the reservation in Mahnomen County. The transfer shall include:

(1) financing, including federal and state funds, grants, and foundation funds; and

(2) services to eligible tribal members and families defined as it applies to state programs being transferred to the tribe.

(b) The determination as to which programs will be transferred to the tribe and the timing of the transfer of the programs shall be made by a consensus decision of the governing body of the tribe and the commissioner. The commissioner shall waive existing rules and seek all federal approvals and waivers as needed to carry out the transfer.

(c) When the commissioner approves transfer of programs and the tribe assumes responsibility under this section, Mahnomen County is relieved of responsibility for providing program services to tribal members and their families who live on or off the reservation while the tribal project is in effect and funded, except that a family member who is not a White Earth member may choose to receive services through the tribe or the county. The commissioner shall have authority to redirect funds provided to Mahnomen County for these services, including administrative expenses, to the White Earth Band of Ojibwe Indians.

(d) Upon the successful transfer of legal responsibility for providing human services for tribal members and their families who reside on and off the reservation in Mahnomen

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County, the commissioner and the White Earth Band of Ojibwe shall develop a plan to transfer legal responsibility for providing human services for tribal members and their families who reside on or off reservation in Clearwater and Becker Counties.

(e) No later than January 15, 2012, the commissioner shall submit a written report detailing the transfer progress to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. If legislation is needed to fully complete the transfer of legal responsibility for providing human services, the commissioner shall submit proposed legislation along with the written report.

Sec. 19. **REPEALER.**

(a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.

(b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

**ARTICLE 10****HEALTH AND HUMAN SERVICES APPROPRIATIONS**Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	<b><u>2012</u></b>		<b><u>2013</u></b>		<b><u>Total</u></b>
<u>General</u>	\$ 5,734,374,000	\$	5,661,437,000	\$	11,395,811,000
<u>State Government Special Revenue</u>	66,851,000		66,769,000		133,620,000
<u>Health Care Access</u>	356,381,000		362,595,000		718,976,000
<u>Federal TANF</u>	277,091,000		279,814,000		556,905,000
<u>Lottery Prize</u>	1,665,000		1,665,000		3,330,000
<u>Special Revenue</u>	500,000		1,000,000		1,500,000
<b><u>Total</u></b>	<b>\$ 6,436,862,000</b>	<b>\$</b>	<b>6,373,280,000</b>	<b>\$</b>	<b>12,810,142,000</b>

Sec. 2. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal year 2013. "The biennium" is fiscal years 2012 and 2013.



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

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

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

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

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

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

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall assure that the maintenance of effort used by the commissioner of management and budget

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for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2015.

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

**Working Family Credit Expenditures to be Claimed for TANF/MOE.** The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

- (1) fiscal year 2012, \$23,692,000;
- (2) fiscal year 2013, \$44,969,000;
- (3) fiscal year 2014, \$32,579,000; and
- (4) fiscal year 2015, \$32,476,000.

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

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

- (1) fiscal year 2012, \$10,020,000;
- (2) fiscal year 2013, \$28,020,000;
- (3) fiscal year 2014, \$14,020,000; and
- (4) fiscal year 2015, \$14,020,000.

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

**Food Stamps Employment and Training Funds.** (a) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement for child care assistance program expenditures must be deposited in the general fund. The amount of funds must be limited to \$500,000 per year in fiscal years 2012 through 2015, contingent upon

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approval by the federal Food and Nutrition Service.

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

**ARRA Food Support Benefit Increases.**  
The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

**Supplemental Security Interim Assistance Reimbursement Funds.** \$2,800,000 of uncommitted revenue available to the commissioner of human services for SSI advocacy and outreach services must be transferred to and deposited into the general fund by October 1, 2011.

