

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2294

02/15/2012 Authored by Abeler, Huntley and Hamilton

The bill was read for the first time and referred to the Committee on Health and Human Services Finance

03/26/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Ways and Means

03/28/2012 Adoption of Report: Pass as Amended and Read Second Time

A bill for an act

1.1 relating to state government; making adjustments to health and human
 1.2 services appropriations; making changes to provisions related to health care,
 1.3 the Department of Health, children and family services, continuing care,
 1.4 chemical dependency, child support, background studies, homelessness,
 1.5 and vulnerable children and adults; providing for data sharing; requiring
 1.6 eligibility determinations; requiring the University of Minnesota to request
 1.7 funding for rural primary care training; providing for the release of medical
 1.8 assistance liens; providing appointments; providing grants; requiring studies
 1.9 and reports; appropriating money; amending Minnesota Statutes 2010, sections
 1.10 62D.02, subdivision 3; 62D.05, subdivision 6; 62D.12, subdivision 1; 62J.496,
 1.11 subdivision 2; 62Q.80; 62U.04, subdivisions 1, 2, 4, 5; 119B.13, subdivision 3a;
 1.12 144.1222, by adding a subdivision; 144.292, subdivision 6; 144.293, subdivision
 1.13 2; 144A.351; 144D.04, subdivision 2; 145.906; 245.697, subdivision 1; 245A.03,
 1.14 by adding a subdivision; 245A.11, subdivision 7; 245B.07, subdivision 1;
 1.15 245C.04, subdivision 6; 245C.05, subdivision 7; 252.27, subdivision 2a;
 1.16 254A.19, by adding a subdivision; 256.01, by adding subdivisions; 256B.056,
 1.17 subdivision 1a; 256B.0625, subdivisions 9, 28a, by adding subdivisions;
 1.18 256B.0659, by adding a subdivision; 256B.0751, by adding a subdivision;
 1.19 256B.0754, subdivision 2; 256B.0915, subdivision 3g; 256B.092, subdivisions
 1.20 1b, 7, by adding subdivisions; 256B.0943, subdivision 9; 256B.431, subdivision
 1.21 17e, by adding a subdivision; 256B.441, by adding a subdivision; 256B.49, by
 1.22 adding a subdivision; 256B.69, subdivision 9, by adding subdivisions; 256D.06,
 1.23 subdivision 1b; 256D.44, subdivision 5; 256E.37, subdivision 1; 256I.05,
 1.24 subdivision 1e; 256J.08, by adding a subdivision; 256J.26, subdivision 1, by
 1.25 adding a subdivision; 256J.45, subdivision 2; 256J.50, by adding a subdivision;
 1.26 256J.521, subdivision 2; 462A.29; 518A.40, subdivision 4; Minnesota Statutes
 1.27 2011 Supplement, sections 62U.04, subdivisions 3, 9; 119B.13, subdivision
 1.28 7; 245A.03, subdivision 7; 256.045, subdivision 3; 256.987, subdivisions 1,
 1.29 2, by adding subdivisions; 256B.056, subdivision 3; 256B.057, subdivision
 1.30 9; 256B.0625, subdivision 38; 256B.0911, subdivisions 3a, 3c; 256B.0915,
 1.31 subdivisions 3e, 3h; 256B.097, subdivision 3; 256B.49, subdivisions 14, 15, 23;
 1.32 256B.5012, subdivision 13; 256B.69, subdivisions 5a, 5c; 256E.35, subdivisions
 1.33 5, 6; 256I.05, subdivision 1a; 256J.49, subdivision 13; 256L.12, subdivision 9;
 1.34 256M.40, subdivision 1; Laws 2010, chapter 374, section 1; Laws 2011, First
 1.35 Special Session chapter 9, article 7, sections 52; 54; article 9, section 18; article
 1.36 10, section 3, subdivisions 1, 3, 4; proposing coding for new law in Minnesota
 1.37 Statutes, chapters 144; 256B.
 1.38

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

2.2 **ARTICLE 1**

2.3 **HEALTH CARE**

2.4 Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 9, is amended to
2.5 read:

2.6 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

2.7 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
2.8 following services:

2.9 (1) comprehensive exams, limited to once every five years;

2.10 (2) periodic exams, limited to one per year;

2.11 (3) limited exams;

2.12 (4) bitewing x-rays, limited to one per year;

2.13 (5) periapical x-rays;

2.14 (6) panoramic x-rays, limited to one every five years except (1) when medically
2.15 necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma
2.16 or (2) once every two years for patients who cannot cooperate for intraoral film due to
2.17 a developmental disability or medical condition that does not allow for intraoral film
2.18 placement;

2.19 (7) prophylaxis, limited to one per year;

2.20 (8) application of fluoride varnish, limited to one per year;

2.21 (9) posterior fillings, all at the amalgam rate;

2.22 (10) anterior fillings;

2.23 (11) endodontics, limited to root canals on the anterior and premolars only;

2.24 (12) removable prostheses, each dental arch limited to one every six years;

2.25 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
2.26 abscesses;

2.27 (14) palliative treatment and sedative fillings for relief of pain; and

2.28 (15) full-mouth debridement, limited to one every five years.

2.29 (c) In addition to the services specified in paragraph (b), medical assistance
2.30 covers the following services for adults, if provided in an outpatient hospital setting or
2.31 freestanding ambulatory surgical center as part of outpatient dental surgery:

2.32 (1) periodontics, limited to periodontal scaling and root planing once every two
2.33 years;

2.34 (2) general anesthesia; and

2.35 (3) full-mouth survey once every five years.

3.1 (d) Medical assistance covers medically necessary dental services for children and
3.2 pregnant women. The following guidelines apply:

3.3 (1) posterior fillings are paid at the amalgam rate;

3.4 (2) application of sealants are covered once every five years per permanent molar for
3.5 children only;

3.6 (3) application of fluoride varnish is covered once every six months; and

3.7 (4) orthodontia is eligible for coverage for children only.

3.8 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
3.9 covers the following services for developmentally disabled adults:

3.10 (1) house calls or extended care facility calls for on-site delivery of covered services;

3.11 (2) behavioral management when additional staff time is required to accommodate
3.12 behavioral challenges and sedation is not used; and

3.13 (3) oral or IV conscious sedation, if the covered dental service cannot be performed
3.14 safely without it or would otherwise require the service to be performed under general
3.15 anesthesia in a hospital or surgical center.

3.16 Sec. 2. Minnesota Statutes 2010, section 256B.0625, is amended by adding a
3.17 subdivision to read:

3.18 Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.**

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

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

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

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

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

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

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

4.1 (c) The Nonemergency Medical Transportation Advisory Committee shall
4.2 coordinate its activities with the Minnesota Council on Transportation Access established
4.3 under section 174.285.

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

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

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

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

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

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

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

4.23 (5) one voting member who represents demonstration providers as defined in section
4.24 256B.69, subdivision 2;

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

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

4.30 (b) Members of the advisory committee shall not be employed by the Department
4.31 of Human Services.

4.32 Sec. 4. Minnesota Statutes 2010, section 256B.0625, subdivision 28a, is amended to
4.33 read:

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

5.5 (b) Licensed physician assistants, who are supervised by a physician certified by
5.6 the American Board of Psychiatry and Neurology or eligible for board certification in
5.7 psychiatry, may bill for medication management and evaluation and management services
5.8 provided to medical assistance enrollees in inpatient hospital settings, consistent with
5.9 their authorized scope of practice, as defined in section 147A.09, with the exception of
5.10 performing psychotherapy, diagnostic assessments, or providing clinical supervision.

5.11 Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 38,
5.12 is amended to read:

5.13 Subd. 38. **Payments for mental health services.** Payments for mental
5.14 health services covered under the medical assistance program that are provided by
5.15 masters-prepared mental health professionals shall be 80 percent of the rate paid to
5.16 doctoral-prepared professionals. Payments for mental health services covered under
5.17 the medical assistance program that are provided by masters-prepared mental health
5.18 professionals employed by community mental health centers shall be 100 percent of the
5.19 rate paid to doctoral-prepared professionals. Payments for mental health services covered
5.20 under the medical assistance program that are provided by physician assistants shall be 65
5.21 percent of the rate paid to psychiatrists.

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

5.24 Subd. 60. **Community paramedic services.** (a) Medical assistance covers services
5.25 provided by community paramedics who are certified under section 144E.28, subdivision
5.26 9, when the services are provided in accordance with this subdivision to an eligible
5.27 recipient as defined in paragraph (b).

5.28 (b) For purposes of this subdivision, an eligible recipient is defined as an individual
5.29 who has received hospital emergency department services three or more times in a period
5.30 of four consecutive months in the past 12 months, or an individual who has been identified
5.31 by the individual's primary health care provider for whom community paramedic services
5.32 identified in paragraph (c) would likely prevent admission to or would allow discharge
5.33 from a nursing facility, or would likely prevent readmission to a hospital or nursing facility.

6.1 (c) Payment for services provided by a community paramedic under this subdivision
6.2 must be a part of a care plan ordered by a primary health care provider in consultation with
6.3 the medical director of an ambulance service and must be billed by an eligible provider
6.4 enrolled in medical assistance that employs or contracts with the community paramedic.
6.5 The care plan must ensure that the services provided by a community paramedic are
6.6 coordinated with other community health providers and local public health agencies and
6.7 that community paramedic services do not duplicate services already provided to the
6.8 patient, including home health and waiver services. Community paramedic services
6.9 shall include health assessment, chronic disease monitoring and education, medication
6.10 compliance, immunizations and vaccinations, laboratory specimen collection, hospital
6.11 discharge follow-up care, and minor medical procedures approved by the ambulance
6.12 medical director.

6.13 (d) Services provided by a community paramedic to an eligible recipient who is
6.14 also receiving care coordination services must be in consultation with the providers of
6.15 the recipient's care coordination services.

6.16 (e) The commissioner shall seek the necessary federal approval to implement this
6.17 subdivision.

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

6.20 Sec. 7. Minnesota Statutes 2010, section 256B.0751, is amended by adding a
6.21 subdivision to read:

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

7.1 Sec. 8. Minnesota Statutes 2010, section 256B.441, is amended by adding a
7.2 subdivision to read:

7.3 Subd. 63. **Special needs nursing facility rate adjustment.** The commissioner may
7.4 increase the medical assistance payment rate for a nursing facility that is participating
7.5 in a health care delivery system demonstration project under sections 256B.0755 or
7.6 256B.0756, or another care coordination project, if the nursing facility has agreed to
7.7 accept patients enrolled in the project in order to reduce hospital or emergency room
7.8 admissions or readmissions, shorten the length of inpatient hospital stays, or prevent a
7.9 medical emergency that would require more costly treatment. The higher rate must reflect
7.10 the higher costs of participating in the care coordination demonstration project and the
7.11 higher costs of serving patients with more complex medical, dental, mental health, and
7.12 socioeconomic conditions.

7.13 Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a, is
7.14 amended to read:

7.15 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
7.16 and section 256L.12 shall be entered into or renewed on a calendar year basis beginning
7.17 January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to
7.18 renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December
7.19 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may
7.20 issue separate contracts with requirements specific to services to medical assistance
7.21 recipients age 65 and older.

7.22 (b) A prepaid health plan providing covered health services for eligible persons
7.23 pursuant to chapters 256B and 256L is responsible for complying with the terms of its
7.24 contract with the commissioner. Requirements applicable to managed care programs
7.25 under chapters 256B and 256L established after the effective date of a contract with the
7.26 commissioner take effect when the contract is next issued or renewed.

7.27 (c) Effective for services rendered on or after January 1, 2003, the commissioner
7.28 shall withhold five percent of managed care plan payments under this section and
7.29 county-based purchasing plan payments under section 256B.692 for the prepaid medical
7.30 assistance program pending completion of performance targets. Each performance target
7.31 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
7.32 of a performance target based on a federal or state law or rule. Criteria for assessment
7.33 of each performance target must be outlined in writing prior to the contract effective
7.34 date. Clinical or utilization performance targets and their related criteria must consider
7.35 evidence-based research and reasonable interventions when available or applicable to

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

8.13 (d) Effective for services rendered on or after January 1, 2009, through December
8.14 31, 2009, the commissioner shall withhold three percent of managed care plan payments
8.15 under this section and county-based purchasing plan payments under section 256B.692
8.16 for the prepaid medical assistance program. The withheld funds must be returned no
8.17 sooner than July 1 and no later than July 31 of the following year. The commissioner may
8.18 exclude special demonstration projects under subdivision 23.

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

8.26 (f) Effective for services rendered on or after January 1, 2010, through December
8.27 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments
8.28 under this section and county-based purchasing plan payments under section 256B.692
8.29 for the prepaid medical assistance program. The withheld funds must be returned no
8.30 sooner than July 1 and no later than July 31 of the following year. The commissioner may
8.31 exclude special demonstration projects under subdivision 23.

8.32 (g) Effective for services rendered on or after January 1, 2011, through December
8.33 31, 2011, the commissioner shall include as part of the performance targets described
8.34 in paragraph (c) a reduction in the health plan's emergency room utilization rate for
8.35 state health care program enrollees by a measurable rate of five percent from the plan's
8.36 utilization rate for state health care program enrollees for the previous calendar year.

9.1 Effective for services rendered on or after January 1, 2012, the commissioner shall include
9.2 as part of the performance targets described in paragraph (c) a reduction in the health plan's
9.3 emergency department utilization rate for medical assistance and MinnesotaCare enrollees,
9.4 as determined by the commissioner. For 2012, the reduction shall be based on the health
9.5 plan's utilization in 2009. To earn the return of the withhold each subsequent year, the
9.6 managed care plan or county-based purchasing plan must achieve a qualifying reduction
9.7 of no less than ten percent of the plan's emergency department utilization rate for medical
9.8 assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs
9.9 described in subdivisions 23 and 28, compared to the previous ~~calendar~~ measurement
9.10 year, until the final performance target is reached. When measuring performance, the
9.11 commissioner must consider the difference in health risk in a plan's membership in the
9.12 baseline year compared to the measurement year and work with the managed care or
9.13 county-based purchasing plan to account for differences that they agree are significant.

9.14 The withheld funds must be returned no sooner than July 1 and no later than July 31
9.15 of the following calendar year if the managed care plan or county-based purchasing plan
9.16 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
9.17 was achieved. The commissioner shall structure the withhold so that the commissioner
9.18 returns a portion of the withheld funds in amounts commensurate with achieved reductions
9.19 in utilization less than the targeted amount.

9.20 The withhold described in this paragraph shall continue for each consecutive
9.21 contract period until the plan's emergency room utilization rate for state health care
9.22 program enrollees is reduced by 25 percent of the plan's emergency room utilization
9.23 rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009.
9.24 Hospitals shall cooperate with the health plans in meeting this performance target and
9.25 shall accept payment withholds that may be returned to the hospitals if the performance
9.26 target is achieved.

9.27 (h) Effective for services rendered on or after January 1, 2012, the commissioner
9.28 shall include as part of the performance targets described in paragraph (c) a reduction
9.29 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare
9.30 enrollees, as determined by the commissioner. To earn the return of the withhold each
9.31 year, the managed care plan or county-based purchasing plan must achieve a qualifying
9.32 reduction of no less than five percent of the plan's hospital admission rate for medical
9.33 assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs
9.34 described in subdivisions 23 and 28, compared to the previous calendar year until the final
9.35 performance target is reached. When measuring performance, the commissioner must
9.36 consider the difference in health risk in a plan's membership in the baseline year compared

10.1 to the measurement year, and work with the managed care or county-based purchasing
10.2 plan to account for differences that they agree are significant.

10.3 The withheld funds must be returned no sooner than July 1 and no later than July
10.4 31 of the following calendar year if the managed care plan or county-based purchasing
10.5 plan demonstrates to the satisfaction of the commissioner that this reduction in the
10.6 hospitalization rate was achieved. The commissioner shall structure the withhold so that
10.7 the commissioner returns a portion of the withheld funds in amounts commensurate with
10.8 achieved reductions in utilization less than the targeted amount.

10.9 The withhold described in this paragraph shall continue until there is a 25 percent
10.10 reduction in the hospital admission rate compared to the hospital admission rates in
10.11 calendar year 2011, as determined by the commissioner. The hospital admissions in this
10.12 performance target do not include the admissions applicable to the subsequent hospital
10.13 admission performance target under paragraph (i). Hospitals shall cooperate with the
10.14 plans in meeting this performance target and shall accept payment withholds that may be
10.15 returned to the hospitals if the performance target is achieved.

10.16 (i) Effective for services rendered on or after January 1, 2012, the commissioner
10.17 shall include as part of the performance targets described in paragraph (c) a reduction in
10.18 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days
10.19 of a previous hospitalization of a patient regardless of the reason, for medical assistance
10.20 and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of
10.21 the withhold each year, the managed care plan or county-based purchasing plan must
10.22 achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance
10.23 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
10.24 subdivisions 23 and 28, of no less than five percent compared to the previous calendar
10.25 year until the final performance target is reached.

