

**CHAPTER 247—H.F.No. 2294**

*An act relating to state government; making adjustments to health and human services appropriations; making changes to provisions related to health care, the Department of Health, children and family services, continuing care, background studies, chemical dependency, and child support; requiring reporting of potential welfare fraud; providing for data sharing; requiring eligibility determinations; providing rulemaking authority; providing penalties; encouraging the University of Minnesota to request funding for rural primary care training; requiring studies and reports; providing appointments; appropriating money; amending Minnesota Statutes 2010, sections 62A.047; 62J.496, subdivision 2; 62Q.80; 72A.201, subdivision 8; 144.292, subdivision 6; 144.298, subdivision 2; 144.5509; 144A.073, by adding a subdivision; 144A.351; 144D.04, subdivision 2; 145.906; 245.697, subdivision 1; 245A.03, by adding a subdivision; 245A.11, subdivisions 2a, 7, 7a; 245B.07, subdivision 1; 245C.04, subdivision 6; 245C.05, subdivision 7; 252.27, subdivision 2a; 254A.19, by adding a subdivision; 256.01, by adding subdivisions; 256.975, subdivision 7; 256.9831, subdivision 2; 256B.056, subdivision 1a; 256B.0625, subdivision 28a, by adding subdivisions; 256B.0659, by adding a subdivision; 256B.0751, by adding a subdivision; 256B.0911, by adding subdivisions; 256B.092, subdivisions 1b, 7; 256B.0943, subdivision 9; 256B.431, subdivision 17e, by adding a subdivision; 256B.434, subdivision 10; 256B.441, by adding a subdivision; 256B.48, by adding a subdivision; 256B.69, subdivision 9, by adding subdivisions; 256D.06, subdivision 1b; 256D.44, subdivision 5; 256E.37, subdivision 1; 256I.05, subdivision 1e; 256J.26, subdivision 1, by adding a subdivision; 256J.575, subdivisions 1, 2, 5, 6, 8; 256L.07, subdivision 3; 518A.40, subdivision 4; 626.556, by adding a subdivision; Minnesota Statutes 2011 Supplement, sections 62E.14, subdivision 4g; 119B.13, subdivision 7; 144.1222, subdivision 5; 245A.03, subdivision 7; 256.987, subdivisions 1, 2, by adding subdivisions; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivision 38; 256B.0631, subdivision 1; 256B.0659, subdivision 11; 256B.0911, subdivisions 3a, 3c; 256B.0915, subdivisions 3e, 3h; 256B.097, subdivision 3; 256B.49, subdivisions 14, 15, 23; 256B.5012, subdivision 13; 256B.69, subdivision 5a; 256B.76, subdivision 4; 256E.35, subdivisions 5, 6; 256I.05, subdivision 1a; 256L.03, subdivision 5; 256L.031, subdivisions 2, 3, 6; 256L.12, subdivision 9; Laws 2010, chapter 374, section 1; Laws 2011, First Special Session chapter 9, article 7, sections 52; 54; article 10, sections 3, subdivisions 1, 3, 4; 8, subdivision 8; proposing coding for new law in Minnesota Statutes, chapters 144; 145; 256B; 626; repealing Minnesota Statutes 2010, sections 62M.09, subdivision 9; 62Q.64; 144A.073, subdivision 9; 256B.48, subdivision 6; Minnesota Rules, parts 4640.0800, subpart 4; 4685.2000.*

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

**ARTICLE 1****HEALTH CARE**

Section 1. Minnesota Statutes 2011 Supplement, section 62E.14, subdivision 4g, is amended 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. The six-month durational residency requirement specified in section 62E.02, subdivision 13, does not apply to individuals enrolled in the healthy Minnesota contribution program.

Sec. 2. Minnesota Statutes 2010, section 72A.201, subdivision 8, is amended to read:

Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial;

(iii) the claim number and the policy number of the insured; and

(iv) if the denied claim is a fire claim, the insured's right to file with the Department of Commerce a complaint regarding the denial, and the address and telephone number of the Department of Commerce;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made;

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency

reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must be filed at the same time its annual statement is submitted under section 60A.13. ~~The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.~~

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

Sec. 3. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.**  
(a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) the development of, and periodic updates to, a policy manual for nonemergency medical transportation services;

(2) policies and a funding source for reimbursing no-load miles;

(3) policies to prevent waste, fraud, and abuse, and to improve the efficiency of the nonemergency medical transportation system;

(4) other issues identified in the 2011 evaluation report by the Office of the Legislative Auditor on medical nonemergency transportation; and

(5) other aspects of the nonemergency medical transportation system, as requested by the commissioner.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2014.

Sec. 4. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) two voting members who represent counties, at least one of whom must represent a county or counties other than Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright;

(2) four voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) four voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees; and

(7) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

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

Subd. 18e. **Single administrative structure and delivery system.** (a) The commissioner shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning July 1, 2013. The single administrative structure and delivery system must:

(1) eliminate the distinction between access transportation services and special transportation services;

(2) enable all medical assistance recipients to follow the same process to obtain nonemergency medical transportation, regardless of their level of need;

(3) provide a single oversight framework for all providers of nonemergency medical transportation; and

(4) provide flexibility in service delivery, recognizing that clients fall along a continuum of needs and resources.

(b) The commissioner shall present to the legislature, by January 15, 2013, any draft legislation necessary to implement the single administrative structure and delivery system for nonemergency medical transportation.

(c) In developing the single administrative structure and delivery system and the draft legislation, the commissioner shall consult with the Nonemergency Medical Transportation Advisory Committee.

Sec. 6. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18f. **Enrollee assessment process.** (a) The commissioner, in consultation with the Nonemergency Medical Transportation Advisory Committee, shall develop and implement, by July 1, 2013, a comprehensive, statewide, standard assessment process for medical assistance enrollees seeking nonemergency medical transportation services. The assessment process must identify a client's level of needs, abilities, and resources, and match the client with the mode of transportation in the client's service area that best meets those needs.

(b) The assessment process must:

(1) address mental health diagnoses when determining the most appropriate mode of transportation;

(2) base decisions on clearly defined criteria that are available to clients, providers, and counties;

(3) be standardized across the state and be aligned with other similar existing processes;

(4) allow for extended periods of eligibility for certain types of nonemergency transportation, when a client's condition is unlikely to change; and

(5) increase the use of public transportation when appropriate and cost-effective, including offering monthly bus passes to clients.

Sec. 7. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18g. **Use of standardized measures.** The commissioner, in consultation with the Nonemergency Medical Transportation Advisory Committee, shall establish performance measures to assess the cost-effectiveness and quality of nonemergency medical transportation. At a minimum, performance measures should include the number of unique participants served by type of transportation provider, number of trips provided by type of transportation provider, and cost per trip by type of transportation provider. The commissioner must also consider the measures identified in the January 2012 Department of Human Services report to the legislature on nonemergency medical transportation. Beginning in calendar year 2013, the commissioner shall collect, audit, and analyze performance data on nonemergency medical transportation annually and report this information on the agency's Web site. The commissioner shall periodically supplement this information with the results of consumer surveys of the quality of services, and shall make these survey findings available to the public on the agency Web site.

Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, consistent with

their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy, diagnostic assessments, or providing clinical supervision.

Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.

Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after 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) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to \$20 upon federal approval;

(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

(6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans

and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (5), from individuals and allow long-term care and waived service providers to assume responsibility for payment.

**EFFECTIVE DATE.** Paragraph (c) is effective January 1, 2012. Paragraph (d) is effective July 1, 2012.

Sec. 11. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 9. **Pediatric care coordination.** The commissioner shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner shall, to the extent possible, use the existing health care home certification and payment structure established under this section and section 256B.0753.

Sec. 12. Minnesota Statutes 2011 Supplement, 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. Clinical or utilization performance targets and their related criteria must consider

evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, 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. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent 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 in programs described in subdivisions 23 and 28, compared to the previous ~~calendar~~ measurement year until the final performance target is reached. When measuring

performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 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 target amount.

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 medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(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 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 in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 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 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 in programs described in subdivisions 23 and 28, 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 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 that the targeted amount.

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 in programs described in subdivisions 23 and 28, 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.

(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.

(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.

(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.

(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.

(p) The return of the withhold under paragraphs (d), (f), and (j) to (m) is not subject to the requirements of paragraph (c).

Sec. 13. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

(c) Each demonstration provider shall report to the commissioner on the extent to which providers employed by or under contract with the demonstration provider use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the demonstration provider to encourage their use.

Sec. 14. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9d. **Financial audit.** (a) The legislative auditor shall contract with an audit firm to conduct a biennial independent third-party financial audit of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the audit firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy, if available. The contract shall require the audit to include a determination of compliance with the federal Medicaid rate certification process. The contract shall require the audit to determine if the administrative expenses and investment income reported by the managed care plans and county-based purchasing plans are compliant with state and federal law.

(b) For purposes of this subdivision, "independent third-party" means an audit firm that is independent in accordance with government auditing standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. An audit firm under contract to provide services in accordance with this subdivision must not have provided services to a managed care plan or county-based purchasing plan during the period for which the audit is being conducted.

(c) The commissioner shall require in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audit of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692, must provide the commissioner and the audit firm contracting with the legislative auditor access to all data required to complete the audit. For purposes of this subdivision, the contracting audit firm shall have the same investigative power as the legislative auditor under section 3.978, subdivision 2.

(d) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols. The audit firm under contract to provide this evaluation must meet the requirements in paragraph (b).

(e) Upon completion of the audit under paragraph (a) and receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature. Upon completion of the evaluation under paragraph (d), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the health finance committees of the legislature.

(f) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

(g) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

**EFFECTIVE DATE.** This section is effective the day following final enactment and applies to the managed care and county-based purchasing plan contracts that are effective January 1, 2014, and biennially thereafter.

Sec. 15. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

Sec. 16. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or after January 1, 2014, the commissioner may utilize a competitive price bidding program for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The program must allow a minimum of two managed care plans to serve the metropolitan area.

(b) In designing the competitive bid program, the commissioner shall consider, and incorporate where appropriate, the procedures and criteria used in the competitive bidding pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96. The pilot program operating in Hennepin County under the authority of section 256B.0756 shall continue to be exempt from competitive bid.

(c) The commissioner shall use past performance data as a factor in selecting vendors and shall consider this information, along with competitive bid and other information, in determining whether to contract with a managed care plan under this subdivision. Where possible, the assessment of past performance in serving persons on public programs shall be based on encounter data submitted to the commissioner. The commissioner shall evaluate past performance based on both the health outcomes of care and success rates in securing participation in recommended preventive and early diagnostic care. Data provided by managed care plans must be provided in a uniform manner as specified by the commissioner and must include only data on medical assistance and MinnesotaCare enrollees. The data submitted must include health outcome measures on reducing the incidence of low birth weight established by the managed care plan under subdivision 32.

Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise

be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare; and

(5) a dental clinic owned and operated by the University of Minnesota or 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. A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off-site at a private dental office if the following requirements are met:~~

~~(1) the designated critical access dental clinic is located within a health professional shortage area as defined under the Code of Federal Regulations, title 42, part 5, and the United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;~~

~~(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;~~

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

(4) the dentist and allied dental professionals providing the services off-site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off-site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

**EFFECTIVE DATE.** This section is effective July 1, 2012, or upon federal approval, whichever is later.

Sec. 18. Minnesota Statutes 2011 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following 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;

(5) \$6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges

submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

(h) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (6). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

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

Sec. 19. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 2, is amended to read:

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, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within ~~three~~ four 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. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) ~~A health plan~~ Coverage purchased under this section must:

(1) ~~provide coverage for~~ include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, the second paragraph.

Sec. 20. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 3, is amended to read:

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)~~ this paragraph 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).

19-29	\$125
30-34	\$135
35-39	\$140
40-44	\$175
45-49	\$215
50-54	\$295
55-59	\$345
60+	\$360

(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.

Sec. 21. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 6, is amended to read:

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.

Sec. 22. Minnesota Statutes 2010, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

- (1) lacks two or more of the following:
  - (i) basic hospital insurance;
  - (ii) medical-surgical insurance;
  - (iii) prescription drug coverage;
  - (iv) dental coverage; or
  - (v) vision coverage;
- (2) requires a deductible of \$100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, ~~general assistance medical care~~, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance ~~or general assistance medical care~~ within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

Sec. 23. Minnesota Statutes 2011 Supplement, 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. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. 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. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent 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 in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 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 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 medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(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

in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 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 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 in programs described in section 256B.69, subdivisions 23 and 28, 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 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 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 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. 24. **NONEMERGENCY MEDICAL TRANSPORTATION SERVICES  
REQUEST FOR INFORMATION.**

(a) The commissioner of human services shall issue a request for information from vendors about potential solutions for the management of nonemergency medical transportation (NEMT) services provided to recipients of Minnesota health care programs. The request for information must require vendors to submit responses by November 1, 2012. The request for information shall seek information from vendors, including but not limited to, the following aspects:

(1) administration of the NEMT program within a single administrative structure, that may include a statewide or regionalized solution;

(2) oversight of transportation services;

(3) a process for assessing an individual's level of need;

(4) methods that promote the appropriate use of public transportation; and

(5) an electronic system that assists providers in managing services to clients and is consistent with the recommendations in the 2011 evaluation report by the Office of the Legislative Auditor on NEMT, related to the use of data to inform decision-making and reduce waste and fraud.