**Subd. 2. Central Office Operations**

The amounts that may be spent from this appropriation for each purpose are as follows:

**(a) Operations**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>78,621,000</u>	<u>77,551,000</u>
<u>Health Care Access</u>	<u>11,508,000</u>	<u>11,508,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>3,440,000</u>	<u>3,440,000</u>
<u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>

**DHS Receipt Center Accounting.** The commissioner is authorized to transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

**Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an

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alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

**Payments for Cost Settlements.** The commissioner is authorized to use amounts repaid to the general assistance medical care program under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, to pay cost settlements for claims for services provided prior to June 1, 2010. Notwithstanding any contrary provision in this article, this provision does not expire.

**Base Adjustment.** The general fund base for fiscal year 2014 shall be increased by \$75,000 and decreased by \$14,000 in fiscal year 2015.

**Human Services Licensing Activities.** \$3,000,000 each year of the biennium is appropriated from the state government special revenue fund to the commissioner for human services licensing activities under Minnesota Statutes, chapter 245A.

**Streamlined Eligibility Determination System for Minnesota Health Care Programs.** Of this appropriation, \$900,000 in fiscal year 2012 and \$1,600,000 in fiscal year 2013 are for transfer to the state systems account authorized in Minnesota Statutes, section 256.014, for the development and implementation of a streamlined eligibility determination system for Minnesota health care programs. This streamlined eligibility determination system will: enhance customer service for applicants and enrollees;

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incorporate eligibility changes in a timely manner; and promote ongoing program integrity.

**Child Support Cost Recovery Fees.** The commissioner shall transfer nonfederal share fee revenue of \$31,000 in fiscal year 2012 only to the PRISM special revenue account to offset PRISM system costs of increasing the child support cost recovery fees.

**(b) Children and Families**

Appropriations by Fund

<u>General</u>	<u>9,452,000</u>	<u>9,337,000</u>
<u>Federal TANF</u>	<u>2,160,000</u>	<u>2,160,000</u>

**Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to \$310,000 each year in fiscal years 2012 and 2013 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

**Base Adjustment.** The general fund base is decreased by \$47,000 in fiscal years 2014 and 2015.

**(c) Health Care**

Appropriations by Fund

<u>General</u>	<u>16,551,000</u>	<u>16,538,000</u>
<u>Health Care Access</u>	<u>22,941,000</u>	<u>23,563,000</u>

**Minnesota Senior Health Options Reimbursement.** Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

**Utilization Review.** Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review

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organization shall be dedicated to the commissioner for these purposes. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

**Base Adjustment.** The general fund base shall be decreased by \$2,000 in fiscal year 2014 and \$114,000 in fiscal year 2015.

The health care access fund base is increased by \$142,000 in fiscal year 2014 and \$16,000 in fiscal year 2015.

**(d) Continuing Care**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>17,873,000</u>	<u>17,769,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

**Region 10 Administrative Expenses.** \$100,000 is appropriated each fiscal year, beginning in fiscal year 2012, for the administration of the State Quality Improvement and Licensing System under Minnesota Statutes, section 256B.097.

**Base Adjustment.** The general fund base is decreased by \$257,000 in fiscal year 2014 and \$254,000 in fiscal year 2015.

**(e) Chemical and Mental Health**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>4,194,000</u>	<u>4,194,000</u>
<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>

**Subd. 3. Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

**(a) MFIP/DWP Grants**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>84,680,000</u>	<u>91,978,000</u>
<u>Federal TANF</u>	<u>84,425,000</u>	<u>75,417,000</u>

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<b><u>(b) MFIP Child Care Assistance Grants</u></b>	<u>55,456,000</u>	<u>30,923,000</u>
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<b><u>(c) General Assistance Grants</u></b>	<u>49,192,000</u>	<u>46,938,000</u>
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**General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at \$203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

**Emergency General Assistance.** The amount appropriated for emergency general assistance funds is limited to no more than \$6,689,812 in fiscal year 2012 and \$6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

<b><u>(d) Minnesota Supplemental Aid Grants</u></b>	<u>38,095,000</u>	<u>39,120,000</u>
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<b><u>(e) Group Residential Housing Grants</u></b>	<u>121,080,000</u>	<u>129,238,000</u>
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<b><u>(f) MinnesotaCare Grants</u></b>	<u>295,046,000</u>	<u>317,272,000</u>
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This appropriation is from the health care access fund.