10.26 The withheld funds must be returned no sooner than July 1 and no later than July
10.27 31 of the following calendar year if the managed care plan or county-based purchasing
10.28 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
10.29 the subsequent hospitalization rate was achieved. The commissioner shall structure the
10.30 withhold so that the commissioner returns a portion of the withheld funds in amounts
10.31 commensurate with achieved reductions in utilization less than the targeted amount.

10.32 The withhold described in this paragraph must continue for each consecutive
10.33 contract period until the plan's subsequent hospitalization rate for medical assistance
10.34 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
10.35 subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization
10.36 rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this

11.1 performance target and shall accept payment withholds that must be returned to the
11.2 hospitals if the performance target is achieved.

11.3 (j) Effective for services rendered on or after January 1, 2011, through December 31,
11.4 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under
11.5 this section and county-based purchasing plan payments under section 256B.692 for the
11.6 prepaid medical assistance program. The withheld funds must be returned no sooner than
11.7 July 1 and no later than July 31 of the following year. The commissioner may exclude
11.8 special demonstration projects under subdivision 23.

11.9 (k) Effective for services rendered on or after January 1, 2012, through December
11.10 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
11.11 under this section and county-based purchasing plan payments under section 256B.692
11.12 for the prepaid medical assistance program. The withheld funds must be returned no
11.13 sooner than July 1 and no later than July 31 of the following year. The commissioner may
11.14 exclude special demonstration projects under subdivision 23.

11.15 (l) Effective for services rendered on or after January 1, 2013, through December 31,
11.16 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
11.17 this section and county-based purchasing plan payments under section 256B.692 for the
11.18 prepaid medical assistance program. The withheld funds must be returned no sooner than
11.19 July 1 and no later than July 31 of the following year. The commissioner may exclude
11.20 special demonstration projects under subdivision 23.

11.21 (m) Effective for services rendered on or after January 1, 2014, the commissioner
11.22 shall withhold three percent of managed care plan payments under this section and
11.23 county-based purchasing plan payments under section 256B.692 for the prepaid medical
11.24 assistance program. The withheld funds must be returned no sooner than July 1 and
11.25 no later than July 31 of the following year. The commissioner may exclude special
11.26 demonstration projects under subdivision 23.

11.27 (n) A managed care plan or a county-based purchasing plan under section 256B.692
11.28 may include as admitted assets under section 62D.044 any amount withheld under this
11.29 section that is reasonably expected to be returned.

11.30 (o) Contracts between the commissioner and a prepaid health plan are exempt from
11.31 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
11.32 (a), and 7.

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

12.1 Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5c,
12.2 is amended to read:

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

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

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

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

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

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

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

12.33 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
12.34 transfer under paragraph (c), the commissioner shall transfer to the medical education
12.35 research fund \$23,936,000 in fiscal ~~years year~~ 2012 ~~and~~, \$24,936,000 in fiscal year 2013,
12.36 ~~and \$36,744,000~~ \$37,744,000 in fiscal year 2014 and thereafter.

13.1 Sec. 11. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

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

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

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

13.18 (2) criteria, written policies, and procedures required to be disclosed under section
13.19 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used
13.20 for each type of service for which authorization is required.

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

13.26 Sec. 12. Minnesota Statutes 2010, section 256B.69, is amended by adding a
13.27 subdivision to read:

13.28 Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner
13.29 shall require managed care and county-based purchasing plans, as a condition of contract,
13.30 to implement strategies to reduce the incidence of low birth weight in geographic areas
13.31 identified by the commissioner as having a higher than average incidence of low birth
13.32 weight. The strategies must coordinate health care with social services and the local
13.33 public health system. Each plan shall develop and report to the commissioner outcome
13.34 measures related to reducing the incidence of low birth weight. The commissioner shall

14.1 consider the outcomes reported when considering plan participation in the competitive
14.2 bidding program established under subdivision 33.

14.3 Sec. 13. Minnesota Statutes 2010, section 256B.69, is amended by adding a
14.4 subdivision to read:

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

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

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

14.26 Sec. 14. Minnesota Statutes 2011 Supplement, section 256L.12, subdivision 9, is
14.27 amended to read:

14.28 **Subd. 9. Rate setting; performance withholds.** (a) Rates will be prospective,
14.29 per capita, where possible. The commissioner may allow health plans to arrange for
14.30 inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with
14.31 an independent actuary to determine appropriate rates.

14.32 (b) For services rendered on or after January 1, 2004, the commissioner shall
14.33 withhold five percent of managed care plan payments and county-based purchasing
14.34 plan payments under this section pending completion of performance targets. Each

15.1 performance target must be quantifiable, objective, measurable, and reasonably attainable,
15.2 except in the case of a performance target based on a federal or state law or rule. Criteria
15.3 for assessment of each performance target must be outlined in writing prior to the contract
15.4 effective date. Clinical or utilization performance targets and their related criteria must
15.5 consider evidence-based research and reasonable interventions, when available or
15.6 applicable to the populations served, and must be developed with input from external
15.7 clinical experts and stakeholders, including managed care plans and providers. The
15.8 managed care plan must demonstrate, to the commissioner's satisfaction, that the data
15.9 submitted regarding attainment of the performance target is accurate. The commissioner
15.10 shall periodically change the administrative measures used as performance targets in
15.11 order to improve plan performance across a broader range of administrative services.
15.12 The performance targets must include measurement of plan efforts to contain spending
15.13 on health care services and administrative activities. The commissioner may adopt
15.14 plan-specific performance targets that take into account factors affecting only one plan,
15.15 such as characteristics of the plan's enrollee population. The withheld funds must be
15.16 returned no sooner than July 1 and no later than July 31 of the following calendar year if
15.17 performance targets in the contract are achieved.

15.18 (c) For services rendered on or after January 1, 2011, the commissioner shall
15.19 withhold an additional three percent of managed care plan or county-based purchasing
15.20 plan payments under this section. The withheld funds must be returned no sooner than
15.21 July 1 and no later than July 31 of the following calendar year. The return of the withhold
15.22 under this paragraph is not subject to the requirements of paragraph (b).

15.23 (d) Effective for services rendered on or after January 1, 2011, through December
15.24 31, 2011, the commissioner shall include as part of the performance targets described in
15.25 paragraph (b) a reduction in the plan's emergency room utilization rate for state health
15.26 care program enrollees by a measurable rate of five percent from the plan's utilization
15.27 rate for the previous calendar year. Effective for services rendered on or after January
15.28 1, 2012, the commissioner shall include as part of the performance targets described in
15.29 paragraph (b) a reduction in the health plan's emergency department utilization rate for
15.30 medical assistance and MinnesotaCare enrollees, as determined by the commissioner.
15.31 For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn
15.32 the return of the withhold each subsequent year, the managed care plan or county-based
15.33 purchasing plan must achieve a qualifying reduction of no less than ten percent of the
15.34 plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding
15.35 Medicare enrollees in programs described in section 256B.69, subdivisions 23 and 28,
15.36 compared to the previous calendar measurement year, until the final performance target is

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

16.5 The withheld funds must be returned no sooner than July 1 and no later than July 31
16.6 of the following calendar year if the managed care plan or county-based purchasing plan
16.7 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
16.8 was achieved. The commissioner shall structure the withhold so that the commissioner
16.9 returns a portion of the withheld funds in amounts commensurate with achieved reductions
16.10 in utilization less than the targeted amount.

16.11 The withhold described in this paragraph shall continue for each consecutive
16.12 contract period until the plan's emergency room utilization rate for state health care
16.13 program enrollees is reduced by 25 percent of the plan's emergency room utilization
16.14 rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009.
16.15 Hospitals shall cooperate with the health plans in meeting this performance target and
16.16 shall accept payment withholds that may be returned to the hospitals if the performance
16.17 target is achieved.

16.18 (e) Effective for services rendered on or after January 1, 2012, the commissioner
16.19 shall include as part of the performance targets described in paragraph (b) a reduction
16.20 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare
16.21 enrollees, as determined by the commissioner. To earn the return of the withhold each
16.22 year, the managed care plan or county-based purchasing plan must achieve a qualifying
16.23 reduction of no less than five percent of the plan's hospital admission rate for medical
16.24 assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs
16.25 described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar
16.26 year, until the final performance target is reached. When measuring performance, the
16.27 commissioner must consider the difference in health risk in a plan's membership in the
16.28 baseline year compared to the measurement year, and work with the managed care or
16.29 county-based purchasing plan to account for differences that they agree are significant.

16.30 The withheld funds must be returned no sooner than July 1 and no later than July
16.31 31 of the following calendar year if the managed care plan or county-based purchasing
16.32 plan demonstrates to the satisfaction of the commissioner that this reduction in the
16.33 hospitalization rate was achieved. The commissioner shall structure the withhold so that
16.34 the commissioner returns a portion of the withheld funds in amounts commensurate with
16.35 achieved reductions in utilization less than the targeted amount.

17.1 The withhold described in this paragraph shall continue until there is a 25 percent
17.2 reduction in the hospitals admission rate compared to the hospital admission rate for
17.3 calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the
17.4 plans in meeting this performance target and shall accept payment withholds that may be
17.5 returned to the hospitals if the performance target is achieved. The hospital admissions
17.6 in this performance target do not include the admissions applicable to the subsequent
17.7 hospital admission performance target under paragraph (f).

17.8 (f) Effective for services provided on or after January 1, 2012, the commissioner
17.9 shall include as part of the performance targets described in paragraph (b) a reduction
17.10 in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a
17.11 previous hospitalization of a patient regardless of the reason, for medical assistance and
17.12 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the
17.13 withhold each year, the managed care plan or county-based purchasing plan must achieve
17.14 a qualifying reduction of the subsequent hospital admissions rate for medical assistance
17.15 and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in
17.16 section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the
17.17 previous calendar year until the final performance target is reached.

17.18 The withheld funds must be returned no sooner than July 1 and no later than July 31
17.19 of the following calendar year if the managed care plan or county-based purchasing plan
17.20 demonstrates to the satisfaction of the commissioner that a reduction in the subsequent
17.21 hospitalization rate was achieved. The commissioner shall structure the withhold so that
17.22 the commissioner returns a portion of the withheld funds in amounts commensurate with
17.23 achieved reductions in utilization less than the targeted amount.

17.24 The withhold described in this paragraph must continue for each consecutive
17.25 contract period until the plan's subsequent hospitalization rate for medical assistance and
17.26 MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization
17.27 rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this
17.28 performance target and shall accept payment withholds that must be returned to the
17.29 hospitals if the performance target is achieved.

17.30 (g) A managed care plan or a county-based purchasing plan under section 256B.692
17.31 may include as admitted assets under section 62D.044 any amount withheld under this
17.32 section that is reasonably expected to be returned.

17.33 **Sec. 15. DATA ON CLAIMS AND UTILIZATION.**

17.34 The commissioner of human services shall develop and provide to the legislature
17.35 by December 15, 2012, a methodology and any draft legislation necessary to allow for

18.1 the release, upon request, of summary data as defined in Minnesota Statutes, section
18.2 13.02, subdivision 19, on claims and utilization for medical assistance and MinnesotaCare
18.3 enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical
18.4 School, Northwestern Health Sciences University, the Institute for Clinical Systems
18.5 Improvement, and other research institutions in Minnesota to conduct analyses of health
18.6 care outcomes and treatment effectiveness, provided:

18.7 (1) a data-sharing agreement is in place that ensures compliance with the Minnesota
18.8 Government Data Practices Act;

18.9 (2) the commissioner of human services determines that the work would produce
18.10 analyses useful in the administration of the medical assistance or MinnesotaCare
18.11 programs; and

18.12 (3) the research institutions do not release private or nonpublic data or data for
18.13 which dissemination is prohibited by law.

18.14 Sec. 16. **MANAGING MEDICAL ASSISTANCE FEE-FOR-SERVICE CARE**
18.15 **DELIVERY.**

18.16 The commissioner of human services may issue a request for proposals to develop
18.17 and administer a care delivery management system for medical assistance enrollees
18.18 served under fee-for-service. The care delivery management system must improve health
18.19 care quality and reduce unnecessary health care costs through the: (1) use of predictive
18.20 modeling tools and comprehensive patient encounter data to identify missed preventive
18.21 care and other gaps in health care delivery and to identify chronically ill and high-cost
18.22 enrollees for targeted interventions and care management; (2) use of claims data to
18.23 evaluate health care providers for overall quality and cost-effectiveness and make this
18.24 information available to enrollees; and (3) establishment of a program integrity initiative
18.25 to reduce fraudulent or improper billing. The commissioner shall award a contract
18.26 under any request for proposals to a Minnesota-based organization by October 1, 2012.
18.27 The contract must require the organization to implement the care delivery management
18.28 system by July 1, 2013.

18.29 Sec. 17. **PHYSICIAN ASSISTANTS AND OUTPATIENT MENTAL HEALTH.**

18.30 The commissioner of human services shall convene a group of interested
18.31 stakeholders to assist the commissioner in developing recommendations on how to
18.32 improve access to, and the quality of, outpatient mental health services for medical
18.33 assistance enrollees through the use of physician assistants. The commissioner shall report

19.1 these recommendations to the chairs and ranking minority members of the legislative
19.2 committees with jurisdiction over health care policy and financing by January 15, 2013.

19.3 **ARTICLE 2**

19.4 **DEPARTMENT OF HEALTH**

19.5 Section 1. Minnesota Statutes 2010, section 62D.02, subdivision 3, is amended to read:

19.6 Subd. 3. **Commissioner of ~~health~~ commerce or commissioner.** "Commissioner of
19.7 ~~health~~ commerce" or "commissioner" means the state commissioner of ~~health~~ commerce
19.8 or a designee.

19.9 **EFFECTIVE DATE.** This section is effective August 1, 2012.

19.10 Sec. 2. Minnesota Statutes 2010, section 62D.05, subdivision 6, is amended to read:

19.11 Subd. 6. **Supplemental benefits.** (a) A health maintenance organization may, as
19.12 a supplemental benefit, provide coverage to its enrollees for health care services and
19.13 supplies received from providers who are not employed by, under contract with, or
19.14 otherwise affiliated with the health maintenance organization. Supplemental benefits may
19.15 be provided if the following conditions are met:

19.16 (1) a health maintenance organization desiring to offer supplemental benefits must at
19.17 all times comply with the requirements of sections 62D.041 and 62D.042;

19.18 (2) a health maintenance organization offering supplemental benefits must maintain
19.19 an additional surplus in the first year supplemental benefits are offered equal to the
19.20 lesser of \$500,000 or 33 percent of the supplemental benefit expenses. At the end of
19.21 the second year supplemental benefits are offered, the health maintenance organization
19.22 must maintain an additional surplus equal to the lesser of \$1,000,000 or 33 percent of the
19.23 supplemental benefit expenses. At the end of the third year benefits are offered and every
19.24 year after that, the health maintenance organization must maintain an additional surplus
19.25 equal to the greater of \$1,000,000 or 33 percent of the supplemental benefit expenses.

19.26 When in the judgment of the commissioner the health maintenance organization's surplus
19.27 is inadequate, the commissioner may require the health maintenance organization to
19.28 maintain additional surplus;

19.29 (3) claims relating to supplemental benefits must be processed in accordance with
19.30 the requirements of section 72A.201; and

19.31 (4) in marketing supplemental benefits, the health maintenance organization shall
19.32 fully disclose and describe to enrollees and potential enrollees the nature and extent of the

20.1 supplemental coverage, and any claims filing and other administrative responsibilities in
 20.2 regard to supplemental benefits.

20.3 (b) The commissioner may, pursuant to chapter 14, adopt, enforce, and administer
 20.4 rules relating to this subdivision, including: rules insuring that these benefits are
 20.5 supplementary and not substitutes for comprehensive health maintenance services by
 20.6 addressing percentage of out-of-plan coverage; rules relating to the establishment of
 20.7 necessary financial reserves; rules relating to marketing practices; and other rules necessary
 20.8 for the effective and efficient administration of this subdivision. ~~The commissioner, in
 20.9 adopting rules, shall give consideration to existing laws and rules administered and
 20.10 enforced by the Department of Commerce relating to health insurance plans.~~

20.11 **EFFECTIVE DATE.** This section is effective August 1, 2012.

20.12 Sec. 3. Minnesota Statutes 2010, section 62D.12, subdivision 1, is amended to read:

20.13 Subdivision 1. **False representations.** No health maintenance organization or
 20.14 representative thereof may cause or knowingly permit the use of advertising or solicitation
 20.15 which is untrue or misleading, or any form of evidence of coverage which is deceptive.
 20.16 Each health maintenance organization shall be subject to sections 72A.17 to 72A.32,
 20.17 relating to the regulation of trade practices, except ~~(a)~~ to the extent that the nature of a
 20.18 health maintenance organization renders such sections clearly inappropriate ~~and (b) that
 20.19 enforcement shall be by the commissioner of health and not by the commissioner of
 20.20 commerce.~~ Every health maintenance organization shall be subject to sections 8.31 and
 20.21 325F.69.

20.22 **EFFECTIVE DATE.** This section is effective August 1, 2012.