(b) The commissioner shall provide the information obtained from the request for information to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by November 15, 2012.

#### **Sec. 25. PHYSICIAN ASSISTANTS AND OUTPATIENT MENTAL HEALTH.**

The commissioner of human services shall convene a group of interested stakeholders to assist the commissioner in developing recommendations on how to improve access to, and the quality of, outpatient mental health services for medical assistance enrollees through the use of physician assistants. The commissioner shall report these recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing by January 15, 2013.

#### **Sec. 26. HEALTH SERVICES ADVISORY COUNCIL.**

The Health Services Advisory Council shall review currently available literature regarding the efficacy of various treatments for autism spectrum disorder, including an evaluation of age-based variation in the appropriateness of existing medical and behavioral interventions. The council shall recommend to the commissioner of human services authorization criteria for services based on existing evidence. The council may recommend coverage with ongoing collection of outcomes evidence in circumstances where evidence is currently unavailable, or where the strength of the evidence is low. The council shall make this recommendation by December 31, 2012.

#### **Sec. 27. REPORTING REQUIREMENTS.**

[256B.0625, subd. 3g, paragraph (f)] Subdivision 1. **Evidence-based childbirth program.** The commissioner of human services may discontinue the evidence-based childbirth program and shall discontinue all affiliated reporting requirements established under Minnesota Statutes, section 256B.0625, subdivision 3g, once the commissioner determines that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

[62D.124, subd. 5] Subd. 2. **Provider networks.** The commissioner of health, the commissioner of commerce, and the commissioner of human services shall merge reporting requirements for health maintenance organizations and county-based purchasing plans related to Minnesota Department of Health oversight of network adequacy under Minnesota Statutes, section 62D.124, and the provider network list reported to the Department of Human Services under Minnesota Rules, part 4685.2100. The commissioners shall work with health maintenance organizations and county-based purchasing plans to ensure that the report merger is done in a manner that simplifies health maintenance organization and county-based purchasing plan reporting processes.

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

Sec. 28. **EMERGENCY MEDICAL ASSISTANCE STUDY.**

(a) The commissioner of human services shall develop a plan to provide coordinated and cost-effective health care and coverage for individuals who meet eligibility standards for emergency medical assistance and who are ineligible for other state public programs. The commissioner shall consult with relevant stakeholders in the development of the plan. The commissioner shall consider the following elements:

(1) strategies to provide individuals with the most appropriate care in the appropriate setting, utilizing higher quality and lower cost providers;

(2) payment mechanisms to encourage providers to manage the care of these populations, and to produce lower cost of care and better patient outcomes;

(3) ensure coverage and payment options that address the unique needs of those needing episodic care, chronic care, and long-term care services;

(4) strategies for coordinating health care and nonhealth care services, and integrating with existing coverage; and

(5) other issues and strategies to ensure cost-effective and coordinated delivery of coverage and services.

(b) The commissioner shall submit the plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by January 15, 2013.

Sec. 29. **EMERGENCY MEDICAL CONDITION COVERAGE EXCEPTIONS.**

(a) Notwithstanding Minnesota Statutes, section 256B.06, subdivision 4, paragraph (h), clause (2), the following services are covered as emergency medical conditions under Minnesota Statutes, section 256B.06, subdivision 4, paragraph (f):

(1) dialysis services provided in a hospital or free-standing dialysis facility; and

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment.

(b) Coverage under paragraph (a) is effective May 1, 2012, until June 30, 2013.

Sec. 30. **COST-SHARING REQUIREMENTS STUDY.**

The commissioner of human services, in consultation with managed care plans, county-based purchasing plans, and other relevant stakeholders, shall develop recommendations to implement a revised cost-sharing structure for state public health care programs that ensures application of meaningful cost-sharing requirements within the limits of title 42, Code of Federal Regulations, section 447.54, for enrollees in these programs. The commissioner shall report 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 these recommendations effective January 1, 2014.

Sec. 31. **STUDY OF MANAGED CARE.**

(a) The commissioner of human services must contract with an independent vendor with demonstrated expertise in evaluating Medicaid managed care programs to evaluate the value of managed care for state public health care programs provided under Minnesota Statutes, sections 256B.69, 256B.692, and 256L.12. Determination of the value of managed care must include consideration of the following, as compared to a fee-for-service program:

(1) the satisfaction of state public health care program recipients and providers;

(2) the ability to measure and improve health outcomes of recipients;

(3) the access to health services for recipients;

(4) the availability of additional services such as care coordination, case management, disease management, transportation, and after-hours nurse lines;

(5) actual and potential cost savings to the state;

(6) the level of alignment with state and federal health reform policies, including a health benefit exchange for individuals not enrolled in state public health care programs; and

(7) the ability to use different provider payment models that provide incentives for cost-effective health care.

(b) The evaluation described in paragraph (a) must also consider the need to continue the requirement for health maintenance organizations to participate in the medical assistance and MinnesotaCare programs as a condition of licensure under Minnesota Statutes, section 62D.04, subdivision 5, and under Minnesota Statutes, section 256B.0644, in terms of continued stability and access to services for enrollees of these programs.

(c) A preliminary report of the evaluation must be submitted to the chairs and ranking minority members of the health and human services legislative committees by February 15, 2013, and the final report must be submitted by July 1, 2013.

Sec. 32. **REPEALER.**

Subdivision 1. **Summary of complaints and grievances.** (a) Minnesota Rules, part 4685.2000, is repealed effective the day following final enactment.

Subd. 2. **Medical necessity denials and appeals.** Minnesota Statutes 2010, section 62M.09, subdivision 9, is repealed effective the day following final enactment.

Subd. 3. **Salary reports.** Minnesota Statutes 2010, section 62Q.64, is repealed effective the day following final enactment.

**ARTICLE 2****DEPARTMENT OF HEALTH**

Section 1. Minnesota Statutes 2010, section 62Q.80, is amended to read:

**62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.**

Subdivision 1. **Scope.** (a) Any community-based health care initiative may develop and operate community-based health care coverage programs that offer to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62M, 62N, 62Q, 62T, or 62U, or any other law or rule that applies to entities licensed under these chapters.

(b) Each initiative shall establish health outcomes to be achieved through the programs and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

(1) a reduction in uncompensated care provided by providers participating in the community-based health network;

(2) an increase in the delivery of preventive health care services; and

(3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community-based initiative and the participating health care providers.

~~Subd. 1a. **Demonstration project.** The commissioner of health and the commissioner of human services shall award demonstration project grants to community-based health care initiatives to develop and operate community-based health care coverage programs in Minnesota. The demonstration projects shall extend for five years and must comply with the requirements of this section.~~

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or unmarried child who is under the age of 19 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative, defined in subdivision 2, paragraph (c), ~~and receiving funds from the Department of Health,~~ shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. ~~Each community-based health initiative as defined in subdivision 2, paragraph (c), and receiving State Health Access Program (SHAP) grant funding shall submit to the commissioner of human services for approval prior to its operation the community-based health care coverage programs developed by the initiatives.~~ The ~~commissioners~~ commissioner shall ensure that each program meets ~~the federal grant requirements and any~~ requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage programs.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** The initiative shall establish and operate upon approval by the ~~commissioners~~ commissioner of health ~~and human services~~ community-based health care coverage programs. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

Subd. 5. **Qualifying employees.** To be eligible for the community-based health care coverage program, an individual must:

(1) reside in or work within the designated community-based geographic area served by the program;

(2) be employed by a qualifying employer, be an employee's dependent, or be self-employed on a full-time basis;

(3) not be enrolled in or have currently available health coverage, except for catastrophic health care coverage; and

(4) not be eligible for or enrolled in medical assistance or general assistance medical care, and not be enrolled in MinnesotaCare or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community-based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage that equals 350 percent of the federal poverty guidelines or less for an individual; and

(3) not have offered employer-subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer-subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community-based health network must accept as payment in full the payment rate established by the initiatives and may not charge to or collect from an enrollee any amount in excess of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The initiatives shall establish the health care benefits offered through the community-based health care coverage programs. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

(i) health education and wellness services;

(ii) health supervision, evaluation, and follow-up;

(iii) immunizations; and

(iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the

programs must be services that are offered within the scope of practice of the participating health care providers.

(c) The initiatives may establish cost-sharing requirements. Any co-payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the programs.

(d) If any of the initiatives amends or alters the benefits offered through the program from the initial offering, that initiative must notify the ~~commissioners~~ commissioner of health ~~and human services~~ and all enrollees of the benefit change.

Subd. 9. **Enrollee information.** (a) The initiatives must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

(1) health care services that are covered under the program;

(2) any exclusions or limitations on the health care services covered, including any cost-sharing arrangements or prior authorization requirements;

(3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community-based health network;

(4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;

(5) the conditions under which the program or coverage under the program may be canceled or terminated; and

(6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The ~~commissioners~~ commissioner of health ~~and human services~~ must approve a copy of the written statement prior to the operation of the program.

Subd. 10. **Complaint resolution process.** (a) The initiatives must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The initiatives must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The initiatives must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73 with any decision rendered under this external review process binding on the initiatives.

Subd. 11. **Data privacy.** The initiatives shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The initiatives may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The initiatives shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The initiatives may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** Each initiative shall submit ~~quarterly~~ an annual status reports report to the commissioner of health on January 15, ~~April 15, July 15, and October 15~~ of each year, with the first report due January 15, 2008. ~~Each initiative receiving funding from the Department of Human Services shall submit status reports to the commissioner of human services as defined in the terms of the contract with the Department of Human Services.~~ Each status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the ~~commissioners~~ commissioner of health; ~~human services~~; or commerce or the legislature.

~~Subd. 14. **Sunset.** This section expires August 31, 2014.~~

Sec. 2. Minnesota Statutes 2011 Supplement, section 144.1222, subdivision 5, is amended to read:

Subd. 5. ~~**Swimming pond exemption Exemptions.**~~ (a) A public swimming pond in existence before January 1, 2008, is not a public pool for purposes of this section and section 157.16, and is exempt from the requirements for public swimming pools under Minnesota Rules, chapter 4717.

~~(b) A naturally treated swimming pool located in the city of Minneapolis is not a public pool for purposes of this section and section 157.16, and is exempt from the requirements for public swimming pools under Minnesota Rules, chapter 4717.~~

~~(b)~~ (c) Notwithstanding ~~paragraph~~ paragraphs (a) and (b), a public swimming pond and a naturally treated swimming pool must meet the requirements for public pools described in subdivisions 1c and 1d.

~~(c)~~ (d) For purposes of this subdivision, a "public swimming pond" means an artificial body of water contained within a lined, sand-bottom basin, intended for public swimming, relaxation, or recreational use that includes a water circulation system for maintaining water quality and does not include any portion of a naturally occurring lake or stream.

~~(c)~~ (e) For purposes of this subdivision, a "naturally treated swimming pool" means an artificial body of water contained in a basin, intended for public swimming, relaxation, or recreational use that uses a chemical free filtration system for maintaining water quality through natural processes, including the use of plants, beneficial bacteria, and microbes.

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

**Sec. 3. [144.1225] ADVANCED DIAGNOSTIC IMAGING SERVICES.**

Subdivision 1. **Definition.** For purposes of this section, "advanced diagnostic imaging services" has the meaning given in United States Code, title 42, section 1395M, except that it does not include x-ray, ultrasound, or fluoroscopy.

Subd. 2. **Accreditation required.** (a)(1) Except as otherwise provided in paragraph (b), advanced diagnostic imaging services eligible for reimbursement from any source, including, but not limited to, the individual receiving such services and any individual or group insurance contract, plan, or policy delivered in this state, including, but not limited to, private health insurance plans, workers' compensation insurance, motor vehicle insurance, the State Employee Group Insurance Program (SEGIP), and other state health care programs, shall be reimbursed only if the facility at which the service has been conducted and processed is accredited by one of the following entities:

(i) American College of Radiology (ACR);

(ii) Intersocietal Accreditation Commission (IAC);

(iii) the Joint Commission; or

(iv) other relevant accreditation organization designated by the secretary of the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1395M.

(2) All accreditation standards recognized under this section must include, but are not limited to:

(i) provisions establishing qualifications of the physician;

(ii) standards for quality control and routine performance monitoring by a medical physicist;

(iii) qualifications of the technologist, including minimum standards of supervised clinical experience;

(iv) guidelines for personnel and patient safety; and

(v) standards for initial and ongoing quality control using clinical image review and quantitative testing.

(b) Any facility that performs advanced diagnostic imaging services and is eligible to receive reimbursement for such services from any source in paragraph (a)(1) must obtain accreditation by August 1, 2013. Thereafter, all facilities that provide advanced diagnostic imaging services in the state must obtain accreditation prior to commencing operations and must, at all times, maintain accreditation with an accrediting organization as provided in paragraph (a).

Subd. 3. **Reporting.** (a) Advanced diagnostic imaging facilities and providers of advanced diagnostic imaging services must annually report to the commissioner demonstration of accreditation as required under this section.

(b) The commissioner may promulgate any rules necessary to administer the reporting required under paragraph (a).

