CHAPTER 262--H.F.No. 2950

An act relating to human services; removing obsolete provisions from statute and rule relating to children and family services, health care, chemical and mental health services, continuing care, and operations; modifying provisions governing the elderly waiver, the alternative care program, and mental health services for children;amending Minnesota Statutes 2012, sections 13.46, subdivision 4; 245.4871, subdivisions 3, 6; 245.4873, subdivision 2; 245.4874, subdivision 1; 245.4881, subdivisions 3, 4; 245.4882, subdivision 1; 245C.04, subdivision 1; 245C.05, subdivision 5; 246.0135; 246.325; 254B.05, subdivision 2; 256.01, subdivision 14b; 256.963, subdivision 2; 256.969, subdivision 9; 256B.0913, subdivisions 5a, 14; 256B.0915, subdivisions 3c, 3d, 3f, 3g; 256B.0943, subdivisions 8, 10, 12; 256B.69, subdivisions 2, 4b, 5, 5a, 5b, 6b, 6d, 17, 26, 29, 30; 256B.692, subdivisions 2, 5; 256D.02, subdivision 11; 256D.04; 256D.045; 256D.07; 256I.04, subdivision 3; 256I.05, subdivision 1c; 256J.425, subdivision 4; 518A.65; 595.06; 626.556, subdivision 3c; Minnesota Statutes 2013 Supplement, sections 245A.03, subdivision 7; 256B.0943, subdivisions 1, 2, 7; 256B.69, subdivisions 5c, 28; 256D.02, subdivision 12a; 517.04; Laws 2013, chapter 108, article 3, section 48; repealing Minnesota Statutes 2012, sections 119A.04, subdivision 1; 119B.09, subdivision 2; 119B.23; 119B.231; 119B.232; 158.13; 158.14; 158.15; 158.16; 158.17; 158.18; 158.19; 245.0311; 245.0312; 245.072; 245.4861; 245.487, subdivisions 4, 5; 245.4871, subdivisions 7, 11, 18, 25; 245.4872; 245.4873, subdivisions 3, 6; 245.4875, subdivisions 3, 6, 7; 245.4883, subdivision 1; 245.490; 245.492, subdivisions 6, 8, 13, 19; 245.4932, subdivisions 2, 3, 4; 245.4933; 245.494; 245.63; 245.652; 245.69, subdivision 1; 245.714; 245.715; 245.717; 245.718; 245.721; 245.77; 245.827; 245A.02, subdivision 7b; 245A.09, subdivision 12; 245A.11, subdivision 5; 246.012; 246.016; 246.023, subdivision 1; 246.28; 251.045; 252.038; 252.05; 252.07; 252.09; 254.01; 254.03; 254.04; 254.06; 254.07; 254.09; 254.10; 254.11; 254A.05, subdivision 1; 254A.07, subdivisions 1, 2; 254A.16, subdivision 1; 254B.01, subdivision 1; 254B.04, subdivision 3; 256.01, subdivisions 3, 14, 14a; 256.964; 256.9691; 256.971; 256.975, subdivision 3; 256.9753, subdivision 4; 256.9792; 256B.04, subdivision 16; 256B.0656; 256B.0657; 256B.075, subdivision 4; 256B.0757, subdivision 7; 256B.0913, subdivision 9; 256B.0916, subdivisions 6, 6a; 256B.0928; 256B.19, subdivision 3; 256B.431, subdivisions 28, 31, 33, 34, 37, 38, 39, 40, 41, 43; 256B.434, subdivision 19; 256B.440; 256B.441, subdivisions 46, 46a; 256B.491; 256B.501, subdivisions 3a, 3b, 3h, 3j, 3k, 3l, 5e; 256B.5016; 256B.503; 256B.53; 256B.69, subdivisions 5e, 6c, 24a; 256B.692, subdivision 10; 256D.02, subdivision 19; 256D.05, subdivision 4; 256D.46; 256I.05, subdivisions 1b, 5; 256I.07; 256J.24, subdivision 10; 256K.35; 259.85, subdivisions 2, 3, 4, 5; 518A.53, subdivision 7; 518A.74; 626.557, subdivision 16; 626.5593; Minnesota Statutes 2013 Supplement, sections 246.0251; 254.05; 254B.13, subdivision 3; 256B.31; 256B.501, subdivision 5b; 256C.05; 256C.29; 259.85, subdivision 1; Minnesota Rules, parts 9549.0020, subparts 2, 12, 13, 20, 23, 24, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 38, 41, 42, 43, 44, 46, 47; 9549.0030; 9549.0035, subparts 4, 5, 6; 9549.0036; 9549.0040; 9549.0041, subparts 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15; 9549.0050; 9549.0051, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14; 9549.0053; 9549.0054; 9549.0055, subpart 4; 9549.0056; 9549.0060, subparts 1, 2, 3, 8, 9, 12, 13; 9549.0061; 9549.0070, subparts 1, 4.