20.23 Sec. 4. Minnesota Statutes 2010, section 62Q.80, is amended to read:

20.24 **62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.**

20.25 Subdivision 1. **Scope.** (a) Any community-based health care initiative may develop
 20.26 and operate community-based health care coverage programs that offer to eligible
 20.27 individuals and their dependents the option of purchasing through their employer health
 20.28 care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A,
 20.29 62A, 62C, 62D, 62M, 62N, 62Q, 62T, or 62U, or any other law or rule that applies to
 20.30 entities licensed under these chapters.

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

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

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

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

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

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

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

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

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

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

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

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

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

22.1 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health
22.2 care coverage program, a community-based health initiative, defined in subdivision
22.3 2, paragraph (c), ~~and receiving funds from the Department of Health,~~ shall submit to
22.4 the commissioner of health for approval the community-based health care coverage
22.5 program developed by the initiative. ~~Each community-based health initiative as defined~~
22.6 ~~in subdivision 2, paragraph (c), and receiving State Health Access Program (SHAP)~~
22.7 ~~grant funding shall submit to the commissioner of human services for approval prior~~
22.8 ~~to its operation the community-based health care coverage programs developed by the~~
22.9 ~~initiatives.~~ The ~~commissioners~~ commissioner shall ensure that each program meets
22.10 ~~the federal grant requirements and any~~ requirements described in this section and is
22.11 actuarially sound based on a review of appropriate records and methods utilized by the
22.12 community-based health initiative in establishing premium rates for the community-based
22.13 health care coverage programs.

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

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

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

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

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

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

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

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

22.28 (3) providing payment to participating providers;

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

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

22.32 (6) initiating disease management services, as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23.34 (2) preventive services, including:

23.35 (i) health education and wellness services;

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

24.1 (iii) immunizations; and

24.2 (iv) early disease detection.

24.3 (b) Coverage of health care services offered by the program may be limited to
24.4 participating health care providers or health networks. All services covered under the
24.5 programs must be services that are offered within the scope of practice of the participating
24.6 health care providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.31 Sec. 5. Minnesota Statutes 2010, section 62U.04, subdivision 1, is amended to read:

25.32 Subdivision 1. **Development of tools to improve costs and quality outcomes.**

25.33 The commissioner of health shall develop a plan to create transparent prices, encourage
 25.34 greater provider innovation and collaboration across points on the health continuum
 25.35 in cost-effective, high-quality care delivery, reduce the administrative burden on

26.1 providers and health plans associated with submitting and processing claims, and provide
 26.2 comparative information to consumers on variation in health care cost and quality across
 26.3 providers. ~~The development must be complete by January 1, 2010.~~

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

26.5 Sec. 6. Minnesota Statutes 2010, section 62U.04, subdivision 2, is amended to read:

26.6 Subd. 2. **Calculation of health care costs and quality.** The commissioner of health
 26.7 shall develop a uniform method of calculating providers' relative cost of care, defined as a
 26.8 measure of health care spending including resource use and unit prices, and relative quality
 26.9 of care. In developing this method, the commissioner must address the following issues:

26.10 (1) provider attribution of costs and quality;

26.11 (2) appropriate adjustment for outlier or catastrophic cases;

26.12 (3) appropriate risk adjustment to reflect differences in the demographics and health
 26.13 status across provider patient populations, using generally accepted and transparent risk
 26.14 adjustment methodologies and case mix adjustment;

26.15 (4) specific types of providers that should be included in the calculation;

26.16 (5) specific types of services that should be included in the calculation;

26.17 (6) appropriate adjustment for variation in payment rates;

26.18 (7) the appropriate provider level for analysis;

26.19 (8) payer mix adjustments, including variation across providers in the percentage of
 26.20 revenue received from government programs; and

26.21 (9) other factors that the commissioner ~~determines~~ and the advisory committee,
 26.22 established under subdivision 3, determine are needed to ensure validity and comparability
 26.23 of the analysis.

26.24 **EFFECTIVE DATE.** This section is effective July 1, 2012, and applies to all
 26.25 information provided or released to the public or to health care providers, pursuant to
 26.26 Minnesota Statutes, section 62U.04, on or after that date.

26.27 Sec. 7. Minnesota Statutes 2011 Supplement, section 62U.04, subdivision 3, is
 26.28 amended to read:

26.29 Subd. 3. **Provider peer grouping; system development; advisory committee.**

26.30 (a) The commissioner shall develop a peer grouping system for providers ~~based on a~~
 26.31 ~~combined measure~~ that incorporates both provider risk-adjusted cost of care and quality of
 26.32 care, and for specific conditions as determined by the commissioner. ~~In developing this~~
 26.33 ~~system, the commissioner shall consult and coordinate with health care providers, health~~

27.1 ~~plan companies, state agencies, and organizations that work to improve health care quality~~
 27.2 ~~in Minnesota.~~ For purposes of the final establishment of the peer grouping system, the
 27.3 commissioner shall not contract with any private entity, organization, or consortium of
 27.4 entities that has or will have a direct financial interest in the outcome of the system.

27.5 (b) The commissioner shall establish an advisory committee comprised of
 27.6 representatives of health care providers, health plan companies, consumers, state agencies,
 27.7 employers, academic researchers, and organizations that work to improve health care
 27.8 quality in Minnesota. The advisory committee shall meet no fewer than three times
 27.9 per year. The commissioner shall consult with the advisory committee in developing
 27.10 and administering the peer grouping system, including but not limited to the following
 27.11 activities:

27.12 (1) establishing peer groups;

27.13 (2) selecting quality measures;

27.14 (3) recommending thresholds for completeness of data and statistical significance
 27.15 for the purposes of public release of provider peer grouping results;

27.16 (4) considering whether adjustments are necessary for facilities that provide medical
 27.17 education, level 1 trauma services, neonatal intensive care, or inpatient psychiatric care;

27.18 (5) recommending inclusion or exclusion of other costs; and

27.19 (6) adopting patient attribution and quality and cost-scoring methodologies.

27.20 Subd. 3a. **Provider peer grouping; dissemination of data to providers.** (b) By

27.21 ~~no later than October 15, 2010,~~ (a) The commissioner shall disseminate information
 27.22 to providers on their total cost of care, total resource use, total quality of care, and the
 27.23 total care results of the grouping developed under this subdivision 3 in comparison to an
 27.24 appropriate peer group. Data used for this analysis must be the most recent data available.

27.25 Any analyses or reports that identify providers may only be published after the provider
 27.26 has been provided the opportunity by the commissioner to review the underlying data in
 27.27 order to verify, consistent with the findings specified in subdivision 3c, paragraph (d), the

27.28 accuracy and representativeness of any analyses or reports and submit comments to the

27.29 commissioner or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request,
 27.30 providers shall be given any data for which they are the subject of the data. The provider

27.31 shall have ~~30~~ 60 days to review the data for accuracy and initiate an appeal as specified
 27.32 in ~~paragraph (d)~~ subdivision 3b.

27.33 ~~(c) By no later than January 1, 2011,~~ (b) The commissioner shall disseminate

27.34 information to providers on their condition-specific cost of care, condition-specific
 27.35 resource use, condition-specific quality of care, and the condition-specific results of the
 27.36 grouping developed under this subdivision 3 in comparison to an appropriate peer group.

28.1 Data used for this analysis must be the most recent data available. Any analyses or
 28.2 reports that identify providers may only be published after the provider has been provided
 28.3 the opportunity by the commissioner to review the underlying data in order to verify,
 28.4 consistent with the findings specified in subdivision 3c, paragraph (d), the accuracy and
 28.5 representativeness of any analyses or reports and submit comments to the commissioner
 28.6 or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request, providers shall
 28.7 be given any data for which they are the subject of the data. The provider shall have ~~30~~
 28.8 60 days to review the data for accuracy and initiate an appeal as specified in ~~paragraph~~
 28.9 ~~(d)~~ subdivision 3b.

28.10 Subd. 3b. Provider peer grouping; appeals process. ~~(d)~~ The commissioner shall
 28.11 establish ~~an appeals~~ a process to resolve disputes from providers regarding the accuracy
 28.12 of the data used to develop analyses or reports or errors in the application of standards
 28.13 or methodology established by the commissioner in consultation with the advisory
 28.14 committee. When a provider ~~appeals the accuracy of the data used to calculate the peer~~
 28.15 ~~grouping system results~~ submits an appeal, the provider shall:

28.16 (1) clearly indicate the reason ~~they believe the data used to calculate the peer group~~
 28.17 ~~system results are not accurate~~ or reasons for the appeal;

28.18 (2) provide any evidence ~~and,~~ calculations, or documentation to support the reason
 28.19 ~~that data was not accurate~~ for the appeal; and

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

28.22 The commissioner shall cooperate with the provider during the data review period
 28.23 specified in subdivisions 3a and 3c by giving the provider information necessary for the
 28.24 preparation of an appeal.

28.25 If a provider does not meet the requirements of this ~~paragraph~~ subdivision, a provider's
 28.26 appeal shall be considered withdrawn. The commissioner shall not publish peer grouping
 28.27 results for a ~~specific provider under paragraph (e) or (f) while that provider has an~~
 28.28 ~~unresolved appeal~~ until the appeal has been resolved.

28.29 Subd. 3c. Provider peer grouping; publication of information for the public.

28.30 ~~(c) Beginning January 1, 2011, the commissioner shall, no less than annually, publish~~
 28.31 ~~information on providers' total cost, total resource use, total quality, and the results of~~
 28.32 ~~the total care portion of the peer grouping process. The results that are published must~~
 28.33 ~~be on a risk-adjusted basis.~~ (a) The commissioner may publicly release summary data
 28.34 related to the peer grouping system as long as the data do not contain information or
 28.35 descriptions from which the identity of individual hospitals, clinics, or other providers
 28.36 may be discerned.

29.1 ~~(f) Beginning March 30, 2011, the commissioner shall no less than annually publish~~
29.2 ~~information on providers' condition-specific cost, condition-specific resource use, and~~
29.3 ~~condition-specific quality, and the results of the condition-specific portion of the peer~~
29.4 ~~grouping process. The results that are published must be on a risk-adjusted basis. (b) The~~
29.5 ~~commissioner may publicly release analyses or results related to the peer grouping system~~
29.6 ~~that identify hospitals, clinics, or other providers only if the following criteria are met:~~

29.7 (1) the results, data, and summaries, including any graphical depictions of provider
29.8 performance, have been distributed to providers at least 120 days prior to publication;

29.9 (2) the commissioner has provided an opportunity for providers to verify and
29.10 review data for which the provider is the subject consistent with the findings specified
29.11 in subdivision 3c, paragraph (d);

29.12 (3) the results meet thresholds of validity, reliability, statistical significance,
29.13 representativeness, and other standards that reflect the recommendations of the advisory
29.14 committee, established under subdivision 3; and

29.15 (4) any public report or other usage of the analyses, report, or data used by the
29.16 state clearly notifies consumers about how to use and interpret the results, including
29.17 any limitations of the data and analysis.

29.18 ~~(g) (c) After publishing the first public report, the commissioner shall, no less~~
29.19 ~~frequently than annually, publish information on providers' total cost, total resource use,~~
29.20 ~~total quality, and the results of the total care portion of the peer grouping process, as well~~
29.21 ~~as information on providers' condition-specific cost, condition-specific resource use,~~
29.22 ~~and condition-specific quality, and the results of the condition-specific portion of the~~
29.23 ~~peer grouping process. The results that are published must be on a risk-adjusted basis,~~
29.24 ~~including case mix adjustments.~~

29.25 (d) The commissioner shall convene a work group comprised of representatives
29.26 of physician clinics, hospitals, their respective statewide associations, and other
29.27 relevant stakeholder organizations to make recommendations on data to be made
29.28 available to hospitals and physician clinics to allow for verification of the accuracy and
29.29 representativeness of the provider peer grouping results.

29.30 **Subd. 3d. Provider peer grouping; standards for dissemination and publication.**

29.31 (a) Prior to disseminating data to providers under paragraph (b) or (c) subdivision 3a or
29.32 publishing information under paragraph (c) or (f) subdivision 3c, the commissioner, in
29.33 consultation with the advisory committee, shall ensure the scientific and statistical validity
29.34 and reliability of the results according to the standards described in paragraph (b).
29.35 If additional time is needed to establish the scientific validity, statistical significance,
29.36 and reliability of the results, the commissioner may delay the dissemination of data to

30.1 providers under ~~paragraph (b) or (c) subdivision 3a~~, or the publication of information under
 30.2 ~~paragraph (c) or (f) subdivision 3c~~. ~~If the delay is more than 60 days, the commissioner~~
 30.3 ~~shall report in writing to the chairs and ranking minority members of the legislative~~
 30.4 ~~committees with jurisdiction over health care policy and finance the following information:~~

30.5 (1) ~~the reason for the delay;~~

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

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

30.9 ~~If there is a delay under this paragraph,~~ The commissioner must disseminate the
 30.10 information to providers under ~~paragraph (b) or (c) subdivision 3a~~ at least ~~90~~ 120 days
 30.11 before publishing results under ~~paragraph (c) or (f) subdivision 3c~~.

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

30.14 (1) use of the best available evidence, research, and methodologies; and

30.15 (2) establishment of ~~an~~ explicit minimum reliability ~~threshold~~ thresholds for both
 30.16 quality and costs developed in collaboration with the subjects of the data and the users of
 30.17 the data, at a level not below nationally accepted standards where such standards exist.

30.18 In achieving these thresholds, the commissioner shall not aggregate clinics that are not
 30.19 part of the same system or practice group. The commissioner shall consult with and
 30.20 solicit feedback from the advisory committee and representatives of physician clinics
 30.21 and hospitals during the peer grouping data analysis process to obtain input on the
 30.22 methodological options prior to final analysis and on the design, development, and testing
 30.23 of provider reports.

30.24 **EFFECTIVE DATE.** This section is effective July 1, 2012, shall be implemented
 30.25 within available resources, and applies to all information provided or released to the
 30.26 public or to health care providers, pursuant to Minnesota Statutes, section 64U.04, on or
 30.27 after that date.

30.28 Sec. 8. Minnesota Statutes 2010, section 62U.04, subdivision 4, is amended to read:

30.29 Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months
 30.30 thereafter, all health plan companies and third-party administrators shall submit encounter
 30.31 data to a private entity designated by the commissioner of health. The data shall be
 30.32 submitted in a form and manner specified by the commissioner subject to the following
 30.33 requirements:

31.1 (1) the data must be de-identified data as described under the Code of Federal
31.2 Regulations, title 45, section 164.514;

31.3 (2) the data for each encounter must include an identifier for the patient's health care
31.4 home if the patient has selected a health care home; and

31.5 (3) except for the identifier described in clause (2), the data must not include
31.6 information that is not included in a health care claim or equivalent encounter information
31.7 transaction that is required under section 62J.536.

31.8 (b) The commissioner or the commissioner's designee shall only use the data
31.9 submitted under paragraph (a) ~~for the purpose of carrying out its responsibilities in this~~
31.10 ~~section, and must maintain the data that it receives according to the provisions of this~~
31.11 ~~section~~ to carry out its responsibilities in this section, including supplying the data to
31.12 providers so they can verify their results of the peer grouping process consistent with the
31.13 findings specified under subdivision 3c, paragraph (d), and, if necessary, submit comments
31.14 to the commissioner or initiate an appeal.

31.15 (c) Data on providers collected under this subdivision are private data on individuals
31.16 or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary
31.17 data in section 13.02, subdivision 19, summary data prepared under this subdivision
31.18 may be derived from nonpublic data. The commissioner or the commissioner's designee
31.19 shall establish procedures and safeguards to protect the integrity and confidentiality of
31.20 any data that it maintains.

31.21 (d) The commissioner or the commissioner's designee shall not publish analyses or
31.22 reports that identify, or could potentially identify, individual patients.

31.23 **EFFECTIVE DATE.** This section is effective July 1, 2012, and applies to all
31.24 information provided or released to the public or to health care providers pursuant to
31.25 Minnesota Statutes, section 62U.04, on or after that date.

31.26 Sec. 9. Minnesota Statutes 2010, section 62U.04, subdivision 5, is amended to read:

31.27 Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1
31.28 thereafter, all health plan companies and third-party administrators shall submit data
31.29 on their contracted prices with health care providers to a private entity designated by
31.30 the commissioner of health for the purposes of performing the analyses required under
31.31 this subdivision. The data shall be submitted in the form and manner specified by the
31.32 commissioner of health.

31.33 (b) The commissioner or the commissioner's designee shall only use the data
31.34 submitted under this subdivision ~~for the purpose of carrying out its responsibilities under~~
31.35 ~~this section~~ to carry out its responsibilities under this section, including supplying the

32.1 data to providers so they can verify their results of the peer grouping process consistent
 32.2 with the findings specified under subdivision 3c, paragraph (d), and, if necessary, submit
 32.3 comments to the commissioner or initiate an appeal.

32.4 (c) Data collected under this subdivision are nonpublic data as defined in section
 32.5 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19,
 32.6 summary data prepared under this section may be derived from nonpublic data. The
 32.7 commissioner shall establish procedures and safeguards to protect the integrity and
 32.8 confidentiality of any data that it maintains.