Sec. 4. Minnesota Statutes 2010, section 144.292, subdivision 6, is amended to read:

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and \$10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative may charge the \$10 retrieval fee, but must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act; except that no fee shall be charged to a person who is receiving public assistance, who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Sec. 5. Minnesota Statutes 2010, section 144.298, subdivision 2, is amended to read:

Subd. 2. **Liability of provider or other person.** A person who does any of the following is liable to the patient for compensatory damages caused by an unauthorized release or an intentional, unauthorized access, plus costs and reasonable attorney fees:

(1) negligently or intentionally requests or releases a health record in violation of sections 144.291 to 144.297;

(2) forges a signature on a consent form or materially alters the consent form of another person without the person's consent; ~~or~~

(3) obtains a consent form or the health records of another person under false pretenses; or

(4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a record locator service without authorization.

Sec. 6. Minnesota Statutes 2010, section 144.5509, is amended to read:

**144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.**

(a) A radiation therapy facility may be constructed only by an entity owned, operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either alone or in cooperation with another entity.

(b) Notwithstanding paragraph (a), there shall be a moratorium on the construction of any radiation therapy facility located in the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright. This paragraph does not apply to the relocation or reconstruction of an existing facility owned by a hospital if the relocation or reconstruction is within one mile of the existing facility. This paragraph does not apply to a radiation therapy facility that is being built attached to a community hospital in Wright County and meets the following conditions prior to August 1, 2007: the capital expenditure report required under Minnesota Statutes, section 62J.17, has been filed with the commissioner of health; a timely construction schedule is developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits applied for. Beginning January 1, 2013, this paragraph does not apply to any construction necessary to relocate a radiation therapy machine from a community hospital-owned radiation therapy facility located in the city of Maplewood to a community hospital campus in the city of Woodbury within the same health system. This paragraph expires August 1, 2014.

(c) Notwithstanding paragraph (a), after August 1, 2014, the construction of a radiation therapy facility located in any of the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright, may occur only if the following requirements are met:

(1) the entity constructing the radiation therapy facility is controlled by or is under common control with a hospital licensed under sections 144.50 to 144.56; and

(2) the new radiation therapy facility is located at least seven miles from an existing radiation therapy facility.

(d) Any referring physician located within a county identified in paragraph (c) must provide each patient who is in need of radiation therapy services with a list of all radiation therapy facilities located within the counties identified in paragraph (c). Physicians with a financial interest in any radiation therapy facility must disclose to the patient the existence of the interest.

(e) For purposes of this section, "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the policies, operations, or activities of an entity, through the ownership of, or right to vote or to direct the disposition of shares, membership interests, or ownership interests of the entity.

(f) For purposes of this section, "financial interest in any radiation therapy facility" means a direct or indirect ownership or investment interest in a radiation therapy facility or a compensation arrangement with a radiation therapy facility.

(g) This section does not apply to the relocation or reconstruction of an existing radiation therapy facility if:

(1) the relocation or reconstruction of the facility remains owned by the same entity;

(2) the relocation or reconstruction is located within one mile of the existing facility;  
and

(3) the period in which the existing facility is closed and the relocated or reconstructed facility begins providing services does not exceed 12 months.

Sec. 7. [145.8811] MATERNAL AND CHILD HEALTH ADVISORY TASK FORCE.

Subdivision 1. Composition of task force. The commissioner shall establish and appoint a Maternal and Child Health Advisory Task Force consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the Minnesota Department of Health. Section 15.059 governs the Maternal and Child Health Advisory Task Force. Notwithstanding section 15.059, the Maternal and Child Health Advisory Task Force expires June 30, 2015.

Subd. 2. Duties. The advisory task force shall meet on a regular basis to perform the following duties:

(1) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(2) review and report on the type, frequency, and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(3) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory task force considers essential to providing an effective maternal and child health care program to low-income populations and high-risk persons and fulfilling the purposes defined in section 145.88;

(4) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(5) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services:

(i) prenatal, delivery, and postpartum care;

(ii) comprehensive health care for children, especially from birth through five years of age;

(iii) adolescent health services;

(iv) family planning services;

(v) preventive dental care;

(vi) special services for chronically ill and disabled children; and

(vii) any other services that promote the health of mothers and children; and

(6) establish, in consultation with the commissioner and the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), statewide outcomes that will improve the health status of mothers and children as required in section 145A.12, subdivision 7.

Sec. 8. Minnesota Statutes 2010, section 145.906, is amended to read:

**145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, the women, infants, and children (WIC) program, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources.

(d) Information about postpartum depression, including its symptoms, potential impact on families, and treatment resources, must be available at WIC sites.

Sec. 9. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

Relating to the evaluations and legislative report completed pursuant to Laws 2011, First Special Session chapter 9, article 2, section 26, the following activities must be completed:

(1) the commissioners of health and human services must update, revise, and link the contents of their Web sites related to supervised living facilities, intermediate care facilities for the developmentally disabled, nursing facilities, board and lodging establishments, and human services licensed programs so that consumers and providers can access consistent clear information about the regulations affecting these facilities; and

(2) the commissioner of management and budget, in consultation with the commissioners of health and human services, must evaluate and recommend options for administering health and human services regulations. The evaluation and recommendations must be submitted in a report to the chairs and ranking minority members of the health and human services legislative committees no later than August 1, 2013, and shall at a minimum: (i) identify and evaluate the regulatory responsibilities of the Departments of Health and Human Services to determine whether to reorganize these regulatory responsibilities to improve how the state administers health and human services regulatory functions, or whether there are ways to improve these regulatory activities without reorganizing; (ii) describe and evaluate the multiple roles of the Department of Human Services as a direct provider of care services, a regulator, and a payor for state program services; and (iii) for long-term care regulated in both departments, evaluate and make recommendations for reasonable client risk assessments, planning for client risk reductions, and determining reasonable assumptions of client risks in relation to directing health care, client health care rights, provider liabilities, and provider responsibilities to provide minimum standards of care.

Sec. 10. **HEALTH RECORD ACCESS STUDY.**

The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee, shall study the following:

(1) the extent to which providers have audit procedures in place to monitor use of representation of consent and unauthorized access to a patient's health records in violation of Minnesota Statutes, sections 144.291 to 144.297;

(2) the feasibility of informing patients if an intentional, unauthorized access of their health records occurs; and

(3) the feasibility of providing patients with a copy of a provider's audit log showing who has accessed their health records.

The commissioner shall report study findings and any relevant patient privacy and other recommendations to the legislature by February 15, 2013.

Sec. 11. **[145.4715] REPORTING PREVALENCE OF SEXUAL VIOLENCE.**

The commissioner of health must routinely report to the public and to the legislature data on the prevalence and incidence of sexual violence in Minnesota, to the extent federal funding is available for this purpose. The commissioner must use existing data provided by the Centers for Disease Control and Prevention, or other source as identified by commissioner.

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

Sec. 12. **LICENSED HOME CARE PROVIDERS.**

By February 1, 2013, the commissioner of health must report recommendations to the legislature as to development of a comprehensive home care plan to increase inspection and oversight of licensed home care providers under Minnesota Statutes, chapter 144A.

Sec. 13. **EVALUATION OF HEALTH AND COMMERCE REGULATORY RESPONSIBILITIES.**

The commissioner of health, in consultation with the commissioner of commerce, shall report to the legislature by February 15, 2013, on recommendations to maximize administrative efficiency in the regulation of health maintenance organizations, county-based purchasers, insurance carriers, and related entities while maintaining quality health outcomes, regulatory stability, and price stability.

Sec. 14. **STUDY OF RADIATION THERAPY FACILITIES CAPACITY.**

(a) To the extent of available appropriations, the commissioner of health shall conduct a study of the following: (1) current treatment capacity of the existing radiation therapy facilities within the state; (2) the present need for radiation therapy services based on population demographics and new cancer cases; and (3) the projected need in the next ten years for radiation therapy services and whether the current facilities can sustain this projected need.

(b) The commissioner may contract with a qualified entity to conduct the study. The study shall be completed by March 15, 2013, and the results shall be submitted to the chairs and ranking minority members of the health and human services committees of the legislature.

Sec. 15. **MERC DISTRIBUTION.**

(a) For the distribution of funds for fiscal year 2013, as required under Minnesota Statutes, section 62J.692, subdivision 4, the commissioner of health shall distribute \$300,000 to Gillette Children's Specialty Healthcare before following the distribution described under Minnesota Statutes, section 62J.692, subdivision 4, paragraph (a).

(b) This section is effective upon federal approval.

**ARTICLE 3**

**CHILDREN AND FAMILY SERVICES**

Section 1. Minnesota Statutes 2011 Supplement, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than ten full-day absent days per child, excluding holidays, in a fiscal year. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ten absent day limit. Child care providers 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) Notwithstanding paragraph (a), children in families may exceed the ten absent days limit if at least one parent is: (1) under the age of 21; (2) does not have a high school or general equivalency diploma; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, 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.

~~(c)~~ (c) 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 absent day limit.

~~(d)~~ (d) A family or child care provider 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.

~~(e)~~ (e) 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.

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

Sec. 2. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18c. **Drug convictions.** (a) The state court administrator shall provide a report every six months by electronic means to the commissioner of human services, including the name, address, date of birth, and, if available, driver's license or state identification card number, date of sentence, effective date of the sentence, and county in which the conviction occurred of each person convicted of a felony under chapter 152 during the previous six months.

(b) The commissioner shall determine whether the individuals who are the subject of the data reported under paragraph (a) are receiving public assistance under chapter 256D or 256J, and if the individual is receiving assistance under chapter 256D or 256J, the commissioner shall instruct the county to proceed under section 256D.024 or 256J.26, whichever is applicable, for this individual.

(c) The commissioner shall not retain any data received under paragraph (a) or (d) that does not relate to an individual receiving publicly funded assistance under chapter 256D or 256J.

(d) In addition to the routine data transfer under paragraph (a), the state court administrator shall provide a onetime report of the data fields under paragraph (a) for individuals with a felony drug conviction under chapter 152 dated from July 1, 1997, until the date of the data transfer. The commissioner shall perform the tasks identified under paragraph (b) related to this data and shall retain the data according to paragraph (c).

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

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

Subd. 18d. **Data sharing with the Department of Human Services; multiple identification cards.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, the address, date of birth, and driver's license or state identification card number of all applicants and holders whose drivers' licenses and state identification cards have been canceled under section 171.14, paragraph (a), clauses (2) or (3), by the commissioner of public safety. After the initial data report has been provided by the commissioner of public safety to the commissioner of human services under this paragraph, subsequent reports shall only include cancellations that occurred after the end date of the cancellations represented in the previous data report.

(b) The commissioner of human services shall compare the information provided under paragraph (a) with the commissioner's data regarding recipients of all public assistance programs managed by the Department of Human Services to determine whether any individual with multiple identification cards issued by the Department of Public Safety has illegally or improperly enrolled in any public assistance program managed by the Department of Human Services.

(c) If the commissioner of human services determines that an applicant or recipient has illegally or improperly enrolled in any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

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

Sec. 4. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18e. **Data sharing with the Department of Human Services; legal presence date.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, address, date of birth, and driver's license or state identification number of all applicants and holders of drivers' licenses and state identification cards whose temporary legal presence date has expired and as a result the driver's license or identification card has been accordingly canceled under section 171.14 by the commissioner of public safety.

(b) The commissioner of human services shall use the information provided under paragraph (a) to determine whether the eligibility of any recipients of public assistance programs managed by the Department of Human Services has changed as a result of the status change in the Department of Public Safety data.

(c) If the commissioner of human services determines that a recipient has illegally or improperly received benefits from any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

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

Sec. 5. Minnesota Statutes 2010, section 256.9831, subdivision 2, is amended to read:

Subd. 2. **Financial transaction cards.** The commissioner shall take all actions necessary to ensure that no person may obtain benefits under chapter 256 ~~or~~ 256D, or 256J through the use of a financial transaction card, as defined in section 609.821, subdivision 1, paragraph (a), at a terminal located in or attached to a gambling establishment, liquor store, tobacco store, or tattoo parlor.

Sec. 6. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 1, is amended to read:

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~~ an 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.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 2, is amended to read:

Subd. 2. **Prohibited purchases.** ~~An individual with an EBT debit cardholders in card issued for one of the~~ programs listed under subdivision 1 ~~are~~ is 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~~ prohibited purchases made under this subdivision shall constitute

~~fraud unlawful use and result in disqualification of the cardholder from the program under section 256.98, subdivision 8 as provided in subdivision 4.~~

Sec. 8. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a subdivision to read:

Subd. 3. **EBT use restricted to certain states.** EBT debit cardholders in programs listed under subdivision 1 are prohibited from using the cash portion of the EBT card at vendors and automatic teller machines located outside of Minnesota, Iowa, North Dakota, South Dakota, or Wisconsin. This subdivision does not apply to the food portion.

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

Sec. 9. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a subdivision to read:

Subd. 4. **Disqualification.** (a) Any person found to be guilty of purchasing tobacco products or alcoholic beverages with their EBT debit card by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the: (1) Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program under chapter 256J; (2) general assistance program under chapter 256D; or (3) Minnesota supplemental aid program under chapter 256D, shall be disqualified from all of the listed programs.

(b) The needs of the disqualified individual shall not be taken into consideration in determining the grant level for that assistance unit: (1) for one year after the first offense; (2) for two years after the second offense; and (3) permanently after the third or subsequent offense.

(c) The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility for postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review.