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

ARTICLE 1

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2012, section 256D.02, subdivision 11, is amended to read:

Subd. 11. **State aid.** "State aid" means state aid to county agencies for general assistance ~~and general assistance medical care~~ expenditures as provided for in section 256D.03, ~~subdivisions~~ subdivision 2 ~~and 3~~.

Sec. 2. Minnesota Statutes 2013 Supplement, section 256D.02, subdivision 12a, is amended to read:

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

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

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

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

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

The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

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

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

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

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

Sec. 3. Minnesota Statutes 2012, section 256D.04, is amended to read:

256D.04 DUTIES OF THE COMMISSIONER.

In addition to any other duties imposed by law, the commissioner shall:

(1) supervise according to section 256.01 the administration of general assistance ~~and general assistance medical care~~ by county agencies as provided in sections 256D.01 to 256D.21;

(2) promulgate uniform rules consistent with law for carrying out and enforcing the provisions of sections 256D.01 to 256D.21, including ~~section 256D.05, subdivision 3, and~~ section 256.01, subdivision 2, paragraph (16), to the end that general assistance may be administered as uniformly as possible throughout the state; rules shall be furnished immediately to all county agencies and other interested persons; in promulgating rules, the provisions of sections 14.001 to 14.69, shall apply;

(3) allocate money appropriated for general assistance ~~and general assistance medical care~~ to county agencies as provided in section 256D.03, ~~subdivisions~~ subdivision 2 ~~and 3~~;

(4) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for general assistance ~~and general assistance medical care~~;

(5) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under sections 256D.01 to 256D.21;

(6) cooperate to the fullest extent with other public agencies empowered by law to provide vocational training, rehabilitation, or similar services;

(7) gather and study current information and report at least annually to the governor on the nature and need for general assistance ~~and general assistance medical care~~, the amounts expended under the supervision of each county agency, and the activities of each county agency and publish such reports for the information of the public;

(8) specify requirements for general assistance ~~and general assistance medical care~~ reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (17); and

(9) ensure that every notice of eligibility for general assistance includes a notice that women who are pregnant may be eligible for medical assistance benefits.

Sec. 4. Minnesota Statutes 2012, section 256D.045, is amended to read:

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. ~~An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible~~

~~for general assistance medical care under section 256D.03.~~ The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

Sec. 5. Minnesota Statutes 2012, section 256D.07, is amended to read:

256D.07 TIME OF PAYMENT OF ASSISTANCE.

An applicant for general assistance ~~or general assistance medical care authorized by section 256D.03, subdivision 3,~~ shall be deemed eligible if the application and the verification of the statement on that application demonstrate that the applicant is within the eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of the commissioner. Any person requesting general assistance ~~or general assistance medical care~~ shall be permitted by the county agency to make an application for assistance as soon as administratively possible and in no event later than the fourth day following the date on which assistance is first requested, and no county agency shall require that a person requesting assistance appear at the offices of the county agency more than once prior to the date on which the person is permitted to make the application. The application shall be in writing in the manner and upon the form prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point." On the date that general assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, assistance for necessary transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2. A person in need of emergency assistance shall be granted emergency assistance immediately, and necessary emergency assistance shall continue for up to 30 days following the date of application. A determination of an applicant's eligibility for general assistance shall be made by the county agency as soon as the required verifications are received by the county agency and in no event later than 30 days following the date that the application is made. Any verifications required of the applicant shall be reasonable, and the commissioner shall by rule establish reasonable verifications. General assistance shall be granted to an eligible applicant without the necessity of first securing action by the board of the county agency. The first month's grant must be computed to cover the time period starting with the date a signed application form is received by the county agency or from the date that the applicant meets all eligibility factors, whichever occurs later.

If upon verification and due investigation it appears that the applicant provided false information and the false information materially affected the applicant's eligibility for general assistance ~~or general assistance medical care provided pursuant to section 256D.03, subdivision 3,~~ or the amount of the applicant's general assistance grant, the county agency may refer the matter to the county attorney. The county attorney may commence a criminal prosecution or a civil action for the recovery of any general assistance wrongfully received, or both.

Sec. 6. Minnesota Statutes 2012, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of group residential housing beds.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except:

(1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

~~(2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with developmental disabilities or mental illness;~~

~~(3)~~ (2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

~~(4)~~ (3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

~~(5) for group residential housing beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving home and community-based waiver services under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six months immediately prior to the month of entry into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus $426.37 for any case;~~

~~(6)~~ (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a group residential housing contract with the county and has been licensed as a board and lodge facility with special services since 1980;

~~(7)~~ (5) for a group residential housing provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

~~(8)~~ (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

~~(9)~~ (7) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

~~(10)~~ (8) for a group residential facility in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

Sec. 7. Minnesota Statutes 2012, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** A county agency may not increase the rates negotiated for group residential housing above those in effect on June 30, 1993, except as provided in paragraphs (a) to ~~(g)~~ (f).

(a) A county may increase the rates for group residential housing settings to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) A county agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total group residential housing rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. County agencies must not include nor increase group residential housing difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When a group residential housing rate is used to pay for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the group residential housing establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, a county agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0050 to 9549.0058.