32.9 **EFFECTIVE DATE.** This section is effective July 1, 2012, and applies to all
 32.10 information provided or released to the public or to health care providers pursuant to
 32.11 Minnesota Statutes, section 62U.04, on or after that date.

32.12 Sec. 10. Minnesota Statutes 2011 Supplement, section 62U.04, subdivision 9, is
 32.13 amended to read:

32.14 Subd. 9. **Uses of information.** ~~(a) For product renewals or for new products that~~
 32.15 ~~are offered, after 12 months have elapsed from publication by the commissioner of the~~
 32.16 ~~information in subdivision 3, paragraph (c):~~

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

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

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

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

32.33 ~~(b) By January 1, 2011, the commissioner of health shall report to the governor~~
 32.34 ~~and the legislature on recommendations to encourage health plan companies to promote~~
 32.35 ~~widespread adoption of products that encourage the use of high-quality, low-cost providers.~~

33.1 ~~The commissioner's recommendations may include tax incentives, public reporting of~~
33.2 ~~health plan performance, regulatory incentives or changes, and other strategies.~~

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

33.4 Sec. 11. Minnesota Statutes 2010, section 144.1222, is amended by adding a
33.5 subdivision to read:

33.6 Subd. 6. **Exemption.** The natural swimming pond project known as Webber Lake
33.7 in the city of Minneapolis is exempt from this chapter and Minnesota Rules, chapter
33.8 4717, for the purpose of allowing a swimming pool that uses an alternative, nonchemical
33.9 filtration system to eliminate pathogens through natural processes. If the commissioner
33.10 determines that this project is unable to provide a safe swimming environment, the
33.11 commissioner shall rescind this exemption.

33.12 **EFFECTIVE DATE.** This section is effective the day the governing body of the
33.13 city of Minneapolis and its chief clerical officer timely complete their compliance with
33.14 Minnesota Statutes, section 645.021, subdivisions 2 and 3.

33.15 Sec. 12. **[144.1225] ADVANCED DIAGNOSTIC IMAGING SERVICES.**

33.16 Subdivision 1. **Definition.** For purposes of this section, "advanced diagnostic
33.17 imaging services" means services entailing the use of diagnostic magnetic resonance
33.18 imaging (MRI) equipment, except that it does not include MRI equipment owned or
33.19 operated by a hospital licensed under sections 144.50 to 144.56 or any facility affiliated
33.20 with or owned by such hospital.

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

33.29 (1) American College of Radiology (ACR);

33.30 (2) Intersocietal Accreditation Commission (IAC); or

33.31 (3) the joint commission.

33.32 (b) Any facility that performs advanced diagnostic imaging services and is eligible
33.33 to receive reimbursement for such services from any source in paragraph (a) must obtain

34.1 accreditation by August 1, 2013. Thereafter, all facilities that provide advanced diagnostic
34.2 imaging services in the state must obtain accreditation prior to commencing operations
34.3 and must, at all times, maintain accreditation with an accrediting organization as provided
34.4 in paragraph (a).

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

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

34.10 Sec. 13. Minnesota Statutes 2010, section 144.292, subdivision 6, is amended to read:

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

34.13 (b) When a provider or its representative makes copies of patient records upon a
34.14 patient's request under this section, the provider or its representative may charge the
34.15 patient or the patient's representative no more than 75 cents per page, plus \$10 for time
34.16 spent retrieving and copying the records, unless other law or a rule or contract provide for
34.17 a lower maximum charge. This limitation does not apply to x-rays. The provider may
34.18 charge a patient no more than the actual cost of reproducing x-rays, plus no more than
34.19 \$10 for the time spent retrieving and copying the x-rays.

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

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

35.1 For purposes of this paragraph, a patient's authorized representative does not include units
 35.2 of state government engaged in the adjudication of Social Security disability claims.

35.3 Sec. 14. Minnesota Statutes 2010, section 144.293, subdivision 2, is amended to read:

35.4 Subd. 2. **Patient consent to release of records.** A provider, or a person who
 35.5 receives health records from a provider, may not release a patient's health records to a
 35.6 person without:

35.7 (1) a signed and dated consent from the patient or the patient's legally authorized
 35.8 representative authorizing the release;

35.9 (2) specific authorization in law; or

35.10 (3) in the case of a medical emergency, a representation from a provider that holds a
 35.11 signed and dated consent from the patient authorizing the release.

35.12 Sec. 15. Minnesota Statutes 2010, section 145.906, is amended to read:

35.13 **145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

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

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

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

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

35.28 Sec. 16. Minnesota Statutes 2010, section 256B.0754, subdivision 2, is amended to
 35.29 read:

35.30 Subd. 2. **Payment reform.** By no later than 12 months after the commissioner of
 35.31 health publishes the information in section ~~62U.04, subdivision 3, paragraph (c)~~ 62U.04,
 35.32 subdivision 3c, paragraph (b), the commissioner of human services ~~shall~~ may use the

36.1 information and methods developed under section 62U.04 to establish a payment system
36.2 that:

36.3 (1) rewards high-quality, low-cost providers;

36.4 (2) creates enrollee incentives to receive care from high-quality, low-cost providers;

36.5 and

36.6 (3) fosters collaboration among providers to reduce cost shifting from one part of
36.7 the health continuum to another.

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

36.9 Sec. 17. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY**
36.10 **RESPONSIBILITIES.**

36.11 Relating to the evaluations and legislative report completed pursuant to Laws
36.12 2011, First Special Session chapter 9, article 2, section 26, the following activities must
36.13 be completed:

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

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

37.1 Sec. 18. **STUDY OF FOR-PROFIT HEALTH MAINTENANCE**37.2 **ORGANIZATIONS.**

37.3 The commissioner of health shall contract with an entity with expertise in health
 37.4 economics and health care delivery and quality to study the efficiency, costs, service
 37.5 quality, and enrollee satisfaction of for-profit health maintenance organizations, relative to
 37.6 not-for-profit health maintenance organizations operating in Minnesota and other states.
 37.7 The study findings must address whether the state could: (1) reduce medical assistance
 37.8 and MinnesotaCare costs and costs of providing coverage to state employees; and (2)
 37.9 maintain or improve the quality of care provided to state health care program enrollees and
 37.10 state employees if for-profit health maintenance organizations were allowed to operate in
 37.11 the state. The commissioner shall require the entity under contract to report study findings
 37.12 to the commissioner and the legislature by January 15, 2013.

37.13 Sec. 19. **REPORTING PREVALENCE OF SEXUAL VIOLENCE.**

37.14 The commissioner of health must routinely report to the public and to the legislature
 37.15 data on the prevalence and incidence of sexual violence in Minnesota. The commissioner
 37.16 must use existing data provided by the Centers for Disease Control and Prevention, or
 37.17 other source as identified by commissioner.

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

37.19 Sec. 20. **LICENSED HOME CARE PROVIDERS.**

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

37.23 **ARTICLE 3**37.24 **CHILDREN AND FAMILY SERVICES**

37.25 Section 1. Minnesota Statutes 2010, section 119B.13, subdivision 3a, is amended to
 37.26 read:

37.27 Subd. 3a. **Provider rate differential for accreditation.** A family child care
 37.28 provider or child care center shall be paid a ~~15~~ 16 percent differential above the maximum
 37.29 rate established in subdivision 1, up to the actual provider rate, if the provider or center
 37.30 holds a current early childhood development credential or is accredited. For a family
 37.31 child care provider, early childhood development credential and accreditation includes
 37.32 an individual who has earned a child development associate degree, a child development

38.1 associate credential, a diploma in child development from a Minnesota state technical
 38.2 college, or a bachelor's or post baccalaureate degree in early childhood education from
 38.3 an accredited college or university, or who is accredited by the National Association
 38.4 for Family Child Care or the Competency Based Training and Assessment Program.
 38.5 For a child care center, accreditation includes accreditation ~~by~~ that meets the following
 38.6 criteria: the accrediting organization must demonstrate the use of standards that promote
 38.7 the physical, social, emotional, and cognitive development of children. The accreditation
 38.8 standards shall include, but are not limited to, positive interactions between adults and
 38.9 children, age-appropriate learning activities, a system of tracking children's learning,
 38.10 use of assessment to meet children's needs, specific qualifications for staff, a learning
 38.11 environment that supports developmentally appropriate experiences for children, health
 38.12 and safety requirements, and family engagement strategies. The commissioner of human
 38.13 services, in conjunction with the commissioners of education and health, will develop an
 38.14 application and approval process based on the criteria in this section and any additional
 38.15 criteria. The process developed by the commissioner of human services must address
 38.16 periodic reassessment of approved accreditations. The commissioner of human services
 38.17 must report the criteria developed, the application, approval, and reassessment processes,
 38.18 and any additional recommendations by February 15, 2013, to the chairs and ranking
 38.19 minority members of the legislative committees having jurisdiction over early childhood
 38.20 issues. The following accreditations shall be recognized for the provider rate differential
 38.21 until an approval process is implemented: the National Association for the Education of
 38.22 Young Children, the Council on Accreditation, the National Early Childhood Program
 38.23 Accreditation, the National School-Age Care Association, or the National Head Start
 38.24 Association Program of Excellence. For Montessori programs, accreditation includes
 38.25 the American Montessori Society, Association of Montessori International-USA, or the
 38.26 National Center for Montessori Education.

38.27 **EFFECTIVE DATE.** This section is effective September 3, 2012.

38.28 Sec. 2. Minnesota Statutes 2011 Supplement, section 119B.13, subdivision 7, is
 38.29 amended to read:

38.30 Subd. 7. **Absent days.** (a) ~~Licensed~~ Child care providers ~~and license-exempt centers~~
 38.31 ~~must~~ may not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding
 38.32 holidays, in a fiscal year, or for more than ten consecutive full day absent days, unless the
 38.33 child has a documented medical condition that causes more frequent absences. Absences
 38.34 due to a documented medical condition of a parent or sibling who lives in the same
 38.35 residence as the child receiving child care assistance do not count against the 25 day absent

39.1 day limit in a fiscal year. Documentation of medical conditions must be on the forms and
39.2 submitted according to the timelines established by the commissioner. A public health
39.3 nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider
39.4 sends a child home early due to a medical reason, including, but not limited to, fever or
39.5 contagious illness, the child care center director or lead teacher may verify the illness in
39.6 lieu of a medical practitioner. ~~Legal nonlicensed family child care providers must not be~~
39.7 reimbursed for absent days. If a child attends for part of the time authorized to be in care
39.8 in a day, but is absent for part of the time authorized to be in care in that same day, the
39.9 absent time must be reimbursed but the time must not count toward the ten consecutive or
39.10 25 cumulative absent day limit limits. Children in families where at least one parent is
39.11 under the age of 21, does not have a high school or general equivalency diploma, and is a
39.12 student in a school district or another similar program that provides or arranges for child
39.13 care, as well as parenting, social services, career and employment supports, and academic
39.14 support to achieve high school graduation, may be exempt from the absent day limits upon
39.15 request of the program and approval by the county. If a child attends part of an authorized
39.16 day, payment to the provider must be for the full amount of care authorized for that day.
39.17 Child care providers must only be reimbursed for absent days if the provider has a written
39.18 policy for child absences and charges all other families in care for similar absences.

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

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

39.29 (d) The provider and family shall receive notification of the number of absent days
39.30 used upon initial provider authorization for a family and ongoing notification of the
39.31 number of absent days used as of the date of the notification.

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

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

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

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

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

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

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

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

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

40.26 Subd. 18d. **Data sharing with Department of Human Services; multiple**
40.27 **identification cards.** (a) The commissioner of public safety shall, on a monthly basis,
40.28 provide the commissioner of human services with the first, middle, and last name,
40.29 the address, date of birth, and driver's license or state identification card number of all
40.30 applicants and holders whose drivers' licenses and state identification cards have been
40.31 canceled under section 171.14, paragraph (a), clause (2) or (3), by the commissioner of
40.32 public safety. After the initial data report has been provided by the commissioner of
40.33 public safety to the commissioner of human services under this paragraph, subsequent

41.1 reports shall only include cancellations that occurred after the end date of the cancellations
41.2 represented in the previous data report.

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

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

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

41.14 Sec. 5. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision
41.15 to read:

41.16 **Subd. 18e. Data sharing with Department of Human Services; legal presence**
41.17 **status.** (a) The commissioner of public safety shall, on a monthly basis, provide the
41.18 commissioner of human services with the first, middle, and last name, address, date of
41.19 birth, and driver's license or state identification number of all applicants and holders of
41.20 drivers' licenses and state identification cards whose temporary legal presence status has
41.21 expired and whose driver's license or identification card has been canceled under section
41.22 171.14 by the commissioner of public safety.

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

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

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

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

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

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

42.12 Subd. 2. **Prohibited purchases.** An individual with an EBT debit cardholders in
42.13 card issued for one of the programs listed under subdivision 1 are is prohibited from using
42.14 the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in
42.15 section 340A.101, subdivision 2. ~~It is unlawful for an EBT cardholder to purchase or~~
42.16 ~~attempt to purchase tobacco products or alcoholic beverages with the cardholder's EBT~~
42.17 ~~card.~~ Any unlawful use prohibited purchases made under this subdivision shall constitute
42.18 fraud unlawful use and result in disqualification of the cardholder from the program ~~under~~
42.19 ~~section 256.98, subdivision 8~~ as provided in subdivision 4.

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

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

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

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

42.29 Subd. 4. **Disqualification.** (a) Any person found to be guilty of purchasing tobacco
42.30 products or alcoholic beverages with their EBT debit card by a federal or state court or
42.31 by an administrative hearing determination, or waiver thereof, through a disqualification
42.32 consent agreement, or as part of any approved diversion plan under section 401.065, or
42.33 any court-ordered stay which carries with it any probationary or other conditions, in

43.1 the: (1) Minnesota family investment program and any affiliated program to include the
43.2 diversionary work program and the work participation cash benefit program under chapter
43.3 256J; (2) general assistance program under chapter 256D; or (3) Minnesota supplemental
43.4 aid program under chapter 256D, shall be disqualified from all of the listed programs.

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

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

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

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

43.16 Subd. 1b. **Earned income savings account.** In addition to the \$50 disregard
43.17 required under subdivision 1, the county agency shall disregard an additional earned
43.18 income up to a maximum of ~~\$150~~ \$500 per month for: (1) persons residing in facilities
43.19 licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to
43.20 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons
43.21 living in supervised apartments with services funded under Minnesota Rules, parts
43.22 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan;
43.23 and (3) persons residing in group residential housing, as that term is defined in section
43.24 256I.03, subdivision 3, for whom the county agency has approved a discharge plan
43.25 which includes work. The additional amount disregarded must be placed in a separate
43.26 savings account by the eligible individual, to be used upon discharge from the residential
43.27 facility into the community. For individuals residing in a chemical dependency program
43.28 licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from
43.29 the savings account require the signature of the individual and for those individuals with
43.30 an authorized representative payee, the signature of the payee. A maximum of ~~\$1,000~~
43.31 \$2,000, including interest, of the money in the savings account must be excluded from
43.32 the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in
43.33 that account in excess of ~~\$1,000~~ \$2,000 must be applied to the resident's cost of care. If
43.34 excluded money is removed from the savings account by the eligible individual at any
43.35 time before the individual is discharged from the facility into the community, the money is

44.1 income to the individual in the month of receipt and a resource in subsequent months. If
44.2 an eligible individual moves from a community facility to an inpatient hospital setting,
44.3 the separate savings account is an excluded asset for up to 18 months. During that time,
44.4 amounts that accumulate in excess of the ~~\$1,000~~ \$2,000 savings limit must be applied to
44.5 the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the
44.6 18-month period, the entire account must be applied to the patient's cost of care.

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

44.8 Sec. 11. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 5, is
44.9 amended to read:

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

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

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

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

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

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

44.31 (1) from state grant and TANF funds, a matching contribution of \$1.50 for every
44.32 \$1 of funds withdrawn from the family asset account equal to the lesser of \$720 per
44.33 year or a \$3,000 lifetime limit; and

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

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

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

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

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

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

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

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

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

45.23 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section
45.24 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37
45.25 for other services necessary to provide room and board provided by the group residence
45.26 if the residence is licensed by or registered by the Department of Health, or licensed by
45.27 the Department of Human Services to provide services in addition to room and board,
45.28 and if the provider of services is not also concurrently receiving funding for services for
45.29 a recipient under a home and community-based waiver under title XIX of the Social
45.30 Security Act; or funding from the medical assistance program under section 256B.0659,
45.31 for personal care services for residents in the setting; or residing in a setting which
45.32 receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is
45.33 available for other necessary services through a home and community-based waiver, or
45.34 personal care services under section 256B.0659, then the GRH rate is limited to the rate

46.1 set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary
46.2 service rate exceed \$426.37. The registration and licensure requirement does not apply to
46.3 establishments which are exempt from state licensure because they are located on Indian
46.4 reservations and for which the tribe has prescribed health and safety requirements. Service
46.5 payments under this section may be prohibited under rules to prevent the supplanting of
46.6 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining
46.7 the approval of the Secretary of Health and Human Services to provide home and
46.8 community-based waiver services under title XIX of the Social Security Act for residents
46.9 who are not eligible for an existing home and community-based waiver due to a primary
46.10 diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is
46.11 determined to be cost-effective.