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

Sec. 10. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

Subd. 1b. **Earned income savings account.** In addition to the \$50 disregard required under subdivision 1, the county agency shall disregard an additional earned income up to a maximum of ~~\$150~~ \$500 per month for: (1) persons residing in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons living in supervised apartments with services funded under Minnesota Rules, parts 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan; and (3) persons residing in group residential housing, as that term is defined in section 256I.03, subdivision 3, for whom the county agency has approved a discharge plan which includes work. The additional amount disregarded must be placed in a separate savings account by the eligible individual, to be used upon discharge from the residential facility into the community. For individuals residing in a chemical dependency program

licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from the savings account require the signature of the individual and for those individuals with an authorized representative payee, the signature of the payee. A maximum of ~~\$1,000~~ \$2,000, including interest, of the money in the savings account must be excluded from the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in that account in excess of ~~\$1,000~~ \$2,000 must be applied to the resident's cost of care. If excluded money is removed from the savings account by the eligible individual at any time before the individual is discharged from the facility into the community, the money is income to the individual in the month of receipt and a resource in subsequent months. If an eligible individual moves from a community facility to an inpatient hospital setting, the separate savings account is an excluded asset for up to 18 months. During that time, amounts that accumulate in excess of the ~~\$1,000~~ \$2,000 savings limit must be applied to the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the 18-month period, the entire account must be applied to the patient's cost of care.

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

Sec. 11. Minnesota Statutes 2011 Supplement, 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. 12. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 6, is amended to read:

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

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

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

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

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

Sec. 13. Minnesota Statutes 2010, section 256E.37, subdivision 1, is amended to read:

Subdivision 1. **Grant authority.** The commissioner may make grants to state agencies and political subdivisions to construct or rehabilitate facilities for early childhood programs, crisis nurseries, or parenting time centers. The following requirements apply:

(1) The facilities must be owned by the state or a political subdivision, but may be leased under section 16A.695 to organizations that operate the programs. The commissioner must prescribe the terms and conditions of the leases.

(2) A grant for an individual facility must not exceed \$500,000 for each program that is housed in the facility, up to a maximum of \$2,000,000 for a facility that houses three programs or more. Programs include Head Start, School Readiness, Early Childhood Family Education, licensed child care, and other early childhood intervention programs.

(3) State appropriations must be matched on a 50 percent basis with nonstate funds. The matching requirement must apply program wide and not to individual grants.

(4) At least 80 percent of grant funds must be distributed to facilities located in counties not included in the definition under section 473.121, subdivision 4.

Sec. 14. Minnesota Statutes 2011 Supplement, section 256I.05, subdivision 1a, is amended to read:

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

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department

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

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

(d) Counties must not negotiate supplementary service rates with providers of group residential housing that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

Sec. 15. Minnesota Statutes 2010, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin County and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

(b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, of a group residential provider that:

(1) is located in St. Louis County and has had a group residential housing contract with the county since 2006;

(2) operates a 62-bed facility; and

(3) serves a chemically dependent adult male clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

(c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for the group residential provider described under paragraphs (a) and (b), not to exceed an additional 115 beds.

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

Sec. 16. Minnesota Statutes 2010, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) ~~Applicants or participants~~ An individual who ~~have~~ has been convicted of a felony level drug offense committed after July 1, 1997, may, if otherwise eligible, receive MFIP benefits subject to the following conditions. during the previous ten years from the date of application or recertification is subject to the following:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant shall be subject to random drug testing as a condition of continued eligibility and following any positive test for an illegal controlled substance is subject to the following sanctions:

(i) for failing a drug test the first time, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or

(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for food stamps or food support. Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

(3) A participant who fails a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction as specified under section 256J.46, subdivision 1, paragraph (d).

(b) Applicants requesting only food stamps or food support or participants receiving only food stamps or food support, who have been convicted of a drug offense that occurred after July 1, 1997, may, if otherwise eligible, receive food stamps or food support if the convicted applicant or participant is subject to random drug testing as a condition of continued eligibility. Following a positive test for an illegal controlled substance, the applicant is subject to the following sanctions:

(1) for failing a drug test the first time, food stamps or food support shall be reduced by an amount equal to 30 percent of the applicable food stamp or food support allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain

the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and

(2) for failing a drug test two times, the participant is permanently disqualified from receiving food stamps or food support. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

~~(c)~~ (b) For the purposes of this subdivision, "drug offense" means an offense that occurred after July 1, 1997, during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, ~~or~~ 152.096, or 152.137. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred after July 1, 1997, during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

**EFFECTIVE DATE.** This section is effective October 1, 2012, for all new MFIP applicants who apply on or after that date and for all recertifications occurring on or after that date.

Sec. 17. Minnesota Statutes 2010, section 256J.26, is amended by adding a subdivision to read:

Subd. 5. **Vendor payment; uninhabitable units.** Upon discovery by the county that a unit has been deemed uninhabitable under section 504B.131, the county shall immediately notify the landlord to return the vendor paid rent under this section for the month in which the discovery occurred. The county shall cease future rent payments for the uninhabitable housing units until the landlord demonstrates the premises are fit for the intended use. A landlord who is required to return vendor paid rent or is prohibited from receiving future rent under this subdivision may not take an eviction action against anyone in the assistance unit.

Sec. 18. Minnesota Statutes 2010, section 256J.575, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** ~~(a) The~~ Family stabilization services serve families who are not making significant progress within the regular employment and training services track of the Minnesota family investment program (MFIP) due to a variety of barriers to employment.

~~(b) The goal of the services is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, or providing care for a disabled household~~

~~member. These services promote and support families to achieve the greatest possible degree of self-sufficiency.~~

Sec. 19. Minnesota Statutes 2010, section 256J.575, subdivision 2, is amended to read:

Subd. 2. **Definitions.** The terms used in this section have the meanings given them in paragraphs (a) ~~to (d)~~ and (b).

(a) ~~"Case manager" means the county-designated staff person or employment services counselor.~~

(b) ~~"Case management"~~ "Family stabilization services" means ~~the services programs, activities, and services~~ provided by or through the county agency or through the employment services agency to participating families, ~~including.~~ Services include, but are not limited to, assessment as defined in section 256J.521, subdivision 1, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

~~(c)~~ (b) "Family stabilization plan" means a plan developed ~~by a case manager and with~~ the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the family's circumstances.

(d) ~~"Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:~~

- ~~(1) obtaining and retaining unsubsidized employment;~~
- ~~(2) family stability;~~
- ~~(3) economic stability; and~~
- ~~(4) barrier reduction.~~

~~The goal of the services is to achieve the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.~~

Sec. 20. Minnesota Statutes 2010, section 256J.575, subdivision 5, is amended to read:

Subd. 5. **~~Case management; Family stabilization plans; coordinated services.~~**  
 (a) ~~The county agency or employment services provider shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family is determined to be eligible for family stabilization services. The case manager, with the full involvement of the participant, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family. Once a participant has been determined eligible for family stabilization services, the county agency or employment services provider must attempt to meet with the participant to develop a plan within 30 days.~~

(b) If a participant is already assigned to a county case manager or a county-designated case manager in social services, disability services, or housing services that case manager already assigned may be the case manager for purposes of these services.

~~(b) The family stabilization plan must include:~~

~~(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;~~

~~(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and~~

~~(3) an identification of the services, supports, education, training, and accommodations needed to reduce or overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.~~

~~(c) The case manager and the participant shall meet within 30 days of the family's referral to the case manager. The initial family stabilization plan must be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and, if necessary, modify the plan under the following circumstances:~~

~~(1) there is a lack of satisfactory progress in achieving the goals of the plan;~~

~~(2) the participant has lost unsubsidized or subsidized employment;~~

~~(3) a family member has failed or is unable to comply with a family stabilization plan requirement;~~

~~(4) services, supports, or other activities required by the plan are unavailable;~~

~~(5) changes to the plan are needed to promote the well-being of the children; or~~

~~(6) the participant and case manager determine that the plan is no longer appropriate for any other reason.~~

(c) Participants determined eligible for family stabilization services must have access to employment and training services under sections 256J.515 to 256J.575, to the extent these services are available to other MFIP participants.

Sec. 21. Minnesota Statutes 2010, section 256J.575, subdivision 6, is amended to read:

Subd. 6. **Cooperation with services requirements.** ~~(a)~~ A participant who is eligible for family stabilization services ~~under this section shall comply with paragraphs (b) to (d):~~

~~(b) Participants shall engage in family stabilization plan services for the appropriate number of hours per week that the activities are scheduled and available, based on the needs of the participant and the participant's family, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate number of hours must be based on the participant's plan.~~

~~(c) The case manager county agency or employment services agency shall review the participant's progress toward the goals in the family stabilization plan every six months to determine whether conditions have changed, including whether revisions to the plan are needed.~~

~~(d) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision is excused when the case management services, training and educational services, or family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.~~

Sec. 22. Minnesota Statutes 2010, section 256J.575, subdivision 8, is amended to read:

Subd. 8. **Funding.** (a) The commissioner of human services shall treat MFIP expenditures made to or on behalf of any minor child under this section, who is part of a household that meets criteria in subdivision 3, as expenditures under a separately funded state program. These expenditures shall not count toward the state's maintenance of effort requirements under the federal TANF program.

(b) A family is no longer part of a separately funded program under this section if the caregiver no longer meets the criteria for family stabilization services in subdivision 3, ~~or if it is determined at recertification that a caregiver with a child under the age of six is working at least 87 hours per month in paid or unpaid employment, or a caregiver without a child under the age of six is working at least 130 hours per month in paid or unpaid employment, whichever occurs sooner.~~

Sec. 23. **[626.5533] REPORTING POTENTIAL WELFARE FRAUD.**

Subdivision 1. **Reports required.** A peace officer must report to the head of the officer's department every arrest where the person arrested possesses more than one welfare electronic benefit transfer card. Each report must include all of the following:

- (1) the name of the suspect;
- (2) the suspect's drivers license or state identification card number, where available;
- (3) the suspect's home address;
- (4) the number on each card;
- (5) the name on each electronic benefit card in the possession of the suspect, in cases where the card has a name printed on it;
- (6) the date of the alleged offense;
- (7) the location of the alleged offense;
- (8) the alleged offense; and
- (9) any other information the commissioner of human services deems necessary.

Subd. 2. **Use of information collected.** The head of a local law enforcement agency or state law enforcement department that employs peace officers licensed under section 626.843 must forward the report required under subdivision 1 to the commissioner of human services within 30 days of receiving the report. The commissioner of human services shall use the report to determine whether the suspect is authorized to possess any of the electronic benefit cards found in the suspect's possession.

Subd. 3. **Reporting forms.** The commissioner of human services, in consultation with the superintendent of the Bureau of Criminal Apprehension, shall adopt reporting forms to be used by law enforcement agencies in making the reports required under this section.

Sec. 24. Minnesota Statutes 2010, section 626.556, is amended by adding a subdivision to read:

Subd. 10n. **Required referral to early intervention services.** A child under age three who is involved in a substantiated case of maltreatment shall be referred for screening under the Individuals with Disabilities Education Act, part C. Parents must be

informed that the evaluation and acceptance of services are voluntary. The commissioner of human services shall monitor referral rates by county and annually report the information to the legislature beginning March 15, 2014. Refusal to have a child screened is not a basis for a child in need of protection or services petition under chapter 260C.

Sec. 25. Laws 2010, chapter 374, section 1, is amended to read:

Section 1. ~~LADDER OUT OF POVERTY~~ ASSET DEVELOPMENT AND FINANCIAL LITERACY TASK FORCE.

Subdivision 1. **Creation.** (a) The task force consists of the following members:

(1) four senators, including two members of the majority party and two members of the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate;

(2) four members of the house of representatives, including two members of the majority party, appointed by the speaker of the house, and two members of the minority party, appointed by the minority leader; and

(3) the commissioner of the Minnesota Department of Commerce or the commissioner's designee; ~~and~~

~~(4) the attorney general or the attorney general's designee.~~

(b) The task force shall ensure that representatives of the following have the opportunity to meet with and present views to the task force: the attorney general; credit unions; independent community banks; state and federal financial institutions; community action agencies; faith-based financial counseling agencies; faith-based social justice organizations; legal services organizations representing low-income persons; nonprofit organizations providing free tax preparation services as part of the volunteer income tax assistance program; relevant state and local agencies; University of Minnesota faculty involved in personal and family financial education; philanthropic organizations that have as one of their missions combating predatory lending; organizations representing older Minnesotans; and organizations representing the interests of women, Latinos and Latinas, African-Americans, Asian-Americans, American Indians, and immigrants.

Subd. 2. **Duties.** (a) At a minimum, the task force must identify specific policies, strategies, and actions to: reduce asset poverty and increase household financial security by improving opportunities for households to earn, learn, save, invest, and protect assets through expansion of such asset building opportunities as the Family Assets for Independence in Minnesota (FAIM) program and Earned Income Tax Credit (EITC) program.

~~(1) increase opportunities for poor and near-poor families and individuals to acquire assets and create and build wealth;~~

~~(2) expand the utilization of Family Assets for Independence in Minnesota (FAIM) or other culturally specific individual development account programs;~~

~~(3) reduce or eliminate predatory financial practices in Minnesota through regulatory actions, legislative enactments, and the development and deployment of alternative, nonpredatory financial products;~~

~~(4) provide incentives or assistance to private sector financial institutions to offer additional programs and services that provide alternatives to and education about predatory financial products;~~

~~(5) provide financial literacy information to low-income families and individuals at the time the recipient has the ability, opportunity, and motivation to receive, understand, and act on the information provided, and~~

~~(6) identify incentives and mechanisms to increase community engagement in combating poverty and helping poor and near-poor families and individuals to acquire assets and create and build wealth.~~

For purposes of this section, "asset poverty" means an individual's or family's inability to meet fixed financial obligations and other financial requirements of daily living with existing assets for a three-month period in the event of a disruption in income or extraordinary economic emergency.