<b><u>(g) Medical Assistance Grants</u></b>	<u>4,501,582,000</u>	<u>4,437,282,000</u>
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**Managed Care Incentive Payments.** The commissioner shall not make managed care incentive payments for expanding preventive services during fiscal years beginning July 1, 2011, and July 1, 2012.

**Reduction of Rates for Congregate Living for Individuals with Lower Needs.** Beginning October 1, 2011, lead agencies must reduce rates in effect on January 1, 2011, by ten percent for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living

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settings for CADI. Lead agencies must adjust contracts within 60 days of the effective date.

**Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs.** Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI.

**Reduce customized living and 24-hour customized living component rates.** Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

**Limit Growth in the Developmental Disability Waiver.** The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the

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priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

**Limit Growth in the Community Alternatives for Disabled Individuals Waiver.**

The commissioner shall limit growth in the community alternatives for disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section 256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

**Personal Care Assistance Relative Care.**

The commissioner shall adjust the capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11.

**(h) Alternative Care Grants**

46,421,000

46,035,000

**Alternative Care Transfer.** Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

**(i) Chemical Dependency Entitlement Grants**

94,675,000

93,298,000

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**Subd. 4. Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

**(a) Support Services Grants**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
<u>Federal TANF</u>	<u>100,525,000</u>	<u>94,611,000</u>

**MFIP Consolidated Fund Grants.** The TANF fund base is reduced by \$10,000,000 each year beginning in fiscal year 2012.

**Subsidized Employment Funding Through ARRA.** The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar year quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

**(b) Basic Sliding Fee Child Care Assistance Grants**37,144,00038,678,000

**Base Adjustment.** The general fund base is decreased by \$990,000 in fiscal year 2014 and \$979,000 in fiscal year 2015.

**Child Care and Development Fund Unexpended Balance.** In addition to the amount provided in this section, the commissioner shall expend \$5,000,000 in fiscal year 2012 from the federal child care and development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child

care and development funds are expended according to the federal child care and development fund regulations.

**(c) Child Care Development Grants** 774,000 774,000

**Base Adjustment.** The general fund base is increased by \$713,000 in fiscal years 2014 and 2015.

**(d) Child Support Enforcement Grants** 50,000 50,000

**Federal Child Support Demonstration Grants.** Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under section 1115a of the Social Security Act is appropriated to the commissioner for this activity.

**(e) Children's Services Grants**

<u>Appropriations by Fund</u>		
<u>General</u>	<u>47,949,000</u>	<u>48,507,000</u>
<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

**Adoption Assistance and Relative Custody Assistance Transfer.** The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

**Privatized Adoption Grants.** Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

**Adoption Assistance Incentive Grants.** Federal funds available during fiscal year 2012 and fiscal year 2013 for adoption incentive grants are appropriated to the commissioner for these purposes.

**(f) Children and Community Services Grants** 53,301,000 53,301,000

**(g) Children and Economic Support Grants**

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Appropriations by Fund

<u>General</u>	<u>16,103,000</u>	<u>16,180,000</u>
<u>Federal TANF</u>	<u>700,000</u>	<u>0</u>

**Long-Term Homeless Services.** \$700,000 is appropriated from the federal TANF fund for the biennium beginning July 1, 2011, to the commissioner of human services for long-term homeless services for low-income homeless families under Minnesota Statutes, section 256K.26. This is a onetime appropriation and is not added to the base.

**Base Adjustment.** The general fund base is increased by \$42,000 in fiscal year 2014 and \$43,000 in fiscal year 2015.

**Minnesota Food Assistance Program.** \$333,000 in fiscal year 2012 and \$408,000 in fiscal year 2013 are to increase the general fund base for the Minnesota food assistance program. Unexpended funds for fiscal year 2012 do not cancel but are available to the commissioner for this purpose in fiscal year 2013.