~~(g) For the rate year beginning July 1, 1996, a county agency may increase the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in a residence that meets the following criteria:~~

~~(1) it is licensed by the commissioner of health as a boarding care home;~~

~~(2) it is not certified for the purposes of the medical assistance program;~~

~~(3) at least 50 percent of its residents have a primary diagnosis of mental illness;~~

~~(4) it has at least 17 beds; and~~

~~(5) it provides medication administration to residents.~~

~~The rate following an increase under this paragraph must not exceed an amount equivalent to the average 1995 medical assistance payment for nursing home resident class A under the age of 65, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0010 to 9549.0080.~~

Sec. 8. Minnesota Statutes 2012, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **Employed participants.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week every month are spent participating in employment;

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week every month are spent participating in employment; or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1), and the participant submits verification from a qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the qualified professional. The participant must be following the treatment recommendations of the qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

(b) For purposes of this section, employment means:

(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);

(2) subsidized employment under section 256J.49, subdivision 13, clause (2);

(3) on-the-job training under section 256J.49, subdivision 13, clause (2);

(4) an apprenticeship under section 256J.49, subdivision 13, clause (1);

(5) supported work under section 256J.49, subdivision 13, clause (2);

(6) a combination of clauses (1) to (5); or

(7) child care under section 256J.49, subdivision 13, clause (7), if it is in combination with paid employment.

(c) If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

(d) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

(e) To be eligible for a hardship extension for employed participants under this subdivision, a participant must be in compliance for at least ten out of the 12 months the participant received MFIP immediately preceding the participant's 61st month on assistance. If ten or fewer months of eligibility for TANF assistance remain at the time the participant from another state applies for assistance, the participant must be in compliance every month.

(f) The employment plan developed under section 256J.521, subdivision 2, for participants under this subdivision must contain at least the minimum number of hours specified in paragraph (a) for the purpose of meeting the requirements for an extension under this subdivision. The job counselor and the participant must sign the employment plan to indicate agreement between the job counselor and the participant on the contents of the plan.

(g) Participants who fail to meet the requirements in paragraph (a), without good cause under section 256J.57, shall be sanctioned or permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which the good cause reason applies. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification.

(h) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification. ~~This exemption is available to each participant two times in a 12-month period.~~

Sec. 9. Minnesota Statutes 2012, section 518A.65, is amended to read:

518A.65 DRIVER'S LICENSE SUSPENSION.

(a) Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's

license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court shall order the commissioner of public safety to suspend the obligor's driver's license. The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518A.69. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518A.69 after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

(b) If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the public authority.

(c) At least 90 days prior to notifying the commissioner of public safety according to paragraph (b), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice must include information that apprises the obligor of the requirement to develop a written payment agreement that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement regarding child support, maintenance, and any arrearages in order to avoid license suspension. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement pursuant to section 518A.69 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph (b).

(d) At a hearing requested by the obligor under paragraph (c), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority.

(e) An obligor whose driver's license or operating privileges are suspended may:

(1) provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements pursuant to section 518A.69;

(2) bring a motion for reinstatement of the driver's license. At the hearing, if the court or child support magistrate orders reinstatement of the driver's license, the court or child support magistrate must establish a written payment agreement pursuant to section 518A.69; or

(3) seek a limited license under section 171.30. A limited license issued to an obligor under section 171.30 expires 90 days after the date it is issued.

Within 15 days of the receipt of that proof or a court order, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

~~(f) On January 15, 1997, and every two years after that, the commissioner of human services shall submit a report to the legislature that identifies the following information relevant to the implementation of this section:~~

~~(1) the number of child support obligors notified of an intent to suspend a driver's license;~~

~~(2) the amount collected in payments from the child support obligors notified of an intent to suspend a driver's license;~~

~~(3) the number of cases paid in full and payment agreements executed in response to notification of an intent to suspend a driver's license;~~

~~(4) the number of cases in which there has been notification and no payments or payment agreements;~~

~~(5) the number of driver's licenses suspended;~~

~~(6) the cost of implementation and operation of the requirements of this section; and~~

~~(7) the number of limited licenses issued and number of cases in which payment agreements are executed and cases are paid in full following issuance of a limited license.~~

~~(g)~~ (f) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

~~(h)~~ (g) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. Prior to suspending a license for noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's driver's license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the Department of Public Safety to suspend the obligor's license under paragraph (b). If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing

specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail at the obligor's last known address. If the obligor appears at the hearing and the court determines that the obligor has failed to comply with an approved written payment agreement, the court or public authority shall notify the Department of Public Safety to suspend the obligor's license under paragraph (b). If the obligor fails to appear at the hearing, the court or public authority must notify the Department of Public Safety to suspend the obligor's license under paragraph (b).

Sec. 10. Laws 2013, chapter 108, article 3, section 48, is amended to read:

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2012, section 256J.24, subdivision 6, is repealed January 1, 2015.

(b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following final enactment.

Sec. 11. **TRANSITION; PROVISIONS GOVERNING PERFORMANCE BASE FUNDS.**

(a) Laws 2013, chapter 107, article 4, section 19, is repealed effective January 1, 2016.