~~(b) By June 1, 2012, During the 2013 and 2014 legislative sessions, the task force must provide the legislature with written recommendations and any draft legislation necessary to implement the recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over commerce and consumer protection fulfill the duties enumerated in paragraph (a). The recommendations may include draft legislation.~~

Subd. 3. **Administrative provisions.** (a) The director of the Legislative Coordinating Commission, or a designee of the director, must convene the initial meeting of the task force by September 15, 2010. The members of the task force must elect a chair or cochairs from the legislative members at the initial meeting.

(b) Members of the task force serve without compensation or payment of expenses except as provided in this paragraph. To the extent possible, meetings of the task force shall be scheduled on dates when legislative members of the task force are able to attend legislative meetings that would make them eligible to receive legislative per diem payments.

~~(c) The task force expires June 1, 2012, or upon the submission of the report required under subdivision 3, whichever is earlier 2014.~~

(d) The task force may accept gifts and grants, which are accepted on behalf of the state and constitute donations to the state. The funds must be deposited in an account in the special revenue fund and are appropriated to the Legislative Coordinating Commission for purposes of the task force.

(e) The Legislative Coordinating Commission shall provide fiscal services to the task force as needed under this subdivision.

Subd. 4. **Deadline for appointments and designations.** The appointments and designations authorized under this section must be completed no later than August 15, ~~2010~~ 2012.

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

Sec. 26. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 1, is amended to read:

Subdivision 1. <b>Total Appropriation</b>	<b>\$</b>	<b>6,259,280,000</b>	<b>\$</b>	<b>6,212,085,000</b>
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Appropriations by Fund		
	2012	2013
General	5,657,737,000	5,584,471,000
State Government		
Special Revenue	3,565,000	3,565,000
Health Care Access	330,435,000	353,283,000
Federal TANF	265,378,000	268,101,000
Lottery Prize	1,665,000	1,665,000
Special Revenue	500,000	1,000,000

**Receipts for Systems Projects.**

Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of management and budget, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

**Nonfederal Share Transfers.** The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

**TANF Maintenance of Effort.**

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) 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 for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2015.

**Working Family Credit Expenditures as TANF/MOE.** The commissioner may claim as TANF maintenance of effort up to \$6,707,000 per year of working family credit expenditures for fiscal years 2012 and 2013.

**Working Family Credit Expenditures to be Claimed for TANF/MOE.** The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2012, \$23,692,000;

(2) fiscal year 2013, ~~\$44,969,000~~  
\$51,978,000;

(3) fiscal year 2014, ~~\$32,579,000~~  
\$43,576,000; and

(4) fiscal year 2015, ~~\$32,476,000~~  
\$43,548,000.

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~~  
\$28,022,000;

(3) fiscal year 2014, ~~\$14,020,000~~  
\$14,030,000; and

(4) fiscal year 2015, ~~\$14,020,000~~  
\$14,030,000.

(b) The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

**Food Stamps Employment and Training Funds.** (a) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement for child care assistance program expenditures must be deposited in the general fund. The amount of funds must be limited to \$500,000 per year in fiscal years 2012 through 2015, contingent upon approval by the federal Food and Nutrition Service.

(b) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance

of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2015.

**ARRA Food Support Benefit Increases.**

The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

**Supplemental Security Interim Assistance Reimbursement Funds.**

\$2,800,000 of uncommitted revenue available to the commissioner of human services for SSI advocacy and outreach services must be transferred to and deposited into the general fund by October 1, 2011.

Sec. 27. **MINNESOTA VISIBLE CHILD WORK GROUP.**

Subdivision 1. Purpose. The Minnesota visible child work group is established to identify and recommend issues that should be addressed in a statewide, comprehensive plan to improve the well-being of children who are homeless or have experienced homelessness.

Subd. 2. Membership. The members of the Minnesota visible child work group include: (1) two members of the Minnesota house of representatives appointed by the speaker of the house, one member from the majority party and one member from the minority party; (2) two members of the Minnesota senate appointed by the senate Subcommittee on Committees of the Committee on Rules and Administration, one member from the majority party and one member from the minority party; (3) three representatives from family shelter, transitional housing, and supportive housing providers appointed by the governor; (4) two individuals appointed by the governor who have experienced homelessness; (5) three housing and child advocates appointed by the governor; (6) three representatives from the business or philanthropic community; and (7) children's cabinet members, or their designees. Work group membership should include people from rural, suburban, and urban areas of the state.

Subd. 3. Duties. The work group shall: (1) recommend goals and objectives for a comprehensive, statewide plan to improve the well-being of children who are homeless or who have experienced homelessness; (2) recommend a definition of "child well-being"; (3) identify evidence-based interventions and best practices improving the well-being of young children; (4) plan implementation timelines and ways to measure progress, including measures of child well-being from birth through adolescence; (5) identify ways to address issues of collaboration and coordination across systems, including education, health, human services, and housing; (6) recommend the type of data and information necessary to develop, effectively implement, and monitor a strategic plan; (7) examine and make recommendations regarding funding to implement an effective plan; and (8) provide recommendations for ongoing reports on the well-being of children, monitoring progress

in implementing the statewide comprehensive plan, and any other issues determined to be relevant to achieving the goals of this section.

Subd. 4. **Work group convening and facilitation.** The work group must be organized, scheduled, and facilitated by the staff of a nonprofit child advocacy, outreach, research, and youth development organization focusing on a wide range of issues affecting children who are vulnerable, and a nonprofit organization working to provide safe, affordable, and sustainable homes for children and families in the seven-county metropolitan area through partnerships with the public and private sector. These two organizations will also be responsible for preparing and submitting the work group's recommendations.

Subd. 5. **Report.** The work group shall make recommendations under subdivision 3 to the legislative committees with jurisdiction over education, housing, health, and human services policy and finance by December 15, 2012. The recommendations must also be submitted to the children's cabinet to provide the foundation for a statewide visible child plan.

Subd. 6. **Expiration.** The Minnesota visible child work group expires on June 30, 2013.

#### **Sec. 28. UNIFORM ASSET LIMIT REQUIREMENTS.**

The commissioner of human services, in consultation with county human services representatives, shall analyze the differences in asset limit requirements across human services assistance programs, including group residential housing, Minnesota supplemental aid, general assistance, Minnesota family investment program, diversionary work program, the federal Supplemental Nutrition Assistance Program, state food assistance programs, and child care programs. The goal of the analysis is to establish a consistent asset limit across human services programs and minimize the administrative burdens on counties in implementing asset tests. The commissioner shall report its findings and conclusions to the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2013, and include draft legislation establishing a uniform asset limit for human services assistance programs.

#### **Sec. 29. DIRECTIONS TO THE COMMISSIONER.**

The commissioner of human services, in consultation with the commissioner of public safety, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance regarding the implementation of Minnesota Statutes, section 256.01, subdivisions 18c, 18d, and 18e, the number of persons affected, and fiscal impact by program by December 1, 2013.

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

#### **Sec. 30. REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "assistance transaction card" or similar terms to "electronic benefit transaction" or similar terms wherever they appear in Minnesota Statutes, chapter 256. The revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

**ARTICLE 4**  
**CONTINUING CARE**

Section 1. Minnesota Statutes 2010, section 62J.496, subdivision 2, is amended to read:

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

- (1) federally qualified health centers;
- (2) community clinics, as defined under section 145.9268;
- (3) nonprofit or local unit of government hospitals licensed under sections 144.50 to 144.56;
- (4) individual or small group physician practices that are focused primarily on primary care;
- (5) nursing facilities licensed under sections 144A.01 to 144A.27;
- (6) local public health departments as defined in chapter 145A; and
- (7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

(b) The commissioner shall administer the loan fund to prioritize support and assistance to:

- (1) critical access hospitals;
- (2) federally qualified health centers;
- (3) entities that serve uninsured, underinsured, and medically underserved individuals, regardless of whether such area is urban or rural; ~~and~~
- (4) individual or small group practices that are primarily focused on primary care; ~~;~~
- (5) nursing facilities certified to participate in the medical assistance program; and
- (6) providers enrolled in the elderly waiver program of customized living or 24-hour customized living of the medical assistance program, if at least half of their annual operating revenue is paid under the medical assistance program.

(c) An eligible applicant must submit a loan application to the commissioner of health on forms prescribed by the commissioner. The application must include, at a minimum:

- (1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used;
- (2) a quote from a vendor;
- (3) a description of the health care entities and other groups participating in the project;
- (4) evidence of financial stability and a demonstrated ability to repay the loan; and
- (5) a description of how the system to be financed interoperates or plans in the future to interoperate with other health care entities and provider groups located in the same geographical area;

(6) a plan on how the certified electronic health record technology will be maintained and supported over time; and

(7) any other requirements for applications included or developed pursuant to section 3014 of the HITECH Act.

Sec. 2. Minnesota Statutes 2010, section 144A.073, is amended by adding a subdivision to read:

Subd. 13. **Moratorium exception funding.** In fiscal year 2013, the commissioner of health may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed \$1,000,000.

Sec. 3. Minnesota Statutes 2010, section 144A.351, is amended to read:

**144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT REQUIRED.**

The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, ~~2004~~ 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The report shall address:

- (1) demographics and need for long-term care services and supports in Minnesota;
- (2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;
- (3) status of long-term care services and mental illnesses, housing options, and supports by county and region including:
  - (i) changes in availability of the range of long-term care services and housing options;
  - (ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and
  - (iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and progress changes over time; and
- (4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

Sec. 4. Minnesota Statutes 2010, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

- (1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 5. Minnesota Statutes 2010, section 245A.03, is amended by adding a subdivision to read:

Subd. 6a. **Adult foster care homes serving people with mental illness; certification.** (a) The commissioner of human services shall issue a mental health certification for adult foster care homes licensed under this chapter and Minnesota Rules, parts 9555.5105 to 9555.6265, that serve people with mental illness where the home is not

the primary residence of the license holder when a provider is determined to have met the requirements under paragraph (b). This certification is voluntary for license holders. The certification shall be printed on the license, and identified on the commissioner's public Web site.

(b) The requirements for certification are:

(1) all staff working in the adult foster care home have received at least seven hours of annual training covering all of the following topics:

(i) mental health diagnoses;

(ii) mental health crisis response and de-escalation techniques;

(iii) recovery from mental illness;

(iv) treatment options including evidence-based practices;

(v) medications and their side effects;

(vi) co-occurring substance abuse and health conditions; and

(vii) community resources;

(2) a mental health professional, as defined in section 245.462, subdivision 18, or a mental health practitioner as defined in section 245.462, subdivision 17, are available for consultation and assistance;

(3) there is a plan and protocol in place to address a mental health crisis; and

(4) each individual's Individual Placement Agreement identifies who is providing clinical services and their contact information, and includes an individual crisis prevention and management plan developed with the individual.

(c) License holders seeking certification under this subdivision must request this certification on forms provided by the commissioner and must submit the request to the county licensing agency in which the home is located. The county licensing agency must forward the request to the commissioner with a county recommendation regarding whether the commissioner should issue the certification.

(d) Ongoing compliance with the certification requirements under paragraph (b) shall be reviewed by the county licensing agency at each licensing review. When a county licensing agency determines that the requirements of paragraph (b) are not met, the county shall inform the commissioner, and the commissioner will remove the certification.

(e) A denial of the certification or the removal of the certification based on a determination that the requirements under paragraph (b) have not been met by the adult foster care license holder are not subject to appeal. A license holder that has been denied a certification or that has had a certification removed may again request certification when the license holder is in compliance with the requirements of paragraph (b).

Sec. 6. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, 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
- (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 statewide licensed capacity for the home foster care settings where the physical location is not the primary residence of the license holder, if the voluntary changes described in paragraph (g) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(f) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (e) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder is certified under the requirements in subdivision 6a.

(g) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (e) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the

long-term care services reports and statewide data and information. By February 1 of each year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

Sec. 7. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

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

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

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

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

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of a fifth bed for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with section 245A.03, subdivision 7, and section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed foster care provider is licensed. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the foster care home; and

(4) individuals living in the foster care home must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

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

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

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

(i) individualized plan of care;

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

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

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

(4) the facility was licensed for adult foster care before March 1, ~~2009~~ 2011.

~~(f)~~ (g) The commissioner shall not issue a new adult foster care license under paragraph ~~(e)~~ (f) after June 30, ~~2011~~ 2016. The commissioner shall allow a facility with an adult foster care license issued under paragraph ~~(e)~~ (f) before June 30, ~~2011~~ 2016, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph ~~(e)~~ (f).