**(h) Health Care Grants**Appropriations by Fund

<u>General</u>	<u>26,000</u>	<u>66,000</u>
<u>Health Care Access</u>	<u>190,000</u>	<u>190,000</u>

**Base Adjustment.** The general fund base is increased by \$24,000 in each of fiscal years 2014 and 2015.

**(i) Aging and Adult Services Grants** 12,154,000 11,456,000

**Aging Grants Reduction.** Effective July 1, 2011, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by \$3,600,000 for each year of the biennium. These reductions are onetime and do not affect base funding for the 2014-2015 biennium. Grants made during the 2012-2013 biennium under Minnesota Statutes, section

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256B.9754, must not be used for new construction or building renovation.

**Essential Community Support Grant**

**Delay.** Upon federal approval to implement the nursing facility level of care on July 1, 2013, essential community supports grants under Minnesota Statutes, section 256B.0917, subdivision 14, are reduced by \$6,410,000 in fiscal year 2013. Base level funding is increased by \$5,541,000 in fiscal year 2014 and \$6,410,000 in fiscal year 2015.

**Base Level Adjustment.** The general fund base is increased by \$10,035,000 in fiscal year 2014 and increased by \$10,901,000 in fiscal year 2015.

<b><u>(j) Deaf and Hard-of-Hearing Grants</u></b>	<u>1,936,000</u>	<u>1,767,000</u>
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<b><u>(k) Disabilities Grants</u></b>	<u>15,945,000</u>	<u>18,284,000</u>
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**Grants for Housing Access Services.** In fiscal year 2012, the commissioner shall make available a total of \$161,000 in housing access services grants to individuals who relocate from an adult foster care home to a community living setting for assistance with completion of rental applications or lease agreements; assistance with publicly financed housing options; development of household budgets; and assistance with funding affordable furnishings and related household matters.

**HIV Grants.** The general fund appropriation for the HIV drug and insurance grant program shall be reduced by \$2,425,000 in fiscal year 2012 and increased by \$2,425,000 in fiscal year 2014. These adjustments are onetime and shall not be applied to the base. Notwithstanding any contrary provision, this provision expires June 30, 2014.

**Region 10.** Of this appropriation, \$100,000 each year is for a grant provided under Minnesota Statutes, section 256B.097.

**Base Level Adjustment.** The general fund base is increased by \$2,944,000 in fiscal year 2014 and \$653,000 in fiscal year 2015.

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**Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs.** The commissioner shall make available a total of \$250,000 per year in local planning grants, beginning July 1, 2011, to assist lead agencies and provider organizations in developing alternatives to congregate living within the available level of resources for the home and community-based services waivers for persons with disabilities.

**Disability Linkage Line.** Of this appropriation, \$125,000 in fiscal year 2012 and \$300,000 in fiscal year 2013 are for assistance to people with disabilities who are considering enrolling in managed care.

**(l) Adult Mental Health Grants**Appropriations by Fund

<u>General</u>	<u>70,570,000</u>	<u>70,570,000</u>
<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
<u>Lottery Prize</u>	<u>1,508,000</u>	<u>1,508,000</u>

**Funding Usage.** Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

**Base Adjustment.** The general fund base is increased by \$200,000 in fiscal years 2014 and 2015.

**(m) Children's Mental Health Grants**16,457,00016,457,000

**Funding Usage.** Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

**Base Adjustment.** The general fund base is increased by \$225,000 in fiscal years 2014 and 2015.

**(n) Chemical Dependency Nonentitlement Grants**1,336,0001,336,000

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**Subd. 5. State-Operated Services**

**Transfer Authority Related to State-Operated Services.** Money appropriated for state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

**(a) State-Operated Services Mental Health**Appropriations by Fund

<u>General</u>	<u>117,407,000</u>	<u>115,135,000</u>
<u>Special Revenue</u>	<u>500,000</u>	<u>1,000,000</u>

**Utilization of State-Operated Services Account.** Up to \$599,000 of the funds available in miscellaneous accounts associated with closed regional treatment centers shall transfer to the state-operated services account established under Minnesota Statutes, section 246.18, subdivision 8. By June 30, 2013, \$3,200,000 must be transferred from this account to the general fund.