(b) Laws 2013, chapter 108, article 3, section 31, is effective January 1, 2016.

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2012, sections 119A.04, subdivision 1; 119B.09, subdivision 2; 119B.23; 119B.231; 119B.232; 256.01, subdivisions 3, 14, and 14a; 256.9792; 256D.02, subdivision 19; 256D.05, subdivision 4; 256D.46; 256I.05, subdivisions 1b and 5; 256I.07; 256K.35; 259.85, subdivisions 2, 3, 4, and 5; 518A.53, subdivision 7; 518A.74; and 626.5593, are repealed.

(b) Minnesota Statutes 2012, section 256J.24, subdivision 10, is repealed effective October 1, 2014.

(c) Minnesota Statutes 2013 Supplement, section 259.85, subdivision 1, is repealed.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256.963, subdivision 2, is amended to read:

Subd. 2. **Evaluation.** ~~(a)~~ The grantee must report to the commissioner on a quarterly basis the following information:

(1) the total number of appointments available for scheduling by specialty;

(2) the average length of time between scheduling and actual appointment;

(3) the total number of patients referred and whether the patient was insured or uninsured; and

(4) the total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

~~(b) The commissioner, in consultation with the Minnesota Hospital Association, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the legislature by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital~~

~~emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.~~

Sec. 2. Minnesota Statutes 2012, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** ~~(a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:~~

~~(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and~~

~~(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.~~

~~(b)~~ (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and

(4) effective August 1, 2005, the payments in ~~paragraph (b),~~ clause (3)~~,~~ shall be reduced to zero.

~~(c)~~ (b) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph ~~(b)~~ (a), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in paragraph (a), clause (3).

~~(d)~~ (c) If federal matching funds are not available for all adjustments under paragraph ~~(b)~~ (a), the commissioner shall reduce payments under paragraph ~~(b)~~ (a), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph ~~(b)~~ (a) qualify for federal match.

~~(e)~~ (d) For purposes of this subdivision, medical assistance does not include general assistance medical care.

~~(f)~~ (e) For hospital services occurring on or after July 1, 2005, to June 30, 2007:

(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:

(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph ~~(b)~~ (a), clauses (1) and (2), may be used for general assistance medical care expenditures;

(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and

(2) certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center

shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

~~(g)~~ (f) Upon federal approval of the related state plan amendment, paragraph ~~(f)~~ (e) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 3. Minnesota Statutes 2012, section 256B.69, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692. ~~Notwithstanding the above, Itasca County may continue to participate as a demonstration provider until July 1, 2004.~~

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 4b, is amended to read:

Subd. 4b. **Individualized education program and individualized family service plan services.** The commissioner shall amend the federal waiver allowing the state to separate out individualized education program and individualized family service plan services for children enrolled in the prepaid medical assistance program and the MinnesotaCare program. ~~Effective July 1, 1999, or upon federal approval,~~ Medical assistance coverage of eligible individualized education program and individualized family service plan services shall not be included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program. ~~Upon federal approval,~~ Local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Sec. 5. Minnesota Statutes 2012, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the

risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. ~~For payments made during calendar year 1990 and later years,~~ The commissioner shall contract with an independent actuary to establish prepayment rates.

~~By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.~~

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older.

Sec. 6. Minnesota Statutes 2012, 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,~~ (d) 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.~~ (e) 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 enrollees in programs described in subdivisions 23 and 28, compared to the previous 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 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)~~ (f) 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 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)~~ (g). 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)~~ (g) 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 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 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, excluding 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)~~ (h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 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)~~ (i) 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)~~ (j) 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)~~ (k) 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)~~ (l) The return of the withhold under paragraphs ~~(d), (f), and (j) to (m)~~ (h) and (i) is not subject to the requirements of paragraph (c).

Sec. 7. Minnesota Statutes 2012, section 256B.69, subdivision 5b, is amended to read:

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 ~~and effective on or after January 1, 2003~~, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 87 percent of the capitation rates for metropolitan counties, excluding Hennepin County. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral. The commissioner, in consultation with a health care actuary, shall evaluate the regional rate relationships based on actual health plan costs for Minnesota health care programs. The commissioner may establish, based on the actuary's recommendation, new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

(b) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. ~~Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and~~ After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

Sec. 9. Minnesota Statutes 2012, section 256B.69, subdivision 6b, is amended to read:

Subd. 6b. **Home and community-based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide ~~no sooner than July 1, 2006,~~ under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating under section 256B.692, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

Sec. 10. Minnesota Statutes 2012, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** ~~Effective January 1, 2004,~~ The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 11. Minnesota Statutes 2012, section 256B.69, subdivision 17, is amended to read:

Subd. 17. **Continuation of prepaid medical assistance.** The commissioner may continue the provisions of this section ~~after June 30, 1990,~~ in any or all of the participating counties if necessary federal authority is granted. The commissioner may adopt permanent rules to continue prepaid medical assistance in these areas.