Sec. 8. Minnesota Statutes 2010, section 245A.11, subdivision 7, is amended to read:

Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow for alternative methods of overnight supervision. The commissioner may grant the variance if the local county licensing agency recommends the variance and the county recommendation includes documentation verifying that:

(1) the county has approved the license holder's plan for alternative methods of providing overnight supervision and determined the plan protects the residents' health, safety, and rights;

(2) the license holder has obtained written and signed informed consent from each resident or each resident's legal representative documenting the resident's or legal representative's agreement with the alternative method of overnight supervision; and

(3) the alternative method of providing overnight supervision, which may include the use of technology, is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

(b) To be eligible for a variance under paragraph (a), the adult foster care license holder must not have had a licensing action conditional license issued under section 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

(c) A license holder requesting a variance under this subdivision to utilize technology as a component of a plan for alternative overnight supervision may request the commissioner's review in the absence of a county recommendation. Upon receipt of such a request from a license holder, the commissioner shall review the variance request with the county.

Sec. 9. Minnesota Statutes 2010, section 245A.11, subdivision 7a, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care license.**

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

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

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

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

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

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

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

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

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

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

- (i) a description of the triggering incident;
- (ii) the date and time of the triggering incident;
- (iii) the time of the response or responses under paragraph (e), clause (1) or (2);
- (iv) whether the response met the resident's needs;
- (v) whether the existing policies and response protocols were followed; and
- (vi) whether the existing policies and protocols are adequate or need modification.

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

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

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

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

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

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the foster care recipient without requiring the initiation of the foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each foster care recipient's individualized plan of care, individual service plan under section 256B.092, subdivision 1b, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the

maximum response time, which may be greater than ten minutes, for the license holder to be on site for that foster care recipient.

(f) ~~At~~ Each foster care recipient's placement agreements agreement, individual service agreements, and plans applicable to the foster care recipient agreement, and plan must clearly state that the adult foster care license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of foster care recipients under paragraph (e), clause (1) or (2); and a signed informed consent from each foster care recipient or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

(1) how any electronic monitoring is incorporated into the alternative supervision system;

(2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;

(3) how the ~~license holder is~~ caregivers are trained on the use of the technology;

(4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects the foster care recipient's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A foster care recipient may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

(6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

(i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and contractors affiliated with the license holder.

(j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely determine what action the license holder needs to take to protect the well-being of the foster care recipient.

(k) The commissioner shall evaluate license applications using the requirements in paragraphs (d) to (f). The commissioner shall provide detailed application forms, including a checklist of criteria needed for approval.

(l) To be eligible for a license under paragraph (a), the adult foster care license holder must not have had a conditional license issued under section 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

(m) The commissioner shall review an application for an alternative overnight supervision license within 60 days of receipt of the application. When the commissioner receives an application that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05. The commissioner shall complete subsequent review within 30 days.

(n) Once the application is considered complete under paragraph (m), the commissioner will approve or deny an application for an alternative overnight supervision license within 60 days.

(o) For the purposes of this subdivision, "supervision" means:

(1) oversight by a caregiver as specified in the individual resident's place agreement and awareness of the resident's needs and activities; and

(2) the presence of a caregiver in a residence during normal sleeping hours, unless a determination has been made and documented in the individual's support plan that the individual does not require the presence of a caregiver during normal sleeping hours.

Sec. 10. Minnesota Statutes 2010, section 245B.07, subdivision 1, is amended to read:

Subdivision 1. **Consumer data file.** The license holder must maintain the following information for each consumer:

(1) identifying information that includes date of birth, medications, legal representative, history, medical, and other individual-specific information, and names and telephone numbers of contacts;

(2) consumer health information, including individual medication administration and monitoring information;

(3) the consumer's individual service plan. When a consumer's case manager does not provide a current individual service plan, the license holder shall make a written request to the case manager to provide a copy of the individual service plan and inform the consumer or the consumer's legal representative of the right to an individual service plan and the right to appeal under section 256.045. In the event the case manager fails to provide an individual service plan after a written request from the license holder, the license holder shall not be sanctioned or penalized financially for not having a current individual service plan in the consumer's data file;

(4) copies of assessments, analyses, summaries, and recommendations;

(5) progress review reports;

(6) incidents involving the consumer;

- (7) reports required under section 245B.05, subdivision 7;
- (8) discharge summary, when applicable;
- (9) record of other license holders serving the consumer that includes a contact person and telephone numbers, services being provided, services that require coordination between two license holders, and name of staff responsible for coordination;
- (10) information about verbal aggression directed at the consumer by another consumer; and
- (11) information about self-abuse.

Sec. 11. Minnesota Statutes 2010, section 245C.04, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** (a) Providers required to initiate background studies under section 256B.4912 must initiate a study before the individual begins in a position allowing direct contact with persons served by the provider.

(b) ~~The commissioner shall conduct~~ Except as provided in paragraph (c), the providers must initiate a background study annually of an individual required to be studied under section 245C.03, subdivision 6.

(c) After an initial background study under this subdivision is initiated on an individual by a provider of both services licensed by the commissioner and the unlicensed services under this subdivision, a repeat annual background study is not required if:

(1) the provider maintains compliance with the requirements of section 245C.07, paragraph (a), regarding one individual with one address and telephone number as the person to receive sensitive background study information for the multiple programs that depend on the same background study, and that the individual who is designated to receive the sensitive background information is capable of determining, upon the request of the commissioner, whether a background study subject is providing direct contact services in one or more of the provider's programs or services and, if so, at which location or locations; and

(2) the individual who is the subject of the background study provides direct contact services under the provider's licensed program for at least 40 hours per year so the individual will be recognized by a probation officer or corrections agent to prompt a report to the commissioner regarding criminal convictions as required under section 245C.05, subdivision 7.

Sec. 12. Minnesota Statutes 2010, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual is:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care programs.

Sec. 13. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 7.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ten percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1:

- (1) the parent applied for insurance for the child;
- (2) the insurer denied insurance;
- (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and
- (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, ~~2013~~ 2015, the parental contribution shall be computed by applying the following contribution schedule to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

Sec. 14. Minnesota Statutes 2010, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must provide long-term care options counseling by assisting older adults, caregivers, and providers in accessing information and options counseling about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options;

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health;

(9) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs; ~~and~~

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability; and

(12) develop referral protocols and processes that will assist certified health care homes and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this

section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation criteria and protocols available at the time of hospital discharge. The commissioner shall keep a record of the number of people who choose long-term care options counseling as a result of this section.

Sec. 15. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except as provided under subdivision 3, paragraph (a), clause (6). 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. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, shall be used, except that effective October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

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

Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

(5) 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 (d); ~~and~~

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013 is required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

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

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

Sec. 17. Minnesota Statutes 2011 Supplement, 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 (d); and

~~(4)~~ (3) 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.

(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; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(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;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(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 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.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under section 256.01, subdivision 18b.

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(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 April 1, 2012.

Sec. 18. Minnesota Statutes 2011 Supplement, 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;

(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) 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. This rate reduction is effective July 1, 2013. 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.

Sec. 19. Minnesota Statutes 2010, section 256B.0659, is amended by adding a subdivision to read:

Subd. 31. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and/or terminating the personal care provider organization's enrollment according to section 256B.064.

Sec. 20. Minnesota Statutes 2011 Supplement, 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.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining their recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed 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 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. 21. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Consultation for housing with services.** (a) The purpose of 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. Prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Registered housing with services establishments shall inform all prospective residents or the prospective resident's designated or legal representative 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 is provided as determined by the commissioner of human services. 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 shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:

(i) the resident verbally requests; or

(ii) the registered housing with services provider has documentation of the designated or legal representative's authority to enter into a lease or contract on behalf of the prospective resident and accepts the documentation in good faith;

(2) the consultation shall be performed in a manner that provides objective and complete information;

~~(2)~~ (3) the consultation must include a review of the prospective resident's reasons for considering 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 housing with services settings that may meet the prospective resident's needs;

~~(3)~~ (4) the prospective resident shall be informed of the availability of a face-to-face visit at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and

~~(4)~~ (5) 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 or the prospective resident's designated or legal representative 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.

(d) Emergency admissions to registered housing with services establishments prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.

Sec. 22. Minnesota Statutes 2010, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3d. **Exemptions.** Individuals shall be exempt from the requirements outlined in subdivision 3c in the following circumstances:

(1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

(2) the individual has previously received a long-term care consultation assessment under this section. In this instance, the assessor who completes the long-term care consultation will issue a verification code and provide it to the individual;

(3) the individual is receiving or is being evaluated for hospice services from a hospice provider licensed under sections 144A.75 to 144A.755; or

(4) the individual has used financial planning services and created a long-term care plan as defined by the commissioner in the 12 months prior to signing a lease or contract with a registered housing with services establishment.

Sec. 23. Minnesota Statutes 2010, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3e. **Consultation at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under section 256.975, subdivision 7. The purpose of the counseling 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 setting.

(b) The individuals who shall be referred under paragraph (a) include older adults who are at risk of nursing home placement. Protocols for identifying at-risk individuals shall be developed under section 256.975, subdivision 7, paragraph (b), clause (12).

(c) Counseling provided under this subdivision shall meet the requirements for the consultation required under section 256B.0911, subdivision 3c.

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

Sec. 24. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, 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) 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. 25. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, 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 July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at

least 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

(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) 24-hour 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.

~~(h)~~ (i) 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. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Individual service plan.** (a) The individual service plan must:

(1) include the results of the assessment information on the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(2) identify the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(3) identify long- and short-range goals for the person;

(4) identify specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The individual service plan shall also specify other services the person needs that are not available;

(5) identify the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(6) identify provider responsibilities to implement and make recommendations for modification to the individual service plan;

(7) include notice of the right to request a conciliation conference or a hearing under section 256.045;

(8) be agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

(9) be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

(b) Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **Screening teams.** (a) For persons with developmental disabilities, screening teams shall be established which shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The evaluation shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or

for whom there is reasonable indication that they might require this level of care. The screening team shall make an evaluation of need within 60 working days of a request for service by a person with a developmental disability, and within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.

(b) The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition.

(c) County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services.

(d) For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waived services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional.

(e) For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs.

(f) The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. With the permission of the person being screened or the person's designated legal representative, the person's current provider of services may submit a written report outlining their recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The screening team must notify the provider of the date by which this information is to be submitted. This information must be provided to the screening team and the person or the person's legal representative and must be considered prior to the finalization of the screening.

(g) No member of the screening team shall have any direct or indirect service provider interest in the case.

(h) Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.

Sec. 28. Minnesota Statutes 2011 Supplement, section 256B.097, subdivision 3, is amended to read:

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;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2013, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(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.

Sec. 29. Minnesota Statutes 2010, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Sec. 30. Minnesota Statutes 2010, section 256B.431, is amended by adding a subdivision to read:

Subd. 45. **Rate adjustments for some moratorium exception projects.** Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest

set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

**EFFECTIVE DATE.** This section is effective upon federal approval.

Sec. 31. Minnesota Statutes 2010, section 256B.434, subdivision 10, is amended to read:

Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

~~(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.~~

~~(d)~~ (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

~~(e)~~ (d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

~~(f)~~ (e) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.

Sec. 32. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with operating payment rates being the sum of 60 percent of the operating payment rate determined in accordance with subdivision 54 and 40 percent of the operating payment rate that would have been allowed had the facility not been designated;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivisions 3f, paragraph (a), and 17e, shall be 40 percent of the amount that would otherwise apply; and

(5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

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

Sec. 33. Minnesota Statutes 2010, section 256B.48, is amended by adding a subdivision to read:

Subd. 6a. **Referrals to Medicare providers required.** Notwithstanding subdivision 1, nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner shall audit nursing facilities that do not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

Sec. 34. Minnesota Statutes 2011 Supplement, 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. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding the recipient's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment.

(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 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify 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.

Sec. 35. Minnesota Statutes 2011 Supplement, 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 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.

(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 and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (g), or as 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 assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by ~~June 30, 2012~~ July 1, 2013.

Sec. 36. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 23, is amended 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 as demonstrated by the lease agreement, or has a plan for transition of a lease from a service provider to the individual. Within two years of signing the initial lease, the service provider shall transfer the lease to the individual. In the event the landlord denies the transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the individual. 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. 37. **[256B.492] HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.**

(a) Individuals receiving services under a home and community-based waiver under Minnesota Statutes, section 256B.092 or 256B.49, may receive services in the following settings:

- (1) an individual's own home or family home;
- (2) a licensed adult foster care setting of up to five people; and
- (3) community living settings as defined in Minnesota Statutes, section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units.

(b) The settings in paragraph (a) must not:

- (1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;
- (2) be located in a building on the grounds of or adjacent to a public or private institution;
- (3) be a housing complex designed expressly around an individual's diagnosis or disability;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of the effective date of this section and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

**Sec. 38. [256B.493] ADULT FOSTER CARE PLANNED CLOSURE.**

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings.

Subd. 2. **Planned closure process needs determination.** The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph (e). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph (e).

Subd. 3. **Application process.** (a) The commissioner shall establish a process for the application, review, and approval of proposals from license holders for the closure of adult foster care settings.

(b) When an application for a planned closure rate adjustment is submitted, the license holder shall provide written notification within five working days to the lead agencies responsible for authorizing the licensed services for the residents of the affected adult foster care settings. This notification shall be deemed confidential until the license holder has received approval of the application by the commissioner.

Subd. 4. **Review and approval process.** (a) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must identify the home or homes, and occupied beds for which a planned closure rate adjustment is requested;

(2) the proposed timetable for any proposed closure, including the proposed dates for notification to residents and the affected lead agencies, commencement of closure, and completion of closure;

(3) the proposed relocation plan jointly developed by the counties of financial responsibility, the residents and their legal representatives, if any, who wish to continue to receive services from the provider, and the providers for current residents of any adult foster care home designated for closure; and

(4) documentation in a format approved by the commissioner that all the adult foster care homes receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under this plan.