**State-Operated Services Mental Health Housing and Other Supports.** \$500,000 in fiscal year 2012 and \$1,000,000 in fiscal year 2013 are appropriated from the account established under Minnesota Statutes, section 246.18, subdivision 8, for housing and other supports for persons with mental illness and other complex conditions. These appropriations are onetime. For the 2014-2015 biennium, base level funding for this activity is \$1,000,000 each year from the general fund. Notwithstanding any contrary provision in this article, this paragraph expires June 30, 2015.

**Community Behavioral Health Hospital-Willmar.** The commissioner shall not close the Community Behavioral Health Hospital-Willmar before March 31, 2012.

**Base Adjustment.** The general fund base is increased by \$1,000,000 in each of fiscal years 2014 and 2015.

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<b><u>(b) Minnesota Security Hospital</u></b>	<b><u>69,582,000</u></b>	<b><u>69,582,000</u></b>
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<b><u>Subd. 6. Sex Offender Program</u></b>	<b><u>70,416,000</u></b>	<b><u>73,412,000</u></b>
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**Transfer Authority Related to Minnesota Sex Offender Program.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

<b><u>Subd. 7. Technical Activities</u></b>	<b><u>77,206,000</u></b>	<b><u>95,551,000</u></b>
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This appropriation is from the federal TANF fund.

**Base Level Adjustment.** The TANF fund base is decreased by \$13,643,000 in fiscal year 2014 and decreased by \$13,216,000 in fiscal year 2015.

#### Sec. 4. **COMMISSIONER OF HEALTH**

<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$</u></b>	<b><u>154,797,000</u></b>	<b><u>\$</u></b>	<b><u>138,481,000</u></b>
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##### Appropriations by Fund

	<u>2012</u>	<u>2013</u>
<u>General</u>	<u>71,451,000</u>	<u>71,780,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>45,687,000</u>	<u>45,676,000</u>
<u>Health Care Access</u>	<u>25,946,000</u>	<u>9,312,000</u>
<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

The amounts that may be spent for each purpose are specified in the following subdivisions.

#### **Subd. 2. Community and Family Health Promotion**

##### Appropriations by Fund

<u>General</u>	<u>45,577,000</u>	<u>46,030,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>

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<u>Health Care Access</u>	<u>16,719,000</u>	<u>1,719,000</u>
<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

**TANF Appropriations.** (1) \$1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) \$3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) \$2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) \$4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. \$4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. \$978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

**TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

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**Statewide Health Improvement Program.**

(a) \$15,000,000 in the biennium ending June 30, 2013, is appropriated from the health care access fund for the statewide health improvement program and is available until expended. Notwithstanding Minnesota Statutes, sections 144.396, and 145.928, the commissioner may use tobacco prevention grant funding and grant funding under Minnesota Statutes, section 145.928, to support the statewide health improvement program. The commissioner may focus the program geographically or on a specific goal of tobacco use reduction or on reducing obesity. By February 15, 2013, the commissioner shall report to the chairs of the health and human services committee on progress toward meeting the goals of the program as outlined in Minnesota Statutes, section 145.986, and estimate the dollar value of the reduced health care costs for both public and private payers.

(b) By February 15, 2012, the commissioner shall develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health maintenance organizations collaboration plans. The implementation plan shall include an advisory board to determine priority needs for health improvement in reducing obesity and tobacco use in Minnesota and to review and approve hospital community benefit activities reported under Minnesota Statutes, section 144.699, and health maintenance organizations collaboration plans in Minnesota Statutes, section 62Q.075. The commissioner shall consult with hospital and health maintenance organizations in creating and implementing the plan. The plan described in this paragraph shall be implemented by July 1, 2012.