Sec. 12. Minnesota Statutes 2012, section 256B.69, subdivision 26, is amended to read:

Subd. 26. **American Indian recipients.** (a) ~~Beginning on or after January 1, 1999,~~ For American Indian recipients of medical assistance who are required to enroll with a demonstration provider under subdivision 4 or in a county-based purchasing entity, if applicable, under section 256B.692, medical assistance shall cover health care services provided at Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, if those services would otherwise be covered under section 256B.0625. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the prepaid medical assistance program under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) ~~Beginning January 1, 2007,~~ The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. ~~The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities.~~ Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 14. Minnesota Statutes 2012, section 256B.69, subdivision 29, is amended to read:

Subd. 29. **Prepaid health plan rates.** In negotiating ~~the~~ prepaid health plan contract rates ~~for services rendered on or after January 1, 2011~~, the commissioner of human services shall take into consideration, and the rates shall reflect, the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

Sec. 15. Minnesota Statutes 2012, section 256B.69, subdivision 30, is amended to read:

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a confirmation letter to the enrollee from the prepaid health plan that explains that the enrollee may change the request at any time;

(2) the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device if the materials contain enrollee data that is individually identifiable;

(3) the enrollee is provided a customer service number on the enrollee's membership card that may be called to request a paper version of the materials provided in an alternative format; and

(4) the materials provided in an alternative format meets all other requirements of the commissioner regarding content, size of the typeface, and any required time frames for distribution. "Required time frames

for distribution" must permit sufficient time for prepaid health plans to distribute materials in alternative formats upon receipt of enrollees' requests for the materials.

(c) A prepaid health plan may provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. The commissioner or local agency, as applicable, shall inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. If the potential enrollee requests an alternative format of the prepaid health plan's primary care network list, a record of that request shall be retained by the commissioner or local agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary care network list to the commissioner and to local agencies within its service area to accommodate potential enrollee requests for paper versions of the primary care network list.

(d) A prepaid health plan may provide in an alternative format materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions of paragraphs (b)~~,~~ and (c)~~, and (e),~~ are met for persons who are eligible for enrollment in managed care.

~~(e) The commissioner shall seek any federal Medicaid waivers within 90 days after the effective date of this subdivision that are necessary to provide alternative formats of required material to enrollees of prepaid health plans as authorized under this subdivision.~~

~~(f)~~ (e) The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to determine how materials required to be made available to enrollees under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with a prepaid health plan may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

Sec. 16. Minnesota Statutes 2012, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and~~,~~ ~~effective January 1, 2010,~~ fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year~~, beginning in calendar year 2009; and~~

~~(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008~~.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 17. Minnesota Statutes 2012, section 256B.692, subdivision 5, is amended to read:

Subd. 5. **County proposals.** (a) ~~On or before September 1, 1997,~~ A county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department ~~on or before July 1, 1997~~. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal ~~on or before July 1, 1998,~~ that demonstrates the ability to meet all the requirements of this section~~, including beginning enrollment on January 1, 1999, unless a delay has been granted under section 256B.69, subdivision 3a, paragraph (g)~~.

(c) ~~After January 1, 1999,~~ For a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

~~(d) The commissioner is not required to terminate contracts for the prepaid medical assistance program that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance program.~~

Sec. 18. **REPEALER.**

Minnesota Statutes 2012, sections 256.964; 256.9691; 256B.075, subdivision 4; 256B.0757, subdivision 7; 256B.19, subdivision 3; 256B.53; 256B.69, subdivisions 5e, 6c, and 24a; and 256B.692, subdivision 10, are repealed.

ARTICLE 3

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 245.4871, subdivision 3, is amended to read:

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, ~~if needed, developing a functional assessment,~~ developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Sec. 2. Minnesota Statutes 2012, section 245.4871, subdivision 6, is amended to read:

Subd. 6. **Child with severe emotional disturbance.** For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of an emotional disturbance; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

~~The term "child with severe emotional disturbance" shall be used only for purposes of county eligibility determinations. In all other written and oral communications, case managers, mental health professionals, mental health practitioners, and all other providers of mental health services shall use the term "child eligible for mental health case management" in place of "child with severe emotional disturbance."~~

Sec. 3. Minnesota Statutes 2012, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; and

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children~~; and~~.

~~(6) perform the duties required under sections 245.494 to 245.495.~~

Sec. 4. Minnesota Statutes 2012, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

~~(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;~~

~~(8)~~ (7) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

~~(9)~~ (8) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

~~(10)~~ (9) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

~~(11)~~ (10) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

~~(12)~~ (11) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

~~(13)~~ (12) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

~~(14)~~ (13) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in out-of-home placement;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in out-of-home placement, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment~~, as defined in section 245.4871~~. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not

covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 5. Minnesota Statutes 2012, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall ~~complete a written functional assessment according to section 245.4871, subdivision 18. The case manager shall~~ develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 6. Minnesota Statutes 2012, section 245.4881, subdivision 4, is amended to read:

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment ~~and a functional assessment~~ and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with severe emotional disturbance, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Sec. 7. Minnesota Statutes 2012, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be subject to the six-month review process established in section 260C.203, and

for children in voluntary placement for treatment, the court review process in section 260D.06. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