46.12 (b) The commissioner is authorized to make cost-neutral transfers from the GRH
46.13 fund for beds under this section to other funding programs administered by the department
46.14 after consultation with the county or counties in which the affected beds are located.
46.15 The commissioner may also make cost-neutral transfers from the GRH fund to county
46.16 human service agencies for beds permanently removed from the GRH census under a plan
46.17 submitted by the county agency and approved by the commissioner. The commissioner
46.18 shall report the amount of any transfers under this provision annually to the legislature.

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

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

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

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

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

46.33 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a
46.34 26-bed facility; and

47.1 (3) serves a chemically dependent clientele, providing 24 hours per day supervision
47.2 and limiting a resident's maximum length of stay to 13 months out of a consecutive
47.3 24-month period.

47.4 (b) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county
47.5 agency shall negotiate a supplementary rate in addition to the rate specified in subdivision
47.6 1, not to exceed \$700 per month, including any legislatively authorized inflationary
47.7 adjustments, for the group residential provider described under paragraph (a), not to
47.8 exceed an additional 175 beds.

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

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

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

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

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

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

47.31 (ii) for failing a drug test two times, the participant is permanently disqualified from
47.32 receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP
47.33 grant must be reduced by the amount which would have otherwise been made available to
47.34 the disqualified participant. Disqualification under this item does not make a participant
47.35 ineligible for food stamps or food support. Before a disqualification under this provision is

48.1 imposed, the job counselor must attempt to meet with the participant face-to-face. During
48.2 the face-to-face meeting, the job counselor must identify other resources that may be
48.3 available to the participant to meet the needs of the family and inform the participant of
48.4 the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is
48.5 not possible, the county agency must send the participant a notice of adverse action as
48.6 provided in section 256J.31, subdivisions 4 and 5, and must include the information
48.7 required in the face-to-face meeting.

48.8 (3) A participant who fails a drug test the first time and is under a sanction due to
48.9 other MFIP program requirements is considered to have more than one occurrence of
48.10 noncompliance and is subject to the applicable level of sanction as specified under section
48.11 256J.46, subdivision 1, paragraph (d).

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

48.18 (1) for failing a drug test the first time, food stamps or food support shall be reduced
48.19 by an amount equal to 30 percent of the applicable food stamp or food support allotment.
48.20 When a sanction under this clause is in effect, a job counselor must attempt to meet with
48.21 the person face-to-face. During the face-to-face meeting, a job counselor must explain
48.22 the consequences of a subsequent drug test failure and inform the participant of the right
48.23 to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible,
48.24 a county agency must send the participant a notice of adverse action as provided in
48.25 section 256J.31, subdivisions 4 and 5, and must include the information required in the
48.26 face-to-face meeting; and

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

49.1 ~~(e)~~ (b) For the purposes of this subdivision, "drug offense" means an offense that
 49.2 occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application
 49.3 or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, ~~or~~ 152.096, or
 49.4 152.137. Drug offense also means a conviction in another jurisdiction of the possession,
 49.5 use, or distribution of a controlled substance, or conspiracy to commit any of these
 49.6 offenses, if the offense occurred ~~after July 1, 1997,~~ during the previous ten years from
 49.7 the date of application or recertification and the conviction is a felony offense in that
 49.8 jurisdiction, or in the case of New Jersey, a high misdemeanor.

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

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

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

49.22 Sec. 18. Laws 2010, chapter 374, section 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50.34 For purposes of this section, "asset poverty" means an individual's or family's
 50.35 inability to meet fixed financial obligations and other financial requirements of daily living

51.1 with existing assets for a three-month period in the event of a disruption in income or
51.2 extraordinary economic emergency.

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

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

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

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

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

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

51.26 Subd. 4. **Deadline for appointments and designations.** The appointments and
51.27 designations authorized under this section must be completed no later than August 15,
51.28 ~~2010~~ 2012.

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

51.30 Sec. 19. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
51.31 1, is amended to read:

51.32 Subdivision 1. **Total Appropriation** \$ **6,259,280,000** \$ **6,212,085,000**

51.33 Appropriations by Fund
51.34 2012 2013

52.1	General	5,657,737,000	5,584,471,000
52.2	State Government		
52.3	Special Revenue	3,565,000	3,565,000
52.4	Health Care Access	330,435,000	353,283,000
52.5	Federal TANF	265,378,000	268,101,000
52.6	Lottery Prize	1,665,000	1,665,000
52.7	Special Revenue	500,000	1,000,000

52.8 **Receipts for Systems Projects.**

52.9 Appropriations and federal receipts for
 52.10 information systems projects for MAXIS,
 52.11 PRISM, MMIS, and SSIS must be deposited
 52.12 in the state systems account authorized in
 52.13 Minnesota Statutes, section 256.014. Money
 52.14 appropriated for computer projects approved
 52.15 by the Minnesota Office of Enterprise
 52.16 Technology, funded by the legislature,
 52.17 and approved by the commissioner
 52.18 of management and budget, may be
 52.19 transferred from one project to another
 52.20 and from development to operations as the
 52.21 commissioner of human services considers
 52.22 necessary. Any unexpended balance in
 52.23 the appropriation for these projects does
 52.24 not cancel but is available for ongoing
 52.25 development and operations.

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

52.31 **TANF Maintenance of Effort.**

52.32 (a) In order to meet the basic maintenance
 52.33 of effort (MOE) requirements of the TANF
 52.34 block grant specified under Code of Federal
 52.35 Regulations, title 45, section 263.1, the
 52.36 commissioner may only report nonfederal

53.1 money expended for allowable activities
53.2 listed in the following clauses as TANF/MOE
53.3 expenditures:

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

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

53.12 (3) state and county MFIP administrative
53.13 costs under Minnesota Statutes, chapters
53.14 256J and 256K;

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

53.18 (5) expenditures made on behalf of legal
53.19 noncitizen MFIP recipients who qualify for
53.20 the MinnesotaCare program under Minnesota
53.21 Statutes, chapter 256L;

53.22 (6) qualifying working family credit
53.23 expenditures under Minnesota Statutes,
53.24 section 290.0671; and

53.25 (7) qualifying Minnesota education credit
53.26 expenditures under Minnesota Statutes,
53.27 section 290.0674.

53.28 (b) The commissioner shall ensure that
53.29 sufficient qualified nonfederal expenditures
53.30 are made each year to meet the state's
53.31 TANF/MOE requirements. For the activities
53.32 listed in paragraph (a), clauses (2) to
53.33 (7), the commissioner may only report
53.34 expenditures that are excluded from the

54.1 definition of assistance under Code of
54.2 Federal Regulations, title 45, section 260.31.

54.3 (c) For fiscal years beginning with state fiscal
54.4 year 2003, the commissioner shall assure
54.5 that the maintenance of effort used by the
54.6 commissioner of management and budget
54.7 for the February and November forecasts
54.8 required under Minnesota Statutes, section
54.9 16A.103, contains expenditures under
54.10 paragraph (a), clause (1), equal to at least 16
54.11 percent of the total required under Code of
54.12 Federal Regulations, title 45, section 263.1.

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

54.19 (e) For the federal fiscal years beginning on
54.20 or after October 1, 2007, the commissioner
54.21 may not claim an amount of TANF/MOE in
54.22 excess of the 75 percent standard in Code
54.23 of Federal Regulations, title 45, section
54.24 263.1(a)(2), except:

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

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

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

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

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

55.17 **Working Family Credit Expenditures**
55.18 **as TANF/MOE.** The commissioner may
55.19 claim as TANF maintenance of effort up to
55.20 \$6,707,000 per year of working family credit
55.21 expenditures for fiscal years 2012 and 2013.

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

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

55.28 (2) fiscal year 2013, \$44,969,000;

55.29 (3) fiscal year 2014, \$32,579,000; and

55.30 (4) fiscal year 2015, \$32,476,000.

55.31 Notwithstanding any contrary provision in
55.32 this article, this rider expires June 30, 2015.

55.33 **TANF Transfer to Federal Child Care**
55.34 **and Development Fund.** (a) The following

56.1 TANF fund amounts are appropriated
56.2 to the commissioner for purposes of
56.3 MFIP/Transition Year Child Care Assistance
56.4 under Minnesota Statutes, section 119B.05:

56.5 (1) fiscal year 2012, \$10,020,000;

56.6 (2) fiscal year 2013, ~~\$28,020,000~~

56.7 \$28,599,000;

56.8 (3) fiscal year 2014, ~~\$14,020,000~~

56.9 \$15,488,000; and

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

56.11 \$15,479,000.

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

56.19 **Food Stamps Employment and Training**
56.20 **Funds.** (a) Notwithstanding Minnesota
56.21 Statutes, sections 256D.051, subdivisions 1a,
56.22 6b, and 6c, and 256J.626, federal food stamps
56.23 employment and training funds received
56.24 as reimbursement for child care assistance
56.25 program expenditures must be deposited in
56.26 the general fund. The amount of funds must
56.27 be limited to \$500,000 per year in fiscal
56.28 years 2012 through 2015, contingent upon
56.29 approval by the federal Food and Nutrition
56.30 Service.

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

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

57.4 **ARRA Food Support Benefit Increases.**

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

57.11 **Supplemental Security Interim Assistance**

57.12 **Reimbursement Funds.** \$2,800,000 of
57.13 uncommitted revenue available to the
57.14 commissioner of human services for SSI
57.15 advocacy and outreach services must be
57.16 transferred to and deposited into the general
57.17 fund by October 1, 2011.

57.18 Sec. 20. **GRANT PROGRAM TO PROMOTE HEALTHY COMMUNITY**
57.19 **INITIATIVES.**

57.20 (a) The commissioner of human services must contract with the Search Institute to
57.21 help local communities develop, expand, and maintain the tools, training, and resources
57.22 needed to foster positive community development and effectively engage people in their
57.23 community. The Search Institute must: (1) provide training in community mobilization,
57.24 youth development, and assets getting to outcomes; (2) provide ongoing technical
57.25 assistance to communities receiving grants under this section; (3) use best practices to
57.26 promote community development; (4) share best program practices with other interested
57.27 communities; (5) create electronic and other opportunities for communities to share
57.28 experiences in and resources for promoting healthy community development; and (6)
57.29 provide an annual report of the strong communities project.

57.30 (b) Specifically, the Search Institute must use a competitive grant process to select
57.31 four interested communities throughout Minnesota to undertake strong community
57.32 mobilization initiatives to support communities wishing to catalyze multiple sectors to
57.33 create or strengthen a community collaboration to address issues of poverty in their
57.34 communities. The Search Institute must provide the selected communities with the
57.35 tools, training, and resources they need for successfully implementing initiatives focused

58.1 on strengthening the community. The Search Institute also must use a competitive
58.2 grant process to provide four strong community innovation grants to encourage current
58.3 community initiatives to bring new innovative approaches to their work to reduce poverty.
58.4 Finally, the Search Institute must work to strengthen networking and information sharing
58.5 activities among all healthy community initiatives throughout Minnesota, including
58.6 sharing best program practices and providing personal and electronic opportunities for
58.7 peer learning and ongoing program support.

58.8 (c) In order to receive a grant under paragraph (b), a community must show
58.9 involvement of at least three sectors of their community and the active leadership of both
58.10 youth and adults. Sectors may include, but are not limited to, local government, schools,
58.11 community action agencies, faith communities, businesses, higher education institutions,
58.12 and the medical community. In addition, communities must agree to: (1) attend training
58.13 on community mobilization processes and strength-based approaches; (2) apply the assets
58.14 getting to outcomes process in their initiative; (3) meet at least two times during the
58.15 grant period to share successes and challenges with other grantees; (4) participate on an
58.16 electronic listserv to share information throughout the period on their work; and (5) all
58.17 communication requirements and reporting processes.

58.18 (d) The commissioner of human services must evaluate the effectiveness of this
58.19 program and must recommend to the committees of the legislature with jurisdiction over
58.20 health and human services reform and finance by February 15, 2013, whether or not
58.21 to make the program available statewide. The Search Institute annually must report to
58.22 the commissioner of human services on the services it provided and the grant money
58.23 it expended under this section.

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

58.25 Sec. 21. **CIRCLES OF SUPPORT GRANTS.**

58.26 The commissioner of human services must provide grants to community action
58.27 agencies to help local communities develop, expand, and maintain the tools, training, and
58.28 resources needed to foster social assets to assist people out of poverty through circles of
58.29 support. The circles of support model must provide a framework for a community to build
58.30 relationships across class and race lines so that people can work together to advocate for
58.31 change in their communities and move individuals toward self-sufficiency.

58.32 Specifically, circles of support initiatives must focus on increasing social capital,
58.33 income, educational attainment, and individual accountability, while reducing debt,
58.34 service dependency, and addressing systemic disparities that hold poverty in place. The

59.1 effort must support the development of local guiding coalitions as the link between the
59.2 community and circles of support for resource development and funding leverage.

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

59.4 Sec. 22. **MINNESOTA VISIBLE CHILD WORK GROUP.**

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

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

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

59.34 Subd. 4. **Work group convening and facilitation.** The work group must be
59.35 organized, scheduled, and facilitated by the staff of a nonprofit child advocacy, outreach,

60.1 research, and youth development organization focusing on a wide range of issues
60.2 affecting children who are vulnerable, and a nonprofit organization working to provide
60.3 safe, affordable, and sustainable homes for children and families in the seven-county
60.4 metropolitan area through partnerships with the public and private sector. These two
60.5 organizations will also be responsible for preparing and submitting the work group's
60.6 recommendations.

60.7 Subd. 5. **Report.** The work group shall make recommendations under subdivision
60.8 3 to the legislative committees with jurisdiction over education, housing, health, and
60.9 human services policy and finance by December 15, 2012. The recommendations must
60.10 also be submitted to the children's cabinet to provide the foundation for a statewide
60.11 visible child plan.

60.12 Subd. 6. **Expiration.** The Minnesota visible child work group expires on June
60.13 30, 2013.

60.14 Sec. 23. **UNIFORM ASSET LIMIT REQUIREMENTS.**

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

60.26 Sec. 24. **DIRECTION TO THE COMMISSIONER.**

60.27 The commissioner of human services, in consultation with the commissioner of
60.28 public safety, shall report to the legislative committees with jurisdiction over health and
60.29 human services policy and finance regarding the implementations of Minnesota Statutes,
60.30 section 256.01, subdivisions 18c, 18d, and 18e, and the number of persons affected and
60.31 fiscal impact by program by April 1, 2013.

60.32 Sec. 25. **REVISOR INSTRUCTION.**

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

61.5 **ARTICLE 4**

61.6 **CONTINUING CARE**

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

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

61.9 (1) federally qualified health centers;

61.10 (2) community clinics, as defined under section 145.9268;

61.11 (3) nonprofit or local unit of government hospitals licensed under sections 144.50
 61.12 to 144.56;

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

61.15 (5) nursing facilities licensed under sections 144A.01 to 144A.27;

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

61.17 (7) other providers of health or health care services approved by the commissioner
 61.18 for which interoperable electronic health record capability would improve quality of
 61.19 care, patient safety, or community health.

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

61.22 (1) critical access hospitals;

61.23 (2) federally qualified health centers;

61.24 (3) entities that serve uninsured, underinsured, and medically underserved
 61.25 individuals, regardless of whether such area is urban or rural; ~~and~~

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

61.27 (5) nursing facilities certified to participate in the medical assistance program; and

61.28 (6) providers enrolled in the elderly waiver program of customized living or 24-hour
 61.29 customized living of the medical assistance program, if at least half of their annual
 61.30 operating revenue is paid under the medical assistance program.

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

61.34 (1) the amount of the loan requested and a description of the purpose or project
 61.35 for which the loan proceeds will be used;

- 62.1 (2) a quote from a vendor;
- 62.2 (3) a description of the health care entities and other groups participating in the
- 62.3 project;
- 62.4 (4) evidence of financial stability and a demonstrated ability to repay the loan; and
- 62.5 (5) a description of how the system to be financed interoperates or plans in the
- 62.6 future to interoperate with other health care entities and provider groups located in the
- 62.7 same geographical area;
- 62.8 (6) a plan on how the certified electronic health record technology will be maintained
- 62.9 and supported over time; and
- 62.10 (7) any other requirements for applications included or developed pursuant to
- 62.11 section 3014 of the HITECH Act.