(b) In reviewing and approving closure proposals, the commissioner shall give first priority to proposals that:

(1) target counties and geographic areas which have:

(i) need for other types of services;

(ii) need for specialized services;

(iii) higher than average per capita use of foster care settings where the license holder does not reside; or

(iv) residents not living in the geographic area of their choice;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative services are based on the recipient's choice of provider and are consistent with federal law, state law, and federally approved waiver plans.

The commissioner shall also consider any information provided by service recipients, their legal representatives, family members, or the lead agency on the impact of the planned closure on the recipients and the services they need.

(c) The commissioner shall select proposals that best meet the criteria established in this subdivision for planned closure of adult foster care settings. The commissioner shall notify license holders of the selections approved by the commissioner.

(d) For each proposal approved by the commissioner, a contract must be established between the commissioner, the counties of financial responsibility, and the participating license holder.

Subd. 5. **Notification of approved proposal.** (a) Once the license holder receives notification from the commissioner that the proposal has been approved, the license holder shall provide written notification within five working days to:

(1) the lead agencies responsible for authorizing the licensed services for the residents of the affected adult foster care settings; and

(2) current and prospective residents, any legal representatives, and family members involved.

(b) This notification must occur at least 45 days prior to the implementation of the closure proposal.

Subd. 6. **Adjustment to rates.** (a) For purposes of this section, the commissioner shall establish enhanced medical assistance payment rates under sections 256B.092 and 256B.49, to facilitate an orderly transition for persons with disabilities from adult foster care to other community-based settings.

(b) The enhanced payment rate shall be effective the day after the first resident has moved until the day the last resident has moved, not to exceed six months.

Sec. 39. Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13, is amended to read:

Subd. 13. **ICF/DD rate decrease effective July 1, ~~2012~~ 2013.** Notwithstanding subdivision 12, and if the commissioner has not received federal approval before July 1, 2013, of the Long-Term Care Realignment Waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, for each facility reimbursed under this section for services provided from July 1, 2013, through December 31, 2013, the commissioner shall decrease operating payments ~~equal~~ up to 1.67 percent of the operating payment rates in effect on June 30, ~~2012~~ 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in article 6, section 2, subdivision 4, paragraph (f). 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. 40. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. In a multifamily building ~~of four or more~~

~~units, the maximum number of apartments that may be used by recipients of this program shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012. of more than four units, the maximum number of units that may be used by recipients of this program shall be the greater of four units or 25 percent of the units in the building. In multifamily buildings of four or fewer units, all of the units may be used by recipients of this program. When housing is controlled by the service provider, the individual may choose their own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.~~

Sec. 41. Laws 2011, First Special Session chapter 9, article 7, section 52, is amended to read:

**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 or after July 1, 2012, for adults and children.

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

Sec. 42. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to read:

**Sec. 54. CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

(a) Notwithstanding any other rate reduction in this article, if the commissioner of human services has not received federal approval before July 1, 2013, of the long-term care realignment waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, 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, 2013, for services rendered on or after those dates from July 1, 2013, through December 31, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in article 6, section 2, subdivision 4, paragraph (f). 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;

(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 up to a 2.34 1.67 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,~~ July 1, 2013, through December 31, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

Sec. 43. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3, is amended to read:

### Subd. 3. Forecasted Programs

The amounts that may be spent from this appropriation for each purpose are as follows:

#### (a) MFIP/DWP Grants

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) MFIP Child Care Assistance Grants 55,456,000 30,923,000

<b>(c) General Assistance Grants</b>	49,192,000	46,938,000
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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>(d) Minnesota Supplemental Aid Grants</b>	38,095,000	39,120,000
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<b>(e) Group Residential Housing Grants</b>	121,080,000	129,238,000
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<b>(f) MinnesotaCare Grants</b>	295,046,000	317,272,000
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This appropriation is from the health care access fund.

<b>(g) Medical Assistance Grants</b>	4,501,582,000	4,437,282,000
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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 settings for CADI. Lead agencies shall consult with providers to review individual service

plans and identify changes or modifications to reduce the utilization of services while maintaining the health and safety of the individual receiving services. Lead agencies must adjust contracts within 60 days of the effective date. If federal waiver approval is obtained under the long-term care realignment waiver application submitted on February 13, 2012, and federal financial participation is authorized for the alternative care program, the commissioner shall adjust this payment rate reduction from ten to five percent for services rendered on or after July 1, 2012, or the first day of the month following federal approval, whichever is later.

**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 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. This rate reduction is effective July 1, 2013.

(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

Sec. 44. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 4, is amended to read:

**Subd. 4. Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	100,525,000	94,611,000

**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**

37,144,000                      38,678,000

**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**

Appropriations by Fund

General	47,949,000	48,507,000
Federal TANF	140,000	140,000

**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.

<b>(f) Children and Community Services Grants</b>	53,301,000	53,301,000
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**(g) Children and Economic Support Grants**

Appropriations by Fund

General	16,103,000	16,180,000
Federal TANF	700,000	0

**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

General	26,000	66,000
Health Care Access	190,000	190,000

**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 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.

(j) **Deaf and Hard-of-Hearing Grants** 1,936,000 1,767,000

(k) **Disabilities Grants** 15,945,000 18,284,000

**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.

**Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs.** (1) 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.

(2) Notwithstanding clause (1), for fiscal years 2012 and 2013 only, the appropriation of \$250,000 for fiscal year 2012 carries forward to fiscal year 2013, effective the day following final enactment.

Of the appropriations available for fiscal year 2013, \$100,000 is for administrative functions related to the planning process required under Minnesota Statutes, sections 144A.351 and 245A.03, subdivision 7, paragraphs (e) and (g), and \$400,000 is for grants required to accomplish that planning process.

(3) Base funding for the grants under clause (1) is not affected by the appropriations under clause (2).

**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		
General	70,570,000	70,570,000
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.

**Base Adjustment.** The general fund base is increased by \$200,000 in fiscal years 2014 and 2015.

**(m) Children's Mental Health Grants** 16,457,000 16,457,000

**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** 1,336,000 1,336,000

**Sec. 45. INDEPENDENT LIVING SERVICES BILLING.**

The commissioner shall allow for daily rate and 15-minute increment billing for independent living services under the brain injury (BI) and CADI waivers. If necessary to comply with this requirement, the commissioner shall submit a waiver amendment to the state plan no later than December 31, 2012.

**Sec. 46. HOME AND COMMUNITY-BASED SERVICES WAIVERS AMENDMENT FOR EXCEPTION.**

By September 1, 2012, the commissioner of human services shall submit amendments to the home and community-based waiver plans consistent with the definition of home and community-based settings under Minnesota Statutes, section 256B.492, including a request to allow an exception for those settings that serve persons with

disabilities under a home and community-based service waiver in more than 25 percent of the units in a building as of January 1, 2012, but otherwise meet the definition under Minnesota Statutes, section 256B.492.

**Sec. 47. COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY.**

By July 1, 2012, the commissioner shall request an amendment to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for those participants who have their 21st birthday and graduate from high school during 2013 and are authorized for more services under consumer-directed community supports prior to graduation than what they are eligible to receive under the current consumer-directed community supports budget methodology. The exception is limited to those who can demonstrate that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits. The commissioner shall consult with the stakeholder group authorized under Minnesota Statutes, section 256B.0657, subdivision 11, to implement this provision. The exception process shall be effective upon federal approval for persons eligible during 2013 and 2014.

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

**Sec. 48. DIRECTION TO OMBUDSMAN FOR LONG-TERM CARE.**

The ombudsman for long-term care shall:

(1) research the existence of differential treatment based on source of payment in assisted living settings;

(2) convene stakeholders to provide technical assistance and expertise in studying and addressing these issues, including but not limited to consumers, health care and housing providers, advocates representing seniors and younger persons with disabilities or mental health challenges, county representatives, and representatives of the Departments of Health and Human Services; and

(3) submit a report of findings to the legislature no later than January 31, 2013, with recommendations for the development of policies and procedures to prevent and remedy instances of discrimination based on participation in or potential eligibility for medical assistance.

**Sec. 49. LICENSING PERSONAL CARE ATTENDANT SERVICES.**

The commissioner of human services shall study the feasibility of licensing personal care attendant services and issue a report to the legislature no later than January 15, 2013, that includes recommendations and proposed legislation for licensure and oversight of these services.

**Sec. 50. AUTISM HOUSING WITH SUPPORTS STUDY.**

The commissioner of human services, in consultation with the commissioners of education, health, and employment and economic development, shall complete a study

to determine one or more models of housing with supports that involve coordination or integration across the human services, educational, and vocational systems for children with a diagnosis of autistic disorder as defined by diagnostic code 299.0 in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This study must include research on recent efforts undertaken or under consideration in other states to address the housing and long-term support needs of children with severe autism, including a campus model. The study shall result in an implementation plan that responds to the housing and service needs of persons with autism. The study is due to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by January 15, 2013.

Sec. 51. **REPEALER.**

(a) Minnesota Statutes 2010, sections 144A.073, subdivision 9; and 256B.48, subdivision 6, are repealed.

(b) Minnesota Rules, part 4640.0800, subpart 4, is repealed.

**ARTICLE 5**

**MISCELLANEOUS**

Section 1. Minnesota Statutes 2010, section 62A.047, is amended to read:

**62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.**

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing in this section prohibits a health carrier that has a network of providers from imposing a deductible, co-payment, or other coinsurance or dollar limitation requirement for child health supervision services and prenatal care services that are delivered by an out-of-network provider. This section does not prohibit the use of policy waiting periods or preexisting condition limitations for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. ~~Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage. Nothing in this section applies to a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or non-expense-incurred basis, or a policy that provides only accident coverage.~~

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as

defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

**EFFECTIVE DATE.** The amendments to this section are effective for policies issued on or after August 1, 2012, and expire June 30, 2013.

Sec. 2. Minnesota Statutes 2010, section 245.697, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created. The council must have ~~30~~ members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

- (1) the assistant commissioner of mental health for the department of human services;
- (2) a representative of the Department of Human Services responsible for the medical assistance program;
- (3) one member of each of the ~~four core mental health professional disciplines (psychiatry, psychology, social work, nursing);~~ following professions:
  - (i) psychiatry;
  - (ii) psychology;
  - (iii) social work;
  - (iv) nursing;
  - (v) marriage and family therapy; and
  - (vi) professional clinical counseling;
- (4) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, Mental Health Consumer/Survivor Network of Minnesota, and Minnesota Disability Law Center;
- (5) providers of mental health services;
- (6) consumers of mental health services;
- (7) family members of persons with mental illnesses;
- (8) legislators;
- (9) social service agency directors;
- (10) county commissioners; and
- (11) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Sec. 3. Minnesota Statutes 2010, section 254A.19, is amended by adding a subdivision to read:

Subd. 4. **Civil commitments.** A Rule 25 assessment, under Minnesota Rules, part 9530.6615, does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section 253B.065, 253B.09, or 253B.095 in order for a county to access consolidated chemical dependency treatment funds under section 254B.04. The county must determine if the individual meets the financial eligibility requirements for the consolidated chemical dependency treatment funds under section 254B.04. Nothing in this subdivision prohibits placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.

Sec. 4. Minnesota Statutes 2010, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is ~~under contract with the county board~~ certified under subdivision 4 to operate a program that meets the requirements of section ~~245.4712, subdivision 2,~~ or 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a two-hour time block. The two-hour time block must include at least one hour of individual or group psychotherapy. The remainder of the structured treatment program may include individual or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. A day treatment program may provide fewer

than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program; and

(4) a therapeutic preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available two hours per day, five days per week, and 12 months of each calendar year. The structured treatment program may include individual or group psychotherapy and individual or group skills training, if included in the client's individual treatment plan. A therapeutic preschool program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (p), as previously taught by a mental health professional or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement treatment strategies

in the individual treatment plan and the individual behavior plan. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) direction of a mental health behavioral aide must include the following:

(i) a clinical supervision plan approved by the responsible mental health professional;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 5. Minnesota Statutes 2010, section 518A.40, subdivision 4, is amended to read:

Subd. 4. **Change in child care.** (a) When a court order provides for child care expenses, and child care support is not assigned under section 256.741, the public authority, if the public authority provides child support enforcement services, ~~must~~ may suspend collecting the amount allocated for child care expenses when:

~~(1)~~ either party informs the public authority that no child care costs are being incurred; and;

~~(2)~~ (1) the public authority verifies the accuracy of the information with the obligee; or

(2) the obligee fails to respond within 30 days of the date of a written request from the public authority for information regarding child care costs. A written or oral response from the obligee that child care costs are being incurred is sufficient for the public authority to continue collecting child care expenses.

The suspension is effective as of the first day of the month following the date that the public authority ~~received the verification~~ either verified the information with the obligee or the obligee failed to respond. The public authority will resume collecting child care expenses when either party provides information that child care costs ~~have resumed~~ are incurred, or when a child care support assignment takes effect under section 256.741, subdivision 4. The resumption is effective as of the first day of the month after the date that the public authority received the information.