~~(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs;~~

~~(2)~~ (1) help the child improve family living and social interaction skills;

~~(3)~~ (2) help the child gain the necessary skills to return to the community;

~~(4)~~ (3) stabilize crisis admissions; and

~~(5)~~ (4) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Sec. 8. Minnesota Statutes 2012, section 246.0135, is amended to read:

246.0135 OPERATION OF REGIONAL TREATMENT CENTERS.

(a) The commissioner of human services is prohibited from closing any regional treatment center or state-operated nursing home or any program at any of the regional treatment centers or state-operated nursing homes, without specific legislative authorization. For persons with developmental disabilities who move from one regional treatment center to another regional treatment center, the provisions of section 256B.092, subdivision 10, must be followed for both the discharge from one regional treatment center and admission to another regional treatment center, except that the move is not subject to the consensus requirement of section 256B.092, subdivision 10, paragraph (b).

(b) Prior to closing or downsizing a regional treatment center, the commissioner of human services shall be responsible for assuring that community-based alternatives developed in response are adequate to meet the program needs identified by each county within the catchment area and do not require additional local county property tax expenditures.

(c) The nonfederal share of the cost of alternative treatment or care developed as the result of the closure of a regional treatment center, including costs associated with fulfillment of responsibilities under chapter 253B shall be paid from state funds appropriated for purposes specified in section 246.013.

(d) ~~Counties in the catchment area of a regional treatment center which has been closed or downsized may not at any time be required to pay a greater cost of care for alternative care and treatment than the county share set by the commissioner for the cost of care provided by regional treatment centers.~~

~~(e)~~ The commissioner may not divert state funds used for providing for care or treatment of persons residing in a regional treatment center for purposes unrelated to the care and treatment of such persons.

Sec. 9. Minnesota Statutes 2012, section 246.325, is amended to read:

246.325 GARDEN OF REMEMBRANCE.

The cemetery located on the grounds of the Cambridge State Hospital shall be known as the Garden of Remembrance. ~~The commissioner of human services shall approve the wording and design for a sign at the cemetery indicating its name. The commissioner may approve a temporary sign before the permanent sign is completed and installed. All costs related to the sign must be paid with nonstate funds.~~

Sec. 10. Minnesota Statutes 2012, section 254B.05, subdivision 2, is amended to read:

Subd. 2. **Regulatory methods.** (a) Where appropriate and feasible, the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of an independent accreditation body have been shown to predict compliance with the rules, the commissioner shall consider compliance with the accreditation standards to be equivalent to partial compliance with the rules; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

~~If the commissioner determines that the methods in clause (2) or (3) can be used in licensing a program, the commissioner may reduce any fee set under section 254B.03, subdivision 3, by up to 50 percent.~~

(b) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

Sec. 11. Minnesota Statutes 2012, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4) have capacity to respond to reports of abuse and neglect under section 626.556;

(5) provide a wide range of services to families in need of child welfare services; and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause ~~(14)~~ (13), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-

fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256B.0943, subdivision 1, is amended to read:

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

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of ~~group~~ psychotherapy for ~~more than~~ three or more individuals and ~~other intensive therapeutic services~~ individual or group skills training provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0372, subpart 1.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional to assist a child retain or generalize psychosocial skills as taught by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(n) "Mental health practitioner" means an individual as defined in section 245.4871, subdivision 26.

(o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Skills training" means individual, family, or group training, delivered by or under the direction of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by

a psychiatric illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the following requirements:

(1) a mental health professional or a mental health practitioner must provide skills training;

(2) the child must always be present during skills training; however, a brief absence of the child for no more than ten percent of the session unit may be allowed to redirect or instruct family members;

(3) skills training delivered to children or their families must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(4) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development and to help the child use in daily life the skills previously taught by a mental health professional or mental health practitioner and to develop or maintain a home environment that supports the child's progressive use skills;

(5) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(i) one mental health professional or one mental health practitioner under supervision of a licensed mental health professional must work with a group of four to eight clients; or

(ii) two mental health professionals or two mental health practitioners under supervision of a licensed mental health professional, or one professional plus one practitioner must work with a group of nine to 12 clients.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) ~~individual~~ patient or family member, family, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) ~~clinical care consultation under section 256B.0625, subdivision 62;~~ children's day treatment.

~~(8) family psychoeducation under section 256B.0625, subdivision 61; and~~

~~(9) services provided by a family peer specialist under section 256B.0616.~~

~~(c) Service components in paragraph (b) may be combined to constitute therapeutic programs, including day treatment programs and therapeutic preschool programs.~~

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

Sec. 14. Minnesota Statutes 2013 Supplement, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional as defined in subdivision 1, paragraph (n); or

(2) a mental health practitioner ~~as defined in section 245.4871, subdivision 26~~ or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional; or

(3) a mental health behavioral aide working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and

(iii) meet preservice and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and

(iii) meet preservice and continuing education requirements in subdivision 8.