62.12 Sec. 2. Minnesota Statutes 2010, section 144A.351, is amended to read:

62.13 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**

62.14 **REPORT REQUIRED.**

62.15 The commissioners of health and human services, in consultation with the

62.16 cooperation of counties and stakeholders, including persons who need or are using

62.17 long-term care services and supports, lead agencies, regional entities, senior, disability,

62.18 and mental health organization representatives, service providers, community members,

62.19 including local businesses, and faith-based representatives shall prepare a report to the

62.20 legislature by August 15, ~~2004~~ 2013, and biennially thereafter, regarding the status of the

62.21 full range of long-term care services and supports for the elderly and children and adults

62.22 with disabilities in Minnesota. The report shall address:

62.23 (1) demographics and need for long-term care services and supports in Minnesota;

62.24 (2) summary of county and regional reports on long-term care gaps, surpluses,

62.25 imbalances, and corrective action plans;

62.26 (3) status of long-term care services and mental illnesses by county and region

62.27 including:

62.28 (i) changes in availability of the range of long-term care services and housing

62.29 options;

62.30 (ii) access problems regarding long-term care services; and

62.31 (iii) comparative measures of long-term care services availability and ~~progress~~

62.32 changes over time; and

62.33 (4) recommendations regarding goals for the future of long-term care services and

62.34 supports, policy and fiscal changes, and resource needs.

63.1 Sec. 3. Minnesota Statutes 2010, section 144D.04, subdivision 2, is amended to read:

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

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

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

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

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

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

63.16 (6) the term of the contract;

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

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

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

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

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

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

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

63.33 (14) billing and payment procedures and requirements;

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

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

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

64.6 Sec. 4. Minnesota Statutes 2010, section 245A.03, is amended by adding a subdivision
64.7 to read:

64.8 **Subd. 6a. Adult foster care homes serving people with mental illness;**
64.9 **certification.** (a) The commissioner of human services shall issue a mental health
64.10 certification for adult foster care homes licensed under this chapter and Minnesota Rules,
64.11 parts 9555.5105 to 9555.6265, that serve people with mental illness where the home is not
64.12 the primary residence of the license holder when a provider is determined to have met
64.13 the requirements under paragraph (b). This certification is voluntary for license holders.
64.14 The certification shall be printed on the license, and identified on the commissioner's
64.15 public Web site.

64.16 (b) The requirements for certification are:

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

64.19 (i) mental health diagnoses;

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

64.21 (iii) recovery from mental illness;

64.22 (iv) treatment options including evidence-based practices;

64.23 (v) medications and their side effects;

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

64.25 (vii) community resources; and

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

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

64.30 (4) each individual's individual placement agreement identifies who is providing
64.31 clinical services and their contact information, and includes an individual crisis prevention
64.32 and management plan developed with the individual.

64.33 (c) License holders seeking certification under this subdivision must request this
64.34 certification on forms provided by the commissioner and must submit the request to the
64.35 county licensing agency in which the home is located. The county licensing agency must

65.1 forward the request to the commissioner with a county recommendation regarding whether
65.2 the commissioner should issue the certification.

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

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

65.12 Sec. 5. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is
65.13 amended to read:

65.14 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
65.15 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
65.16 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
65.17 9555.6265, under this chapter for a physical location that will not be the primary residence
65.18 of the license holder for the entire period of licensure. If a license is issued during this
65.19 moratorium, and the license holder changes the license holder's primary residence away
65.20 from the physical location of the foster care license, the commissioner shall revoke the
65.21 license according to section 245A.07. Exceptions to the moratorium include:

65.22 (1) foster care settings that are required to be registered under chapter 144D;

65.23 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
65.24 and determined to be needed by the commissioner under paragraph (b);

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

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

65.30 (5) new foster care licenses determined to be needed by the commissioner for the
65.31 transition of people from personal care assistance to the home and community-based
65.32 services.

65.33 (b) The commissioner shall determine the need for newly licensed foster care homes
65.34 as defined under this subdivision using the resource need determination process described
65.35 in paragraph (f). As part of the determination, the commissioner shall consider the

66.1 availability of foster care capacity in the area in which the licensee seeks to operate, ~~and~~
66.2 ~~the recommendation of the local county board. The determination by the commissioner~~
66.3 ~~must be final. A determination of need is not required for a change in ownership at~~
66.4 ~~the same address~~ and other data and information, including the report on the status of
66.5 long-term care services required under section 144A.351.

66.6 (c) Residential settings that would otherwise be subject to the moratorium established
66.7 in paragraph (a), that are in the process of receiving an adult or child foster care license as
66.8 of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult
66.9 or child foster care license. For this paragraph, all of the following conditions must be met
66.10 to be considered in the process of receiving an adult or child foster care license:

66.11 (1) participants have made decisions to move into the residential setting, including
66.12 documentation in each participant's care plan;

66.13 (2) the provider has purchased housing or has made a financial investment in the
66.14 property;

66.15 (3) the lead agency has approved the plans, including costs for the residential setting
66.16 for each individual;

66.17 (4) the completion of the licensing process, including all necessary inspections, is
66.18 the only remaining component prior to being able to provide services; and

66.19 (5) the needs of the individuals cannot be met within the existing capacity in that
66.20 county.

66.21 To qualify for the process under this paragraph, the lead agency must submit
66.22 documentation to the commissioner by August 1, 2009, that all of the above criteria are
66.23 met.

66.24 (d) The commissioner shall study the effects of the license moratorium under this
66.25 subdivision and shall report back to the legislature by January 15, 2011. This study shall
66.26 include, but is not limited to the following:

66.27 (1) the overall capacity and utilization of foster care beds where the physical location
66.28 is not the primary residence of the license holder prior to and after implementation
66.29 of the moratorium;

66.30 (2) the overall capacity and utilization of foster care beds where the physical
66.31 location is the primary residence of the license holder prior to and after implementation
66.32 of the moratorium; and

66.33 (3) the number of licensed and occupied ICF/MR beds prior to and after
66.34 implementation of the moratorium.

66.35 (e) When a foster care recipient moves out of a foster home that is not the
66.36 primary residence of the license holder according to section 256B.092, subdivision 1e,

67.1 paragraph (d), or 256B.49, subdivision 15, paragraph (f), the county shall immediately
 67.2 inform the Department of Human Services Licensing Division, and. The department
 67.3 shall immediately decrease the licensed capacity for the home. If the voluntary changes
 67.4 described in paragraph (f) are not sufficient to meet the savings required by 2011
 67.5 reductions in licensed bed capacity and maintain statewide long-term care residential
 67.6 services capacity within budgetary limits, the commissioner shall delicense ... beds
 67.7 by June 30, 2013, using the needs determination process. Under this paragraph, the
 67.8 commissioner has the authority to reduce unused licensed capacity of a current foster care
 67.9 program to accomplish the consolidation or closure of settings. A decreased licensed
 67.10 capacity according to this paragraph is not subject to appeal under this chapter.

67.11 (f) A resource need determination process, managed at the state level, using the
 67.12 available reports required by section 144A.351, and other data and information shall be
 67.13 used to determine where the reduced capacity required under Laws 2011, First Special
 67.14 Session chapter 9, article 7, sections 1 and 40 will occur. The commissioner shall consult
 67.15 with the stakeholders described in section 144A.351, and employ a variety of methods to
 67.16 improve the state's capacity to meet long-term care service needs within budgetary limits,
 67.17 including seeking proposals from service providers or lead agencies to change service type,
 67.18 capacity, or location to improve services, increase the independence of residents, allow for
 67.19 payment to hold a person's bed open from permanent reassignment up to 60 days while
 67.20 the person tries living in a more independent setting, and better meet needs identified by
 67.21 the long-term care services reports and statewide data and information. By February 1 of
 67.22 each year, the commissioner shall provide information and data on the overall capacity of
 67.23 licensed long-term care services, actions taken under this subdivision to manage statewide
 67.24 long-term care services and supports resources, and any recommendations for change to
 67.25 the legislative committees with jurisdiction over the health and human services budget.

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

67.27 Sec. 6. Minnesota Statutes 2010, section 245A.11, subdivision 7, is amended to read:

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

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

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

68.7 (3) the alternative method of providing overnight supervision, which may include
68.8 the use of technology, is specified for each resident in the resident's: (i) individualized
68.9 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
68.10 required; or (iii) individual resident placement agreement under Minnesota Rules, part
68.11 9555.5105, subpart 19, if required.

68.12 (b) To be eligible for a variance under paragraph (a), the adult foster care license
68.13 holder must not have had a ~~licensing action~~ conditional license issued under section
68.14 245A.06 or any other licensing sanction issued under section 245A.07 during the prior 24
68.15 months based on failure to provide adequate supervision, health care services, or resident
68.16 safety in the adult foster care home.

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

68.22 Sec. 7. Minnesota Statutes 2010, section 245B.07, subdivision 1, is amended to read:

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

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

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

68.30 (3) the consumer's individual service plan. When a consumer's case manager does
68.31 not provide a current individual service plan, the license holder shall make a written
68.32 request to the case manager to provide a copy of the individual service plan and inform
68.33 the consumer or the consumer's legal representative of the right to an individual service
68.34 plan and the right to appeal under section 256.045. In the event the case manager fails
68.35 to provide an individual service plan after a written request from the license holder, the

69.1 license holder shall not be sanctioned or penalized financially for not having a current
 69.2 individual service plan in the consumer's data file;

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

69.4 (5) progress review reports;

69.5 (6) incidents involving the consumer;

69.6 (7) reports required under section 245B.05, subdivision 7;

69.7 (8) discharge summary, when applicable;

69.8 (9) record of other license holders serving the consumer that includes a contact
 69.9 person and telephone numbers, services being provided, services that require coordination
 69.10 between two license holders, and name of staff responsible for coordination;

69.11 (10) information about verbal aggression directed at the consumer by another
 69.12 consumer; and

69.13 (11) information about self-abuse.

69.14 Sec. 8. Minnesota Statutes 2010, section 245C.04, subdivision 6, is amended to read:

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

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

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

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

69.33 (2) the individual who is the subject of the background study provides direct
 69.34 contact services under the provider's licensed program for at least 40 hours per year so
 69.35 the individual will be recognized by a probation officer or corrections agent to prompt

70.1 a report to the commissioner regarding criminal convictions as required under section
70.2 245C.05, subdivision 7.

70.3 Sec. 9. Minnesota Statutes 2010, section 245C.05, subdivision 7, is amended to read:

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

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

70.11 (2) has been convicted of a crime constituting a disqualification under section
70.12 245C.14.

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

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

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

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

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

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

70.30 Sec. 10. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

70.31 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
70.32 child, including a child determined eligible for medical assistance without consideration of
70.33 parental income, must contribute to the cost of services used by making monthly payments
70.34 on a sliding scale based on income, unless the child is married or has been married,

71.1 parental rights have been terminated, or the child's adoption is subsidized according to
71.2 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
71.3 is a partial or full payment for medical services provided for diagnostic, therapeutic,
71.4 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
71.5 defined in United States Code, title 26, section 213, needed by the child with a chronic
71.6 illness or disability.

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

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

71.13 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
71.14 poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines,
71.15 the parental contribution shall be determined using a sliding fee scale established by the
71.16 commissioner of human services which begins at one percent of adjusted gross income at
71.17 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted
71.18 gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal
71.19 poverty guidelines;

71.20 (3) if the adjusted gross income is greater than ~~545~~ 525 percent of federal
71.21 poverty guidelines and less than 675 percent of federal poverty guidelines, the parental
71.22 contribution shall be ~~7.5~~ 9.5 percent of adjusted gross income;

71.23 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
71.24 poverty guidelines and less than ~~975~~ 900 percent of federal poverty guidelines, the parental
71.25 contribution shall be determined using a sliding fee scale established by the commissioner
71.26 of human services which begins at ~~7.5~~ 9.5 percent of adjusted gross income at 675 percent
71.27 of federal poverty guidelines and increases to ~~ten~~ 12 percent of adjusted gross income for
71.28 those with adjusted gross income up to ~~975~~ 900 percent of federal poverty guidelines; and

71.29 (5) if the adjusted gross income is equal to or greater than ~~975~~ 900 percent of
71.30 federal poverty guidelines, the parental contribution shall be ~~12.5~~ 13.5 percent of adjusted
71.31 gross income.

71.32 If the child lives with the parent, the annual adjusted gross income is reduced by
71.33 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
71.34 specified in section 256B.35, the parent is responsible for the personal needs allowance
71.35 specified under that section in addition to the parental contribution determined under this

72.1 section. The parental contribution is reduced by any amount required to be paid directly to
72.2 the child pursuant to a court order, but only if actually paid.

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

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

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

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

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

72.34 (h) The contribution under paragraph (b) shall be increased by an additional five
72.35 percent if the local agency determines that insurance coverage is available but not
72.36 obtained for the child. For purposes of this section, "available" means the insurance is a

73.1 benefit of employment for a family member at an annual cost of no more than five percent
73.2 of the family's annual income. For purposes of this section, "insurance" means health
73.3 and accident insurance coverage, enrollment in a nonprofit health service plan, health
73.4 maintenance organization, self-insured plan, or preferred provider organization.

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

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

73.13 (1) the parent applied for insurance for the child;

73.14 (2) the insurer denied insurance;

73.15 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
73.16 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
73.17 commerce, or litigated the complaint or appeal; and

73.18 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

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

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

73.26 ~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~
73.27 ~~2013, the parental contribution shall be computed by applying the following contribution~~
73.28 ~~schedule to the adjusted gross income of the natural or adoptive parents:~~

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

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

74.1 ~~gross income for those with adjusted gross income up to 525 percent of federal poverty~~
74.2 ~~guidelines;~~

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

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

74.12 ~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal~~
74.13 ~~poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross~~
74.14 ~~income. If the child lives with the parent, the annual adjusted gross income is reduced by~~
74.15 ~~\$2,400 prior to calculating the parental contribution. If the child resides in an institution~~
74.16 ~~specified in section 256B.35, the parent is responsible for the personal needs allowance~~
74.17 ~~specified under that section in addition to the parental contribution determined under this~~
74.18 ~~section. The parental contribution is reduced by any amount required to be paid directly to~~
74.19 ~~the child pursuant to a court order, but only if actually paid.~~

74.20 Sec. 11. Minnesota Statutes 2011 Supplement, section 256.045, subdivision 3, is
74.21 amended to read:

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

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

74.29 (2) any patient or relative aggrieved by an order of the commissioner under section
74.30 252.27;

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

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

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

75.4 (6) any person to whom a right of appeal according to this section is given by other
75.5 provision of law;

75.6 (7) an applicant aggrieved by an adverse decision to an application for a hardship
75.7 waiver under section 256B.15;

75.8 (8) an applicant aggrieved by an adverse decision to an application or redetermination
75.9 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

75.10 (9) except as provided under chapter 245A, an individual or facility determined
75.11 to have maltreated a minor under section 626.556, after the individual or facility has
75.12 exercised the right to administrative reconsideration under section 626.556;

75.13 (10) except as provided under chapter 245C, an individual disqualified under
75.14 sections 245C.14 and 245C.15, following a reconsideration decision issued under section
75.15 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the
75.16 evidence that the individual has committed an act or acts that meet the definition of any of
75.17 the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports
75.18 required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
75.19 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
75.20 this clause in which the basis for a disqualification is serious or recurring maltreatment,
75.21 shall be consolidated into a single fair hearing. In such cases, the scope of review by
75.22 the human services referee shall include both the maltreatment determination and the
75.23 disqualification. The failure to exercise the right to an administrative reconsideration shall
75.24 not be a bar to a hearing under this section if federal law provides an individual the right to
75.25 a hearing to dispute a finding of maltreatment. Individuals and organizations specified in
75.26 this section may contest the specified action, decision, or final disposition before the state
75.27 agency by submitting a written request for a hearing to the state agency within 30 days
75.28 after receiving written notice of the action, decision, or final disposition, or within 90 days
75.29 of such written notice if the applicant, recipient, patient, or relative shows good cause why
75.30 the request was not submitted within the 30-day time limit; or

75.31 (11) any person with an outstanding debt resulting from receipt of public assistance,
75.32 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
75.33 Department of Human Services or a county agency. The scope of the appeal is the validity
75.34 of the claimant agency's intention to request a setoff of a refund under chapter 270A
75.35 against the debt.

76.1 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
76.2 (10), is the only administrative appeal to the final agency determination specifically,
76.3 including a challenge to the accuracy and completeness of data under section 13.04.
76.4 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment
76.5 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
76.6 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
76.7 contested case proceeding under the provisions of chapter 14. Hearings requested under
76.8 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
76.9 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
76.10 only available when there is no juvenile court or adult criminal action pending. If such
76.11 action is filed in either court while an administrative review is pending, the administrative
76.12 review must be suspended until the judicial actions are completed. If the juvenile court
76.13 action or criminal charge is dismissed or the criminal action overturned, the matter may be
76.14 considered in an administrative hearing.

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

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

76.23 (e) The scope of hearings involving appeals related to the reduction, suspension,
76.24 denial, or termination of personal care assistance services under section 256B.0659, or
76.25 home and community-based services waivers under sections 256B.092 and 256B.49, shall
76.26 be limited to the specific issues under written appeal.

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

76.31 ~~(f)~~ (g) An applicant or recipient is not entitled to receive social services beyond the
76.32 services prescribed under chapter 256M or other social services the person is eligible
76.33 for under state law.

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

77.1 **EFFECTIVE DATE.** This section is effective for all notices of action dated on or
77.2 after July 1, 2012.