(c) The commissioners of Minnesota management and budget, human services, and health shall include in each forecast beginning February of 2013 a report that identifies an estimated dollar value of the health care savings in the state health care

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programs that are directly attributable to the strategies funded from the statewide health improvement program. The report shall include a description of methodologies and assumptions used to calculate the estimate.

**Funding Usage.** Up to 75 percent of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program and up to 75 percent of the fiscal year 2013 appropriation may be used for calendar year 2012 allocations. The fiscal year 2014 base shall be increased by \$5,193,000.

**Base Level Adjustment.** The general fund base is increased by \$5,188,000 in fiscal year 2014 and decreased by \$5,000 in 2015.

**Subd. 3. Policy Quality and Compliance**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>9,704,000</u>	<u>9,532,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>14,026,000</u>	<u>14,083,000</u>
<u>Health Care Access</u>	<u>9,227,000</u>	<u>7,593,000</u>

**Medical Education and Research Costs (MERC) Fund Transfers.** The commissioner of management and budget shall transfer \$9,800,000 from the MERC fund to the general fund by October 1, 2011.

**White Earth Urban Clinic Needs Assessment.** \$100,000 is appropriated in fiscal year 2012 from the general fund for a needs assessment for a health clinic or other health care needs of the White Earth Tribe in the Twin Cities metropolitan area. The results of this assessment shall be reported to the legislature by February 15, 2012.

**Comprehensive Advanced Life Support.** Of the general fund appropriation, \$31,000 each year is added to the base of the comprehensive advanced life support (CALs) program under Minnesota Statutes, section 144.6062.

**Unused Federal Match Funds.** Of the funds appropriated in Laws 2009, chapter

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79, article 13, section 4, subdivision 3, for state matching funds for the federal Health Information Technology for Economic and Clinical Health Act, \$2,800,000 is transferred to the health care access fund by October 1, 2011.

**Administrative Reports.** Of the general fund appropriation, \$82,000 in fiscal year 2012 and \$10,000 in fiscal year 2013 are for transfer to the commissioner of management and budget for the reduction of the administrative report study.

**Base Level Adjustment.** The state government special revenue fund base shall be reduced by \$141,000 in fiscal years 2014 and 2015. The health care access base shall be increased by \$1,900,000 in fiscal year 2014 and by \$1,300,000 in fiscal year 2015.

**Subd. 4. Health Protection**

	<u>Appropriations by Fund</u>	
<u>General</u>	<u>9,370,000</u>	<u>9,370,000</u>
<u>State Government</u>		
<u>Special Revenue</u>	<u>30,628,000</u>	<u>30,560,000</u>

**Subd. 5. Administrative Support Services** 6,800,000 6,848,000

**Sec. 5. COUNCIL ON DISABILITY** \$ 524,000 \$ 524,000

**Sec. 6. OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** \$ 1,655,000 \$ 1,655,000

Funds appropriated for fiscal year 2011 are available until expended.

**Sec. 7. OMBUDSPERSON FOR FAMILIES** \$ 265,000 \$ 265,000

**Sec. 8. HEALTH-RELATED BOARDS**

**Subdivision 1. Total Appropriation** \$ 17,599,000 \$ 17,528,000

This appropriation is from the state government special revenue fund. The

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amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners** 469,000 469,000

Subd. 3. **Board of Dentistry** 1,829,000 1,814,000

**Health Professional Services Program.** Of this appropriation, \$704,000 in fiscal year 2012 and \$704,000 in fiscal year 2013 from the state government special revenue fund are for the health professional services program.