~~(c) A preschool program multidisciplinary team must include at least one mental health professional and one or more of the following individuals under the clinical supervision of a mental health professional:~~

~~(i) a mental health practitioner; or~~

~~(ii) a program person, including a teacher, assistant teacher, or aide, who meets the qualifications and training standards of a level I mental health behavioral aide.~~

~~(d)~~ (c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.

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

Sec. 15. Minnesota Statutes 2012, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include ~~topics specified in Minnesota Rules, part 9535.4068, subparts 1 and 2, and~~ parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family. ~~The topics covered in orientation and training must conform to Minnesota Rules, part 9535.4068.~~

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for

each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

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

Sec. 16. Minnesota Statutes 2012, section 256B.0943, subdivision 10, is amended to read:

Subd. 10. **Service authorization.** ~~The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate the list are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision on whether prior authorization is required for a health service is not subject to administrative appeal.~~ Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

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

Sec. 17. Minnesota Statutes 2012, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

~~(iii) consultation with other providers or service agency staff about the care or progress of a client;~~

~~(iv)~~ (iii) prevention or education programs provided to the community; and

~~(v)~~ (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse~~; and~~.

~~(7) activities that are not direct service time.~~

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

Sec. 18. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245.0311; 245.0312; 245.4861; 245.487, subdivisions 4 and 5; 245.4871, subdivisions 7, 11, 18, and 25; 245.4872; 245.4873, subdivisions 3 and 6; 245.4875, subdivisions 3, 6, and 7; 245.4883, subdivision 1; 245.490; 245.492, subdivisions 6, 8, 13, and 19; 245.4932, subdivisions 2, 3, and 4; 245.4933; 245.494; 245.63; 245.652; 245.69, subdivision 1; 245.714; 245.715; 245.717; 245.718; 245.721; 245.77; 245.827; 246.012; 246.016; 246.023, subdivision 1; 246.28; 251.045; 252.038; 252.05; 252.07; 252.09; 254.01; 254.03; 254.04; 254.06; 254.07; 254.09; 254.10; 254.11; 254A.05, subdivision 1; 254A.07, subdivisions 1 and 2; 254A.16, subdivision 1; 254B.01, subdivision 1; and 254B.04, subdivision 3, are repealed.

(b) Minnesota Statutes 2013 Supplement, sections 246.0251; 254.05; and 254B.13, subdivision 3, are repealed.

ARTICLE 4

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. The lead agency must ensure that the benefit department recovery system in the Medicaid Management Information System (MMIS) has the necessary information on any other health insurance or third-party insurance policy to which the client may have access. ~~For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program.~~ Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may ~~contract with~~ authorize services to be provided by a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is

also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 2. Minnesota Statutes 2012, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the lead agency or vendor must submit invoices within 12 months following the date of service. The lead agency and its vendors ~~under contract~~ shall not be reimbursed for services which exceed the county allocation. Service rates are governed by section 256B.0915, subdivision 3g.

~~(c) The lead agency shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.~~

~~(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.~~

~~(2) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.~~

Sec. 3. Minnesota Statutes 2012, section 256B.0915, subdivision 3c, is amended to read:

Subd. 3c. **Service approval ~~and contracting~~ provisions.** ~~(a)~~ Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the coordinated service and support plan.

~~(b) A lead agency is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.~~

Sec. 4. Minnesota Statutes 2012, section 256B.0915, subdivision 3d, is amended to read:

Subd. 3d. **Adult foster care rate.** The adult foster care rate ~~shall be considered a difficulty of care payment and~~ shall not include room and board. ~~The adult foster care service rate shall be negotiated between the lead agency and the foster care provider.~~ The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Sec. 5. Minnesota Statutes 2012, section 256B.0915, subdivision 3f, is amended to read:

Subd. 3f. **~~Individual service rates~~ Payments for services; expenditure forecasts.** (a) ~~The lead agency shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the lead agency's current approved rate. Persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.~~ Lead agencies shall authorize payments for services in accordance with the payment rates and limits published annually by the commissioner.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Sec. 6. Minnesota Statutes 2012, section 256B.0915, subdivision 3g, is amended to read:

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide ~~maximum~~ service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for statewide service rate limits, except those described or defined in subdivisions 3d ~~and~~, 3e, and 3h, the statewide service rate limit for each service shall be the greater of the alternative care statewide ~~maximum~~ rate or the elderly waiver statewide ~~maximum~~ rate.

~~(c) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.~~

Sec. 7. Minnesota Statutes 2013 Supplement, section 517.04, is amended to read:

517.04 PERSONS AUTHORIZED TO PERFORM CIVIL MARRIAGES.

Civil marriages may be solemnized throughout the state by an individual who has attained the age of 21 years and is a judge of a court of record, a retired judge of a court of record, a court administrator, a retired court administrator with the approval of the chief judge of the judicial district, a former court commissioner who is employed by the court system or is acting pursuant to an order of the chief judge of the commissioner's judicial district, the residential school ~~administrators~~ superintendent of the Minnesota State Academy for the Deaf and the Minnesota State Academy for the Blind, a licensed or ordained minister of any religious denomination, or by any mode recognized in section 517.18. For purposes of this section, a court of record includes the Office of Administrative Hearings under section 14.48.