77.3 Sec. 12. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to
77.4 read:

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

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

77.25 Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3,
77.26 is amended to read:

77.27 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
77.28 medical assistance, a person must not individually own more than \$3,000 in assets, or if a
77.29 member of a household with two family members, husband and wife, or parent and child,
77.30 the household must not own more than \$6,000 in assets, plus \$200 for each additional
77.31 legal dependent. In addition to these maximum amounts, an eligible individual or family
77.32 may accrue interest on these amounts, but they must be reduced to the maximum at the
77.33 time of an eligibility redetermination. The accumulation of the clothing and personal
77.34 needs allowance according to section 256B.35 must also be reduced to the maximum at

78.1 the time of the eligibility redetermination. The value of assets that are not considered in
78.2 determining eligibility for medical assistance is the value of those assets excluded under
78.3 the supplemental security income program for aged, blind, and disabled persons, with
78.4 the following exceptions:

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

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

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

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

78.14 (5) for a person who no longer qualifies as an employed person with a disability due
78.15 to loss of earnings, assets allowed while eligible for medical assistance under section
78.16 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
78.17 of ineligibility as an employed person with a disability, to the extent that the person's total
78.18 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph
78.19 (d); ~~and~~

78.20 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
78.21 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
78.22 before the person's 65th birthday, the assets owned by the person and the person's spouse
78.23 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
78.24 when determining eligibility for medical assistance under section 256B.055, subdivision
78.25 7. The income of a spouse of a person enrolled in medical assistance under section
78.26 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
78.27 65th birthday must be disregarded when determining eligibility for medical assistance
78.28 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
78.29 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
78.30 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
78.31 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

78.32 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
78.33 15.

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

79.1 Sec. 14. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9,
79.2 is amended to read:

79.3 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
79.4 for a person who is employed and who:

79.5 (1) but for excess earnings or assets, meets the definition of disabled under the
79.6 Supplemental Security Income program;

79.7 (2) ~~is at least 16 but less than 65 years of age;~~

79.8 ~~(3)~~ meets the asset limits in paragraph (d); and

79.9 ~~(4)~~ (3) pays a premium and other obligations under paragraph (e).

79.10 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
79.11 for medical assistance under this subdivision, a person must have more than \$65 of earned
79.12 income. Earned income must have Medicare, Social Security, and applicable state and
79.13 federal taxes withheld. The person must document earned income tax withholding. Any
79.14 spousal income or assets shall be disregarded for purposes of eligibility and premium
79.15 determinations.

79.16 (c) After the month of enrollment, a person enrolled in medical assistance under
79.17 this subdivision who:

79.18 (1) is temporarily unable to work and without receipt of earned income due to a
79.19 medical condition, as verified by a physician; or

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

79.25 (d) For purposes of determining eligibility under this subdivision, a person's assets
79.26 must not exceed \$20,000, excluding:

79.27 (1) all assets excluded under section 256B.056;

79.28 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
79.29 Keogh plans, and pension plans;

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

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

79.32 (e) All enrollees must pay a premium to be eligible for medical assistance under this
79.33 subdivision, except as provided under section 256.01, subdivision 18b.

79.34 (1) An enrollee must pay the greater of a \$65 premium or the premium calculated
79.35 based on the person's gross earned and unearned income and the applicable family size
79.36 using a sliding fee scale established by the commissioner, which begins at one percent of

80.1 income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of
80.2 income for those with incomes at or above 300 percent of the federal poverty guidelines.

80.3 (2) Annual adjustments in the premium schedule based upon changes in the federal
80.4 poverty guidelines shall be effective for premiums due in July of each year.

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

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

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

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

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

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

80.33 (j) The commissioner shall notify enrollees annually beginning at least 24 months
80.34 before the person's 65th birthday of the medical assistance eligibility rules affecting
80.35 income, assets, and treatment of a spouse's income and assets that will be applied upon
80.36 reaching age 65.

81.1 (k) For enrollees whose income does not exceed 200 percent of the federal poverty
81.2 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
81.3 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
81.4 paragraph (a).

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

81.6 Sec. 15. Minnesota Statutes 2010, section 256B.0659, is amended by adding a
81.7 subdivision to read:

81.8 Subd. 31. **Appeals.** (a) A recipient who is adversely affected by the reduction,
81.9 suspension, denial, or termination of services under this section may appeal the decision
81.10 according to section 256.045. The notice of the reduction, suspension, denial, or
81.11 termination of services from the lead agency to the applicant or recipient must be made
81.12 in plain language and must include a form for written appeal. The commissioner may
81.13 provide lead agencies with a model form for written appeal. The appeal must be in
81.14 writing and identify the specific issues the recipient would like to have considered in the
81.15 appeal hearing and a summary of the basis, with supporting professional documentation
81.16 if available, for contesting the decision.

81.17 (b) If a recipient has a change in condition or new information after the date of
81.18 the assessment, temporary services may be authorized according to section 256B.0652,
81.19 subdivision 9, until a new assessment is completed.

81.20 Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a,
81.21 is amended to read:

81.22 **Subd. 3a. Assessment and support planning.** (a) Persons requesting assessment,
81.23 services planning, or other assistance intended to support community-based living,
81.24 including persons who need assessment in order to determine waiver or alternative care
81.25 program eligibility, must be visited by a long-term care consultation team within 15
81.26 calendar days after the date on which an assessment was requested or recommended. After
81.27 January 1, 2011, these requirements also apply to personal care assistance services, private
81.28 duty nursing, and home health agency services, on timelines established in subdivision 5.
81.29 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

81.30 (b) The county may utilize a team of either the social worker or public health nurse,
81.31 or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the
81.32 assessment in a face-to-face interview. The consultation team members must confer
81.33 regarding the most appropriate care for each individual screened or assessed.

82.1 (c) The assessment must be comprehensive and include a person-centered
82.2 assessment of the health, psychological, functional, environmental, and social needs of
82.3 referred individuals and provide information necessary to develop a support plan that
82.4 meets the consumers needs, using an assessment form provided by the commissioner.

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

82.19 (e) The person, or the person's legal representative, must be provided with written
82.20 recommendations for community-based services, including consumer-directed options,
82.21 or institutional care that include documentation that the most cost-effective alternatives
82.22 available were offered to the individual, and alternatives to residential settings, including,
82.23 but not limited to, foster care settings that are not the primary residence of the license
82.24 holder. For purposes of this requirement, "cost-effective alternatives" means community
82.25 services and living arrangements that cost the same as or less than institutional care.

82.26 (f) If the person chooses to use community-based services, the person or the person's
82.27 legal representative must be provided with a written community support plan, regardless
82.28 of whether the individual is eligible for Minnesota health care programs. A person may
82.29 request assistance in identifying community supports without participating in a complete
82.30 assessment. Upon a request for assistance identifying community support, the person must
82.31 be transferred or referred to the services available under sections 256.975, subdivision 7,
82.32 and 256.01, subdivision 24, for telephone assistance and follow up.

82.33 (g) The person has the right to make the final decision between institutional
82.34 placement and community placement after the recommendations have been provided,
82.35 except as provided in subdivision 4a, paragraph (c).

83.1 (h) The team must give the person receiving assessment or support planning, or
83.2 the person's legal representative, materials, and forms supplied by the commissioner
83.3 containing the following information:

83.4 (1) the need for and purpose of preadmission screening if the person selects nursing
83.5 facility placement;

83.6 (2) the role of the long-term care consultation assessment and support planning in
83.7 waiver and alternative care program eligibility determination;

83.8 (3) information about Minnesota health care programs;

83.9 (4) the person's freedom to accept or reject the recommendations of the team;

83.10 (5) the person's right to confidentiality under the Minnesota Government Data
83.11 Practices Act, chapter 13;

83.12 (6) the long-term care consultant's decision regarding the person's need for
83.13 institutional level of care as determined under criteria established in section 144.0724,
83.14 subdivision 11, or 256B.092; and

83.15 (7) the person's right to appeal the decision regarding the need for nursing facility
83.16 level of care or the county's final decisions regarding public programs eligibility according
83.17 to section 256.045, subdivision 3.

83.18 (i) Face-to-face assessment completed as part of eligibility determination for
83.19 the alternative care, elderly waiver, community alternatives for disabled individuals,
83.20 community alternative care, and traumatic brain injury waiver programs under sections
83.21 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
83.22 than 60 calendar days after the date of assessment. The effective eligibility start date
83.23 for these programs can never be prior to the date of assessment. If an assessment was
83.24 completed more than 60 days before the effective waiver or alternative care program
83.25 eligibility start date, assessment and support plan information must be updated in a
83.26 face-to-face visit and documented in the department's Medicaid Management Information
83.27 System (MMIS). The effective date of program eligibility in this case cannot be prior to
83.28 the date the updated assessment is completed.

83.29 Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3c,
83.30 is amended to read:

83.31 Subd. 3c. **Consultation for housing with services.** (a) The purpose of long-term
83.32 care consultation for registered housing with services is to support persons with current or
83.33 anticipated long-term care needs in making informed choices among options that include
83.34 the most cost-effective and least restrictive settings. Prospective residents maintain the
83.35 right to choose housing with services or assisted living if that option is their preference.

84.1 (b) Registered housing with services establishments shall inform all prospective
84.2 residents of the availability of long-term care consultation and the need to receive and
84.3 verify the consultation prior to signing a lease or contract. Long-term care consultation
84.4 for registered housing with services is provided as determined by the commissioner of
84.5 human services. The service is delivered under a partnership between lead agencies as
84.6 defined in subdivision 1a, paragraph (d), and the Area Agencies on Aging, and is a point
84.7 of entry to a combination of telephone-based long-term care options counseling provided
84.8 by Senior LinkAge Line and in-person long-term care consultation provided by lead
84.9 agencies. The point of entry service must be provided within five working days of the
84.10 request of the prospective resident as follows:

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

84.13 (2) the consultation must include a review of the prospective resident's reasons for
84.14 considering housing with services, the prospective resident's personal goals, a discussion
84.15 of the prospective resident's immediate and projected long-term care needs, and alternative
84.16 community services or housing with services settings that may meet the prospective
84.17 resident's needs;

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

84.21 (4) verification of counseling shall be generated and provided to the prospective
84.22 resident by Senior LinkAge Line upon completion of the telephone-based counseling.

84.23 (c) Housing with services establishments registered under chapter 144D shall:

84.24 (1) inform all prospective residents of the availability of and contact information for
84.25 consultation services under this subdivision;

84.26 (2) except for individuals seeking lease-only arrangements in subsidized housing
84.27 settings, receive a copy of the verification of counseling prior to executing a lease or
84.28 service contract with the prospective resident, and prior to executing a service contract
84.29 with individuals who have previously entered into lease-only arrangements; and

84.30 (3) retain a copy of the verification of counseling as part of the resident's file.

84.31 (d) Exemptions from the consultation requirement under paragraph (b) and
84.32 emergency admissions to registered housing with services establishments prior to
84.33 consultation under paragraph (b) are permitted according to policies established by the
84.34 commissioner.

84.35 (e) Prospective residents who have used financial planning services and created a
84.36 long-term care plan in the 12 months prior to signing a lease or contract with a registered

85.1 housing with services or assisted living establishment are exempt from the long-term care
85.2 consultation requirements under this subdivision. Housing with services establishments
85.3 registered under chapter 144D are exempt from the requirements of paragraph (c),
85.4 clauses (2) and (3), for prospective residents who are exempt from the requirements
85.5 of this subdivision.

85.6 Sec. 18. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3e,
85.7 is amended to read:

85.8 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
85.9 services shall be a monthly rate authorized by the lead agency within the parameters
85.10 established by the commissioner. The payment agreement must delineate the amount of
85.11 each component service included in the recipient's customized living service plan. The
85.12 lead agency, with input from the provider of customized living services, shall ensure that
85.13 there is a documented need within the parameters established by the commissioner for all
85.14 component customized living services authorized.

85.15 (b) The payment rate must be based on the amount of component services to be
85.16 provided utilizing component rates established by the commissioner. Counties and tribes
85.17 shall use tools issued by the commissioner to develop and document customized living
85.18 service plans and rates.

85.19 (c) Component service rates must not exceed payment rates for comparable elderly
85.20 waiver or medical assistance services and must reflect economies of scale. Customized
85.21 living services must not include rent or raw food costs.

85.22 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
85.23 individualized monthly authorized payment for the customized living service plan shall
85.24 not exceed 50 percent of the greater of either the statewide or any of the geographic
85.25 groups' weighted average monthly nursing facility rate of the case mix resident class
85.26 to which the elderly waiver eligible client would be assigned under Minnesota Rules,
85.27 parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described
85.28 in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the
85.29 resident assessment system as described in section 256B.438 for nursing home rate
85.30 determination is implemented. Effective on July 1 of the state fiscal year in which
85.31 the resident assessment system as described in section 256B.438 for nursing home
85.32 rate determination is implemented and July 1 of each subsequent state fiscal year, the
85.33 individualized monthly authorized payment for the services described in this clause shall
85.34 not exceed the limit which was in effect on June 30 of the previous state fiscal year

86.1 updated annually based on legislatively adopted changes to all service rate maximums for
86.2 home and community-based service providers.

86.3 (e) Effective July 1, 2011, the individualized monthly payment for the customized
86.4 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
86.5 monthly authorized payment limit for customized living for individuals classified as case
86.6 mix A, reduced by 25 percent. This rate limit must be applied to all new participants
86.7 enrolled in the program on or after July 1, 2011, who meet the criteria described in
86.8 subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who
86.9 meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

86.10 (f) Customized living services are delivered by a provider licensed by the
86.11 Department of Health as a class A or class F home care provider and provided in a
86.12 building that is registered as a housing with services establishment under chapter 144D.
86.13 Licensed home care providers are subject to section 256B.0651, subdivision 14.

86.14 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
86.15 family for additional units of any allowable component service beyond those available
86.16 under the service rate limits described in paragraph (d), nor for additional units of any
86.17 allowable component service beyond those approved in the service plan by the lead agency.

86.18 Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 3g, is amended to
86.19 read:

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

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

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

86.29 (d) Notwithstanding the requirements of paragraphs (a) through (c), or the
86.30 requirements in subdivisions 3e and 3h, and as part of waiver reform proposals
86.31 developed under authority in section 256B.021, subdivision 4, paragraphs (f) and (g),
86.32 the commissioner may develop proposals for alternative or enhanced service payment
86.33 rate systems for purposes of ensuring reasonable and adequate access to home and
86.34 community-based services for elderly waiver participants throughout the state based
86.35 on criteria established to designate areas as critical access home and community-based

87.1 service areas. These proposals, to be submitted to the legislature no later than February
87.2 15, 2013, must be based on an evaluation of statewide capacity and the determination of
87.3 critical access home and community-based services areas. Alternative or enhanced service
87.4 payment rate systems will be limited to providers delivering services to individuals
87.5 residing in communities, counties, or groups of counties designated as critical access
87.6 areas for home and community-based services. The commissioner shall consult with
87.7 stakeholders who authorize and provide elderly waiver services as well as with consumer
87.8 advocates and the ombudsman for long-term care.

87.9 (1) Alternative or enhanced payment rate systems may be developed in designated
87.10 areas for elderly waiver services providers that may include:

87.11 (i) licensed home care providers qualified to enroll in Minnesota health care
87.12 programs that are delivering services in housing with services establishments in critical
87.13 access areas of the state;

87.14 (ii) providers as described in subdivision 3h, paragraph (g). Any calculation of
87.15 an enhanced or alternative service rate under this clause or clause (i), must be limited
87.16 to services only and cannot include rent, utilities, raw food, or nonallowable service
87.17 component costs or charges; and

87.18 (iii) other nonresidential elderly waiver services.

87.19 (2) In order to develop critical access criteria and alternative or enhanced payment
87.20 systems for critical access home and community-based services areas, the commissioner
87.21 shall utilize information available from existing sources whenever possible.

87.22 (3) Providers applying for alternative or enhanced rates in critical access areas may
87.23 be required to provide additional information as recommended by the commissioner
87.24 and approved by the legislature.

87.25 Sec. 20. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3h,
87.26 is amended to read:

87.27 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
87.28 payment rate for 24-hour customized living services is a monthly rate authorized by the
87.29 lead agency within the parameters established by the commissioner of human services.
87.30 The payment agreement must delineate the amount of each component service included
87.31 in each recipient's customized living service plan. The lead agency, with input from
87.32 the provider of customized living services, shall ensure that there is a documented need
87.33 within the parameters established by the commissioner for all component customized
87.34 living services authorized. The lead agency shall not authorize 24-hour customized living
87.35 services unless there is a documented need for 24-hour supervision.

88.1 (b) For purposes of this section, "24-hour supervision" means that the recipient
88.2 requires assistance due to needs related to one or more of the following:

88.3 (1) intermittent assistance with toileting, positioning, or transferring;

88.4 (2) cognitive or behavioral issues;

88.5 (3) a medical condition that requires clinical monitoring; or

88.6 (4) for all new participants enrolled in the program on or after July 1, 2011, and
88.7 all other participants at their first reassessment after July 1, 2011, dependency in at
88.8 least three of the following activities of daily living as determined by assessment under
88.9 section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency
88.10 score in eating is three or greater; and needs medication management and at least 50
88.11 hours of service per month. The lead agency shall ensure that the frequency and mode
88.12 of supervision of the recipient and the qualifications of staff providing supervision are
88.13 described and meet the needs of the recipient.