Subd. 4. **Board of Dietetic and Nutrition Practice** 110,000 110,000

Subd. 5. **Board of Marriage and Family Therapy** 192,000 167,000

**Rulemaking.** Of this appropriation, \$25,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Subd. 6. **Board of Medical Practice** 3,866,000 3,866,000

Subd. 7. **Board of Nursing** 3,545,000 3,545,000

Subd. 8. **Board of Nursing Home Administrators** 2,153,000 2,145,000

**Rulemaking.** Of this appropriation, \$44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

**Electronic Licensing System Adaptors.** Of this appropriation, \$761,000 in fiscal year 2013 from the state government special revenue fund is to the administrative services unit to cover the costs to connect to the e-licensing system. Minnesota Statutes, section 16E.22. Base level funding for this activity in fiscal year 2014 shall be \$100,000. Base level funding for this activity in fiscal year 2015 shall be \$50,000.

**Development and Implementation of a Disciplinary, Regulatory, Licensing and Information Management System.** Of this appropriation, \$800,000 in fiscal year 2012 and \$300,000 in fiscal year 2013 are for the

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development of a shared system. Base level funding for this activity in fiscal year 2014 shall be \$50,000.

**Administrative Services Unit - Operating Costs.** Of this appropriation, \$526,000 in fiscal year 2012 and \$526,000 in fiscal year 2013 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

**Administrative Services Unit - Retirement Costs.** Of this appropriation in fiscal year 2012, \$225,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

**Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, \$150,000 in fiscal year 2012 and \$150,000 in fiscal year 2013 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

**Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, \$200,000 in fiscal year 2012 and \$200,000 in fiscal year 2013 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

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**Base Adjustment.** The State Government Special Revenue Fund base is decreased by \$911,000 in fiscal year 2014 and \$1,011,000 in fiscal year 2015.

Subd. 9. <b><u>Board of Optometry</u></b>	<u>106,000</u>	<u>106,000</u>
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Subd. 10. <b><u>Board of Pharmacy</u></b>	<u>2,341,000</u>	<u>2,344,000</u>
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**Prescription Electronic Reporting.** Of this appropriation, \$356,000 in fiscal year 2012 and \$356,000 in fiscal year 2013 from the state government special revenue fund are to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126. Base level funding for this activity in fiscal year 2014 shall be \$356,000.

Subd. 11. <b><u>Board of Physical Therapy</u></b>	<u>389,000</u>	<u>345,000</u>
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**Rulemaking.** Of this appropriation, \$44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Subd. 12. <b><u>Board of Podiatry</u></b>	<u>75,000</u>	<u>75,000</u>
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Subd. 13. <b><u>Board of Psychology</u></b>	<u>846,000</u>	<u>846,000</u>
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Subd. 14. <b><u>Board of Social Work</u></b>	<u>1,036,000</u>	<u>1,053,000</u>
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Subd. 15. <b><u>Board of Veterinary Medicine</u></b>	<u>228,000</u>	<u>229,000</u>
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Subd. 16. <b><u>Board of Behavioral Health and Therapy</u></b>	<u>414,000</u>	<u>414,000</u>
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Sec. 9. <b><u>EMERGENCY MEDICAL SERVICES REGULATORY BOARD</u></b>	<u>\$ 2,742,000</u>	<u>\$ 2,742,000</u>
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**Regional Grants.** \$585,000 in fiscal year 2012 and \$585,000 in fiscal year 2013 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions. Notwithstanding Minnesota Statutes, section 144E.50, 100 percent of the appropriation shall be granted to the emergency medical service regions.

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**Cooper/Sams Volunteer Ambulance Program.** \$700,000 in fiscal year 2012 and \$700,000 in fiscal year 2013 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(a) Of this amount, \$611,000 in fiscal year 2012 and \$611,000 in fiscal year 2013 are for the ambulance service personnel longevity award and incentive program, under Minnesota Statutes, section 144E.40.

(b) Of this amount, \$89,000 in fiscal year 2012 and \$89,000 in fiscal year 2013 are for the operations of the ambulance service personnel longevity award and incentive program, under Minnesota Statutes, section 144E.40.