Sec. 8. Minnesota Statutes 2012, section 595.06, is amended to read:

595.06 CAPACITY OF WITNESS.

When ~~an infant, or~~ a person ~~apparently of weak intellect,~~ is produced as a witness, the court may examine the ~~infant or witness~~ person to ascertain capacity, and whether the person understands the nature

and obligations of an oath, and the court may inquire of any person what peculiar ceremonies the person deems most obligatory in taking an oath.

Sec. 9. **REPEALER.**

(a) Minnesota Statutes 2012, sections 158.13; 158.14; 158.15; 158.16; 158.17; 158.18; 158.19; 245.072; 256.971; 256.975, subdivision 3; 256.9753, subdivision 4; 256B.04, subdivision 16; 256B.0656; 256B.0657; 256B.0913, subdivision 9; 256B.0916, subdivisions 6 and 6a; 256B.0928; 256B.431, subdivisions 28, 31, 33, 34, 37, 38, 39, 40, 41, and 43; 256B.434, subdivision 19; 256B.440; 256B.441, subdivisions 46 and 46a; 256B.491; 256B.501, subdivisions 3a, 3b, 3h, 3j, 3k, 3l, and 5e; 256B.5016; 256B.503; and 626.557, subdivision 16, are repealed.

(b) Minnesota Statutes 2013 Supplement, sections 256B.31; 256B.501, subdivision 5b; 256C.05; and 256C.29, are repealed.

(c) Minnesota Rules, parts 9549.0020, subparts 2, 12, 13, 20, 23, 24, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 38, 41, 42, 43, 44, 46, and 47; 9549.0030; 9549.0035, subparts 4, 5, and 6; 9549.0036; 9549.0040; 9549.0041, subparts 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, and 15; 9549.0050; 9549.0051, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 14; 9549.0053; 9549.0054; 9549.0055, subpart 4; 9549.0056; 9549.0060, subparts 1, 2, 3, 8, 9, 12, and 13; 9549.0061; and 9549.0070, subparts 1 and 4, are repealed.

ARTICLE 5

OPERATIONS

Section 1. Minnesota Statutes 2012, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) When a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant or license holder as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is disqualified under chapter 245C, the identity of the license holder or applicant as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant or license holder requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

~~(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections, except as provided under clause (1).~~

~~(3)~~ (2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

~~(4)~~ (3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

~~(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04,~~

~~subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study. If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that an individual subject to disqualification under chapter 245C is disqualified, the disqualification as a basis for the licensing sanction or denial is public data. As specified in clause (1), item (iv), if the disqualified individual is the license holder or applicant, the identity of the license holder or applicant and the reason for the disqualification are public data; and, if the license holder or applicant requested reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data. If the disqualified individual is an individual other than the license holder or applicant, the identity of the disqualified individual shall remain private data.~~

~~(6)~~ (4) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

~~(7)~~ (5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health for purposes of completing background studies

pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under chapters 245A, 245B, and 245C, and sections 626.556 and 626.557 may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2013 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. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. 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, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing

movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses or community residential setting 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 or community residential settings 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) When an adult resident served by the program 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), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) 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, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) 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)~~ if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) 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 (c) 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, 2013, and August 1, 2014, and each following 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.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

Sec. 3. Minnesota Statutes 2012, section 245C.04, subdivision 1, is amended to read:

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

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

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

~~(1) registered under chapter 144D; or~~

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

~~(3)~~ the following conditions are met:

~~(i)~~ (1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

~~(ii)~~ (2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

~~(iii)~~ (3) the last study of the individual was conducted on or after October 1, 1995.

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

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

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

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

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

~~(i)~~ (g) A license holder must initiate a new background study through the commissioner's online background study system when:

(1) an individual returns to a position requiring a background study following an absence of 90 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 90 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

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

~~(k)~~ (i) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

Sec. 4. Minnesota Statutes 2012, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) For purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) ~~Except as specified under section 245C.04, subdivision 1, paragraph (d),~~ For background studies conducted by the commissioner for child foster care or adoptions, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

Sec. 5. Minnesota Statutes 2012, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family

child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245B, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.46.

~~(d) The commissioners of human services, public safety, and education must jointly submit a written report by January 15, 2007, to the education policy and finance committees of the legislature recommending the most efficient and effective allocation of agency responsibility for assessing or investigating reports of maltreatment and must specifically address allegations of maltreatment that currently are not the responsibility of a designated agency.~~

Sec. 6. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall make necessary technical cross-reference changes in Minnesota Statutes and Minnesota Rules to conform with the sections and parts repealed in articles 1 to 5.

Sec. 7. **REPEALER.**

Minnesota Statutes 2012, sections 245A.02, subdivision 7b; 245A.09, subdivision 12; and 245A.11, subdivision 5, are repealed.

Presented to the governor May 14, 2014

Signed by the governor May 16, 2014, 10:46 a.m.