(b) If the parties provide conflicting information to the public authority regarding whether child care expenses are being incurred, ~~or if the public authority is unable to verify with the obligee that no child care costs are being incurred;~~ the public authority will continue or resume collecting child care expenses. Either party, by motion to the court, may challenge the suspension, continuation, or resumption of the collection of child care expenses under this subdivision. If the public authority suspends collection activities for the amount allocated for child care expenses, all other provisions of the court order remain in effect.

(c) In cases where there is a substantial increase or decrease in child care expenses, the parties may modify the order under section 518A.39.

Sec. 6. Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, is amended to read:

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 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.

**Base Adjustment.** The State Government Special Revenue Fund base is decreased by \$911,000 in fiscal year 2014 and ~~\$1,011,000~~ \$961,000 in fiscal year 2015.

**Sec. 7. FOSTER CARE FOR INDIVIDUALS WITH AUTISM.**

The commissioner of human services shall identify and coordinate with one or more counties that agree to issue a foster care license and authorize funding for people with autism who are currently receiving home and community-based services under Minnesota Statutes, section 256B.092 or 256B.49. Children eligible under this section must be in an out-of-home placement approved by the lead agency that has legal responsibility for the placement. Nothing in this section must be construed as restricting an individual's choice of provider. The commissioner will assist the interested county or counties with obtaining necessary capacity within the moratorium under Minnesota Statutes, section 245A.03, subdivision 7. The commissioner shall coordinate with the interested counties and issue a request for information to identify providers who have the training and skills to meet the needs of the individuals identified in this section.

**Sec. 8. CHEMICAL HEALTH INTEGRATED MODEL OF CARE DEVELOPMENT.**

(a) The commissioner of human services, in partnership with the counties, tribes, and stakeholders, shall develop a community-based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals. The plan shall identify methods to reduce duplication of efforts, promote scientifically supported practices, and improve efficiency. This plan shall consider the potential for geographically or demographically disparate impact on individuals who need chemical dependency services.

(b) The commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report detailing necessary statutory and rule changes and a proposed pilot project to implement the plan no later than March 15, 2013.

**Sec. 9. [137.028] BIENNIAL BUDGET REQUEST; UNIVERSITY OF MINNESOTA.**

Beginning in 2013, as part of the biennial budget request submitted to the Department of Management and Budget and the legislature, the Board of Regents of the University of Minnesota is encouraged to include a request for funding for rural primary care training by family practice residence programs to prepare doctors for the practice of primary care medicine in rural areas of the state. The funding request should provide for ongoing support of rural primary care training through the University of Minnesota's general operation and maintenance funding or through dedicated health science funding.

**ARTICLE 6**

**HEALTH AND HUMAN SERVICES APPROPRIATIONS**

**Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other 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 addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2012, are effective the day following final enactment unless a different effective date is explicit.

**APPROPRIATIONS**  
**Available for the Year**  
**Ending June 30**  
**2012**                      **2013**

**Sec. 2. COMMISSIONER OF HUMAN SERVICES**

<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>1,352,000</u>	<u>\$</u>	<u>19,849,000</u>
<u>Appropriations by Fund</u>				
		<u>2012</u>		<u>2013</u>
<u>General</u>		<u>803,000</u>		<u>9,680,000</u>
<u>Health Care Access</u>		<u>-0-</u>		<u>3,000</u>

Federal TANF	<u>-0-</u>	<u>7,453,000</u>
Special Revenue	<u>549,000</u>	<u>2,713,000</u>

**Subd. 2. Central Office Operations**

<b>(a) <u>Operations</u></b>	<u>118,000</u>	<u>356,000</u>
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**Base Level Adjustment.** The general fund base is increased by \$91,000 in fiscal year 2014 and \$44,000 in fiscal year 2015.

<b>(b) <u>Health Care</u></b>	<u>24,000</u>	<u>346,000</u>
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This is a onetime appropriation.

**Managed Care Audit Activities.** In fiscal year 2014, and in each even-numbered year thereafter, the commissioner shall transfer from the health care access fund \$1,740,000 to the legislative auditor for managed care audit services under Minnesota Statutes, section 256B.69, subdivision 9d. This is a biennial appropriation. The health care access fund base is increased by \$1,842,000 in fiscal year 2014. Notwithstanding any contrary provision in this article, this paragraph does not expire.

<b>(c) <u>Continuing Care</u></b>	<u>19,000</u>	<u>375,000</u>
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**Base Level Adjustment.** The general fund base is decreased by \$159,000 in fiscal years 2014 and 2015.

<b>Subd. 3. <u>Chemical and Mental Health</u></b>	<u>19,000</u>	<u>68,000</u>
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**Base Level Adjustment.** The general fund base is decreased by \$68,000 in fiscal years 2014 and 2015.

**Subd. 4. Forecasted Programs**

**(a) MFIP/DWP Grants**

Appropriations by Fund

2012

2013

<u>General</u>	<u>-0-</u>	<u>(7,009,000)</u>
<u>Federal TANF</u>	<u>-0-</u>	<u>7,000,000</u>
<b><u>(b) General Assistance Grants</u></b>	<u>-0-</u>	<u>(8,000)</u>
<b><u>(c) Minnesota Supplemental Aid Grants</u></b>	<u>-0-</u>	<u>152,000</u>
<b><u>(d) MinnesotaCare Grants</u></b>	<u>-0-</u>	<u>3,000</u>
<u>This appropriation is from the health care access fund.</u>		
<b><u>(e) Group Residential Housing Grants</u></b>	<u>-0-</u>	<u>(202,000)</u>
<b><u>(f) Medical Assistance Grants</u></b>	<u>623,000</u>	<u>14,303,000</u>

**PCA Relative Care Payment Recovery.** Notwithstanding any law to the contrary, and if, at the conclusion of the HealthStar Home Health, Inc et al v. Commissioner of Human Services litigation, the PCA relative rate reduction under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (c), is upheld, the commissioner is prohibited from recovering the difference between the 100 percent rate paid to providers and the 80 percent rate, during the period of the temporary injunction issued on October 26, 2011. This section does not prohibit the commissioner from recovering any other overpayments from providers.

**Long-Term Care Realignment Waiver Conformity.** Notwithstanding Minnesota Statutes, section 256B.0916, subdivision 14, and upon federal approval of the long-term care realignment waiver application, essential community support grants must be made available in a manner that is consistent with the state's long-term care realignment waiver application submitted on February 13, 2012. The commissioner is authorized to use increased federal matching funds resulting from approval of the long-term care realignment waiver as necessary to meet the fiscal year 2013 demand for essential community support grants administered in a manner that is consistent with the terms and conditions of the long-term care realignment

waiver, and that amount of federal funds is appropriated to the commissioner for this purpose.

**Continuing Care Provider Payment Delay.** The commissioner of human services shall delay the last payment or payments in fiscal year 2013 to providers listed in Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, paragraph (b), by up to \$20,688,000. In calculating the actual payment amounts to be delayed, the commissioner must reduce the \$20,688,000 amount by any cash basis state share savings to be realized in fiscal year 2013 from implementing the long-term care realignment waiver before July 1, 2013. The commissioner shall make the delayed payments in July 2013. Notwithstanding any contrary provision in this article, this provision expires on August 1, 2013.

**Critical Access Nursing Facilities Designation.** \$500,000 is appropriated in fiscal year 2013 for critical access nursing facilities under Minnesota Statutes, section 256B.441, subdivision 63. This is a onetime appropriation and is available until expended.

#### Subd. 5. Grant Programs

##### (a) Children and Economic Support Grants

-0-

450,000

**Long-Term Homeless Supportive Services.** \$200,000 in fiscal year 2013 from the TANF fund is for long-term homeless supportive services for low-income families under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

**Family Assets for Independence Program.** \$250,000 in fiscal year 2013 from the TANF fund is for grants for the family assets for independence program under Minnesota Statutes, section 256E.35. This appropriation must be used to serve families with income below 200 percent of the federal poverty guidelines and minor children in the

household. This is a onetime appropriation and is available until June 30, 2014.

**TANF Transfer to Federal Child Care and Development Fund.** (1) In addition to the amount provided in this section, the commissioner shall transfer TANF funds to basic sliding fee child care assistance under Minnesota Statutes, section 119B.03:

(i) fiscal year 2013, \$1,000; and

(ii) fiscal year 2014 and ongoing, \$6,000.

(2) 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.

**(b) Aging and Adult Services Grants** -0- 999,000

In fiscal year 2013, upon federal approval to implement the nursing facility level of care under Minnesota Statutes, section 144.0724, subdivision 11, \$999,000 is for essential community supports grants. This is a onetime appropriation.

**(c) Disabilities Grants** -0- 300,000

**Intractable Epilepsy.** This appropriation includes \$65,000 for living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689, article 2, section 251. This appropriation is ongoing.

**Self-advocacy Network for Persons with Disabilities.**

(1) \$50,000 is appropriated in fiscal year 2013 to establish and maintain a statewide self-advocacy network for persons with intellectual and developmental disabilities. This is a onetime appropriation and is available until expended.

(2) The self-advocacy network must focus on ensuring that persons with disabilities are:

(i) informed of and educated about their legal rights in the areas of education, employment, housing, transportation, and voting; and

(ii) educated and trained to self-advocate for their rights under law.

(3) Self-advocacy network activities under this section include but are not limited to:

(i) education and training, including preemployment and workplace skills;

(ii) establishment and maintenance of a communication and information exchange system for self-advocacy groups; and

(iii) financial and technical assistance to self-advocacy groups.

**Base Level Adjustment.** The general fund base is increased by \$23,000 in fiscal year 2014 and decreased by \$235,000 in fiscal year 2015.

<b><u>Subd. 6. State-Operated Services</u></b>	<u>549,000</u>	<u>2,713,000</u>
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**Minnesota Specialty Health Services - Willmar.** \$549,000 in fiscal year 2012 and \$2,713,000 in fiscal year 2013 from the account established under Minnesota Statutes, section 246.18, subdivision 8, is for continued operation of the Minnesota Specialty Health Services - Willmar. These appropriations are onetime from the special revenue fund. Closure of the facility shall not occur prior to June 30, 2013.

<b><u>Subd. 7. Technical Activities</u></b>	<u>-0-</u>	<u>3,000</u>
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This appropriation is from the TANF fund.

**Base Level Adjustment.** The TANF fund base is increased by \$13,000 in fiscal years 2014 and 2015.

**Sec. 3. COMMISSIONER OF HEALTH**

<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b>	<b><u>\$</u></b>	<b><u>501,000</u></b>
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Appropriations by Fund

<u>2012</u>	<u>2013</u>
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<u>General</u>	<u>-0-</u>	<u>364,000</u>
<u>Health Care Access</u>	<u>-0-</u>	<u>137,000</u>

**Subd. 2. Community and Family Health Promotions**

-0-                      200,000

**Autism Study.**            \$200,000 is for the commissioner of health, in partnership with the University of Minnesota, to conduct a qualitative study focused on cultural and resource-based aspects of autism spectrum disorders (ASD) that are unique to the Somali community. By February 15, 2014, the commissioner shall report the findings of this study to the legislature. The report must include recommendations as to establishment of a population-based public health surveillance system for ASD. This is a onetime appropriation and is available until June 30, 2014.

**Subd. 3. Policy Quality and Compliance**

Appropriations by Fund

	<u>2012</u>	<u>2013</u>
<u>General</u>	<u>-0-</u>	<u>164,000</u>
<u>Health Care Access</u>	<u>-0-</u>	<u>137,000</u>

**Web Site Changes.**            \$36,000 is for Web site changes required as part of the evaluation of health and human services regulatory responsibilities. This is a onetime appropriation and must be shared with the Department of Human Services through an interagency agreement.

**Management and Budget.**    \$100,000 is for transfer to the commissioner of management and budget for the evaluation of health and human services regulatory responsibilities. This is a onetime appropriation.

**Nursing Facility Moratorium Exceptions.** In fiscal year 2013, \$8,000 is for administrative costs related to review of moratorium exception projects under Minnesota Statutes, section 144A.073, subdivision 13. This is a onetime appropriation.

**Health Record Access Study.** \$20,000  
in fiscal year 2013 is for the health record access study. This is a onetime appropriation.

**Radiation Therapy Facilities Study.** In  
fiscal year 2013, \$137,000 from the health care access fund is for a study of radiation therapy facilities capacity. This is a onetime appropriation.

Sec. 4. **BOARD OF NURSING HOME ADMINISTRATORS**

\$

-0- \$

10,000

**Administrative Services Unit.** This  
appropriation is to provide a grant to the Minnesota Ambulance Association to coordinate and prepare an assessment of the extent and costs of uncompensated care as a direct result of emergency responses on interstate highways in Minnesota. The study will collect appropriate information from medical response units and ambulance services regulated under Minnesota Statutes, chapter 144E, and to the extent possible, firefighting agencies. In preparing the assessment, the Minnesota Ambulance Association shall consult with its membership, the Minnesota Fire Chiefs Association, the Office of the State Fire Marshal, and the Emergency Medical Services Regulatory Board. The findings of the assessment will be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health and public safety by January 1, 2013.

Sec. 5. **MANAGED CARE ORGANIZATION EXCESS PROFITS.**

Excess profits of managed care organizations paid to the commissioner of human services in fiscal year 2013 shall be deposited in the funds from which the payments originated. These amounts are estimated to be \$27,740,000 for the general fund and \$7,300,000 for the health care access fund.

Sec. 6. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 7. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2012, unless a different effective date is explicit.

Presented to the governor April 25, 2012

Signed by the governor April 28, 2012, 4:24 p.m.