**Ambulance Training Grant.** \$361,000 in fiscal year 2012 and \$361,000 in fiscal year 2013 are for training grants.

**EMSRB Board Operations.** \$1,096,000 in fiscal year 2012 and \$1,096,000 in fiscal year 2013 are for operations.

Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; and

(2) reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6, is amended to read:

**Subd. 6. Continuing Care Grants**

(a) **Aging and Adult Services Grants** (3,600,000) (3,600,000)

**Community Service/Service Development Grants Reduction.** Effective retroactively from July 1, 2009, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by \$5,807,000 for each year of the biennium.

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Grants made during the biennium under Minnesota Statutes, section 256.9754, shall not be used for new construction or building renovation.

**Aging Grants Delay.** Aging grants must be reduced by \$917,000 in fiscal year 2011 and increased by \$917,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

**(b) Medical Assistance Long-Term Care Facilities Grants**

(3,827,000)

(2,745,000)

**ICF/MR Variable Rates Suspension.** Effective retroactively from July 1, 2009, to June 30, 2010, no new variable rates shall be authorized for intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, section 256B.5013, subdivision 1.

**ICF/MR Occupancy Rate Adjustment Suspension.** Effective retroactively from July 1, 2009, to June 30, 2011, approval of new applications for occupancy rate adjustments for unoccupied short-term beds under Minnesota Statutes, section 256B.5013, subdivision 7, is suspended.

**(c) Medical Assistance Long-Term Care Waivers and Home Care Grants**

(2,318,000)

(5,807,000)

**Developmental Disability Waiver Acuity Factor.** Effective retroactively from January 1, 2010, the January 1, 2010, one percent growth factor in the developmental disability waiver allocations under Minnesota Statutes, section 256B.092, subdivisions 4 and 5, that is attributable to changes in acuity, is suspended to June 30, 2011 eliminated. Notwithstanding any law to the contrary, this provision does not expire.

**(d) Adult Mental Health Grants**

(5,000,000)

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**(e) Chemical Dependency Entitlement Grants**

(3,622,000)

(3,622,000)

## 2011 First Special Session

**(f) Chemical Dependency Nonentitlement Grants**

(393,000) (393,000)

**(g) Other Continuing Care Grants**-0- ~~(2,500,000)~~  
(1,414,000)**Other Continuing Care Grants Delay.**

Other continuing care grants must be reduced by \$1,414,000 in fiscal year 2011 and increased by \$1,414,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

**(h) Deaf and Hard-of-Hearing Grants**-0- (169,000)**Deaf and Hard-of-Hearing Grants Delay.**

Effective retroactively from July 1, 2010, deaf and hard-of-hearing grants must be reduced by \$169,000 in fiscal year 2011 and increased by \$169,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

**Sec. 12. TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, and after notification of the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2013, within fiscal years among the MFIP; general assistance; general assistance medical care under Minnesota Statutes, section 256D.03, subdivision 3; medical assistance; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid; MinnesotaCare, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee quarterly about transfers made under this provision.

**Sec. 13. DONATIONS TO STATE.**

A donation to the state from a health maintenance organization to reduce the projected state budget deficit for the fiscal year 2012-2013 biennium shall qualify as an authorized expense of a health maintenance organization under Minnesota Statutes, section 62D.12, subdivision 9a, clause (4), and shall be deposited in the general fund.

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**Sec. 14. FEDERAL MATCHING FUNDS; NONHOSPITAL-BASED GOVERNMENTAL HEALTH CENTERS.**

The commissioner of human services shall apply for federal matching funds to be deposited in the general fund as a nondedicated revenue based on Minnesota Statutes, section 256B.198, until the requirements of Minnesota Statutes, section 256B.198, paragraph (c), are met.

**Sec. 15. INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

**Sec. 16. EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

**ARTICLE 11****EFFECTIVE DATES****Section 1. EFFECTIVE DATE; RELATIONSHIP TO OTHER APPROPRIATIONS.**

Unless another effective date is specified, this act is effective retroactively from July 1, 2011, and supersedes and replaces funding authorized by order of the Second Judicial District Court in Case No. 62-CV-11-5203.

Presented to the governor July 20, 2011

Signed by the governor July 20, 2011, 9:10 a.m.