88.14 (c) The payment rate for 24-hour customized living services must be based on the
88.15 amount of component services to be provided utilizing component rates established by the
88.16 commissioner. Counties and tribes will use tools issued by the commissioner to develop
88.17 and document customized living plans and authorize rates.

88.18 (d) Component service rates must not exceed payment rates for comparable elderly
88.19 waiver or medical assistance services and must reflect economies of scale.

88.20 (e) The individually authorized 24-hour customized living payments, in combination
88.21 with the payment for other elderly waiver services, including case management, must not
88.22 exceed the recipient's community budget cap specified in subdivision 3a. Customized
88.23 living services must not include rent or raw food costs.

88.24 (f) The individually authorized 24-hour customized living payment rates shall not
88.25 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
88.26 living services in effect and in the Medicaid management information systems on March
88.27 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
88.28 to 9549.0059, to which elderly waiver service clients are assigned. When there are
88.29 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
88.30 shall multiply the calculated service payment rate maximum for the A classification by
88.31 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
88.32 9549.0059, to determine the applicable payment rate maximum. Service payment rate
88.33 maximums shall be updated annually based on legislatively adopted changes to all service
88.34 rates for home and community-based service providers.

88.35 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
88.36 may establish alternative payment rate systems for 24-hour customized living services in

89.1 housing with services establishments which are freestanding buildings with a capacity of
89.2 16 or fewer, by applying a single hourly rate for covered component services provided
89.3 in either:

89.4 (1) licensed corporate adult foster homes; or

89.5 (2) specialized dementia care units which meet the requirements of section 144D.065

89.6 and in which:

89.7 (i) each resident is offered the option of having their own apartment; or

89.8 (ii) the units are licensed as board and lodge establishments with maximum capacity
89.9 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
89.10 subparts 1, 2, 3, and 4, item A.

89.11 (h) 24-hour customized living services are delivered by a provider licensed by
89.12 the Department of Health as a class A or class F home care provider and provided in a
89.13 building that is registered as a housing with services establishment under chapter 144D.
89.14 Licensed home care providers are subject to section 256B.0651, subdivision 14.

89.15 ~~(h)~~ (i) A provider may not bill or otherwise charge an elderly waiver participant
89.16 or their family for additional units of any allowable component service beyond those
89.17 available under the service rate limits described in paragraph (e), nor for additional
89.18 units of any allowable component service beyond those approved in the service plan
89.19 by the lead agency.

89.20 Sec. 21. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
89.21 read:

89.22 Subd. 1b. **Individual service plan.** (a) The individual service plan must:

89.23 (1) include the results of the assessment information on the person's need for service,
89.24 including identification of service needs that will be or that are met by the person's
89.25 relatives, friends, and others, as well as community services used by the general public;

89.26 (2) identify the person's preferences for services as stated by the person, the person's
89.27 legal guardian or conservator, or the parent if the person is a minor;

89.28 (3) identify long- and short-range goals for the person;

89.29 (4) identify specific services and the amount and frequency of the services to be
89.30 provided to the person based on assessed needs, preferences, and available resources.

89.31 The individual service plan shall also specify other services the person needs that are
89.32 not available;

89.33 (5) identify the need for an individual program plan to be developed by the provider
89.34 according to the respective state and federal licensing and certification standards, and
89.35 additional assessments to be completed or arranged by the provider after service initiation;

90.1 (6) identify provider responsibilities to implement and make recommendations for
90.2 modification to the individual service plan;

90.3 (7) include notice of the right to request a conciliation conference or a hearing
90.4 under section 256.045;

90.5 (8) be agreed upon and signed by the person, the person's legal guardian
90.6 or conservator, or the parent if the person is a minor, and the authorized county
90.7 representative; and

90.8 (9) be reviewed by a health professional if the person has overriding medical needs
90.9 that impact the delivery of services.

90.10 (b) Service planning formats developed for interagency planning such as transition,
90.11 vocational, and individual family service plans may be substituted for service planning
90.12 formats developed by county agencies.

90.13 (c) Approved, written, and signed changes to a consumer's services that meet the
90.14 criteria in this subdivision shall be an addendum to that consumer's individual service plan.

90.15 Sec. 22. Minnesota Statutes 2010, section 256B.092, is amended by adding a
90.16 subdivision to read:

90.17 Subd. 1h. **Commissioner's authority to reduce licensed capacity of adult foster**
90.18 **care.** At the time of reassessment, lead agency case managers shall assess each recipient
90.19 of home and community-based services waivers for individuals with developmental
90.20 disabilities currently residing in a licensed adult foster care home that is not the primary
90.21 residence of the license holder, or in which the license holder is not the primary caregiver,
90.22 to determine if that resident could appropriately be served in a community-living setting.
90.23 If appropriate for the recipient, the case manager shall offer the recipient, through a
90.24 person-centered planning process, the option to receive alternative housing and service
90.25 options. In the event that the recipient chooses to transfer from the adult foster care home,
90.26 the vacated bed shall not be filled with another recipient of waiver services and group
90.27 residential housing, unless provided under section 245A.03, subdivision 7, paragraph (a),
90.28 clauses (3) and (4), and the licensed capacity shall be reduced accordingly. If the adult
90.29 foster care home becomes no longer viable due to these transfers, the county agency, with
90.30 the assistance of the commissioner, shall facilitate a consolidation of settings or closure.
90.31 This reassessment process shall be completed by July 1, 2013.

90.32 Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

90.33 Subd. 7. **Screening teams.** (a) For persons with developmental disabilities,
90.34 screening teams shall be established which shall evaluate the need for the level of care

91.1 provided by residential-based habilitation services, residential services, training and
91.2 habilitation services, and nursing facility services. The evaluation shall address whether
91.3 home and community-based services are appropriate for persons who are at risk of
91.4 placement in an intermediate care facility for persons with developmental disabilities, or
91.5 for whom there is reasonable indication that they might require this level of care. The
91.6 screening team shall make an evaluation of need within 60 working days of a request for
91.7 service by a person with a developmental disability, and within five working days of
91.8 an emergency admission of a person to an intermediate care facility for persons with
91.9 developmental disabilities.

91.10 (b) The screening team shall consist of the case manager for persons with
91.11 developmental disabilities, the person, the person's legal guardian or conservator, or the
91.12 parent if the person is a minor, and a qualified developmental disability professional, as
91.13 defined in the Code of Federal Regulations, title 42, section 483.430, as amended through
91.14 June 3, 1988. The case manager may also act as the qualified developmental disability
91.15 professional if the case manager meets the federal definition.

91.16 (c) County social service agencies may contract with a public or private agency
91.17 or individual who is not a service provider for the person for the public guardianship
91.18 representation required by the screening or individual service planning process. The
91.19 contract shall be limited to public guardianship representation for the screening and
91.20 individual service planning activities. The contract shall require compliance with the
91.21 commissioner's instructions and may be for paid or voluntary services.

91.22 (d) For persons determined to have overriding health care needs and are
91.23 seeking admission to a nursing facility or an ICF/MR, or seeking access to home and
91.24 community-based waived services, a registered nurse must be designated as either the
91.25 case manager or the qualified developmental disability professional.

91.26 (e) For persons under the jurisdiction of a correctional agency, the case manager
91.27 must consult with the corrections administrator regarding additional health, safety, and
91.28 supervision needs.

91.29 (f) The case manager, with the concurrence of the person, the person's legal guardian
91.30 or conservator, or the parent if the person is a minor, may invite other individuals to
91.31 attend meetings of the screening team. With the permission of the person being screened
91.32 or the person's designated legal representative, the person's current provider of services
91.33 may submit a written report outlining their recommendations regarding the person's care
91.34 needs prepared by a direct service employee with at least 20 hours of service to that client.
91.35 The screening team must notify the provider of the date by which this information is to
91.36 be submitted. This information must be provided to the screening team and the person

92.1 or the person's legal representative and must be considered prior to the finalization of
92.2 the screening.

92.3 (g) No member of the screening team shall have any direct or indirect service
92.4 provider interest in the case.

92.5 (h) Nothing in this section shall be construed as requiring the screening team
92.6 meeting to be separate from the service planning meeting.

92.7 Sec. 24. Minnesota Statutes 2010, section 256B.092, is amended by adding a
92.8 subdivision to read:

92.9 Subd. 13. **Appeals.** A recipient who is adversely affected by the reduction,
92.10 suspension, denial, or termination of services under this section may appeal the decision
92.11 according to section 256.045. The notice of the reduction, suspension, denial, or
92.12 termination of services from the lead agency to the applicant or recipient must be made
92.13 in plain language and must include a form for written appeal. The commissioner may
92.14 provide lead agencies with a model form for written appeal. The appeal must be in
92.15 writing and identify the specific issues the recipient would like to have considered in the
92.16 appeal hearing and a summary of the basis, with supporting professional documentation
92.17 if available, for contesting the decision.

92.18 Sec. 25. Minnesota Statutes 2011 Supplement, section 256B.097, subdivision 3,
92.19 is amended to read:

92.20 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
92.21 Council which must define regional quality councils, and carry out a community-based,
92.22 person-directed quality review component, and a comprehensive system for effective
92.23 incident reporting, investigation, analysis, and follow-up.

92.24 (b) By August 1, 2011, the commissioner of human services shall appoint the
92.25 members of the initial State Quality Council. Members shall include representatives
92.26 from the following groups:

92.27 (1) disability service recipients and their family members;

92.28 (2) during the first two years of the State Quality Council, there must be at least three
92.29 members from the Region 10 stakeholders. As regional quality councils are formed under
92.30 subdivision 4, each regional quality council shall appoint one member;

92.31 (3) disability service providers;

92.32 (4) disability advocacy groups; and

92.33 (5) county human services agencies and staff from the Department of Human
92.34 Services and Ombudsman for Mental Health and Developmental Disabilities.

93.1 (c) Members of the council who do not receive a salary or wages from an employer
93.2 for time spent on council duties may receive a per diem payment when performing council
93.3 duties and functions.

93.4 (d) The State Quality Council shall:

93.5 (1) assist the Department of Human Services in fulfilling federally mandated
93.6 obligations by monitoring disability service quality and quality assurance and
93.7 improvement practices in Minnesota; ~~and~~

93.8 (2) establish state quality improvement priorities with methods for achieving results
93.9 and provide an annual report to the legislative committees with jurisdiction over policy
93.10 and funding of disability services on the outcomes, improvement priorities, and activities
93.11 undertaken by the commission during the previous state fiscal year;

93.12 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
93.13 with disabilities from optimizing choice of community-based services; and

93.14 (4) recommend to the chairs of the legislative committees with jurisdiction over
93.15 human services and civil law by January 15, 2013, statutory and rule changes related to
93.16 the findings under clause (3) that promote individualized service and housing choices
93.17 balanced with appropriate individualized protection.

93.18 (e) The State Quality Council, in partnership with the commissioner, shall:

93.19 (1) approve and direct implementation of the community-based, person-directed
93.20 system established in this section;

93.21 (2) recommend an appropriate method of funding this system, and determine the
93.22 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

93.23 (3) approve measurable outcomes in the areas of health and safety, consumer
93.24 evaluation, education and training, providers, and systems;

93.25 (4) establish variable licensure periods not to exceed three years based on outcomes
93.26 achieved; and

93.27 (5) in cooperation with the Quality Assurance Commission, design a transition plan
93.28 for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

93.29 (f) The State Quality Council shall notify the commissioner of human services that a
93.30 facility, program, or service has been reviewed by quality assurance team members under
93.31 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

93.32 (g) The State Quality Council, in partnership with the commissioner, shall establish
93.33 an ongoing review process for the system. The review shall take into account the
93.34 comprehensive nature of the system which is designed to evaluate the broad spectrum of
93.35 licensed and unlicensed entities that provide services to persons with disabilities. The
93.36 review shall address efficiencies and effectiveness of the system.

94.1 (h) The State Quality Council may recommend to the commissioner certain
94.2 variances from the standards governing licensure of programs for persons with disabilities
94.3 in order to improve the quality of services so long as the recommended variances do
94.4 not adversely affect the health or safety of persons being served or compromise the
94.5 qualifications of staff to provide services.

94.6 (i) The safety standards, rights, or procedural protections referenced under
94.7 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
94.8 recommendations to the commissioner or to the legislature in the report required under
94.9 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
94.10 procedural protections referenced under subdivision 2, paragraph (c).

94.11 (j) The State Quality Council may hire staff to perform the duties assigned in this
94.12 subdivision.

94.13 Sec. 26. Minnesota Statutes 2010, section 256B.431, subdivision 17e, is amended to
94.14 read:

94.15 Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.**
94.16 Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2),
94.17 for a total replacement, as defined in subdivision 17d, authorized under section
94.18 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation,
94.19 renovation, upgrading, or conversion completed on or after July 1, 2001, or any
94.20 building project eligible for reimbursement under section 256B.434, subdivision 4f, the
94.21 replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed
94.22 rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating
94.23 the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part
94.24 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be
94.25 adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1,
94.26 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph
94.27 (a), beginning October 1, 2012.

94.28 Sec. 27. Minnesota Statutes 2010, section 256B.431, is amended by adding a
94.29 subdivision to read:

94.30 Subd. 45. **Rate adjustments for some moratorium exception projects.**
94.31 Notwithstanding any other law to the contrary, money available for moratorium exception
94.32 projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the
94.33 incremental rate increases resulting from this section for any nursing facility with a
94.34 moratorium exception project approved under section 144A.073, and completed after

95.1 August 30, 2010, where the replacement-costs-new limits under subdivision 17e were
95.2 higher at any time after project approval than at the time of project completion. The
95.3 commissioner shall calculate the property rate increase for these facilities using the highest
95.4 set of limits; however, any rate increase under this section shall not be effective until on
95.5 or after the effective date of this section, contingent upon federal approval. No property
95.6 rate decrease shall result from this section.

95.7 **EFFECTIVE DATE.** This section is effective upon federal approval.

95.8 Sec. 28. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14,
95.9 is amended to read:

95.10 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
95.11 strengths, informal support systems, and need for services shall be completed within 20
95.12 working days of the recipient's request as provided in section 256B.0911. Reassessment of
95.13 each recipient's strengths, support systems, and need for services shall be conducted at
95.14 least every 12 months and at other times when there has been a significant change in the
95.15 recipient's functioning. With the permission of the recipient or the recipient's designated
95.16 legal representative, the recipient's current provider of services may submit a written
95.17 report outlining their recommendations regarding the recipient's care needs prepared by
95.18 a direct service employee with at least 20 hours of service to that client. The person
95.19 conducting the assessment or reassessment must notify the provider of the date by which
95.20 this information is to be submitted. This information shall be provided to the person
95.21 conducting the assessment and the person or the person's legal representative and must be
95.22 considered prior to the finalization of the assessment or reassessment.

95.23 (b) There must be a determination that the client requires a hospital level of care or a
95.24 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
95.25 (d), at initial and subsequent assessments to initiate and maintain participation in the
95.26 waiver program.

95.27 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
95.28 appropriate to determine nursing facility level of care for purposes of medical assistance
95.29 payment for nursing facility services, only face-to-face assessments conducted according
95.30 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
95.31 determination or a nursing facility level of care determination must be accepted for
95.32 purposes of initial and ongoing access to waiver services payment.

95.33 (d) Persons with developmental disabilities who apply for services under the nursing
95.34 facility level waiver programs shall be screened for the appropriate level of care according
95.35 to section 256B.092.

96.1 (e) Recipients who are found eligible for home and community-based services under
96.2 this section before their 65th birthday may remain eligible for these services after their
96.3 65th birthday if they continue to meet all other eligibility factors.

96.4 (f) The commissioner shall develop criteria to identify recipients whose level of
96.5 functioning is reasonably expected to improve and reassess these recipients to establish
96.6 a baseline assessment. Recipients who meet these criteria must have a comprehensive
96.7 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
96.8 reassessed every six months until there has been no significant change in the recipient's
96.9 functioning for at least 12 months. After there has been no significant change in the
96.10 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
96.11 informal support systems, and need for services shall be conducted at least every 12
96.12 months and at other times when there has been a significant change in the recipient's
96.13 functioning. Counties, case managers, and service providers are responsible for
96.14 conducting these reassessments and shall complete the reassessments out of existing funds.

96.15 Sec. 29. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15,
96.16 is amended to read:

96.17 Subd. 15. **Individualized service plan; comprehensive transitional service plan;**
96.18 **maintenance service plan.** (a) Each recipient of home and community-based waived
96.19 services shall be provided a copy of the written service plan which:

96.20 (1) is developed and signed by the recipient within ten working days of the
96.21 completion of the assessment;

96.22 (2) meets the assessed needs of the recipient;

96.23 (3) reasonably ensures the health and safety of the recipient;

96.24 (4) promotes independence;

96.25 (5) allows for services to be provided in the most integrated settings; and

96.26 (6) provides for an informed choice, as defined in section 256B.77, subdivision 2,
96.27 paragraph (p), of service and support providers.

96.28 (b) In developing the comprehensive transitional service plan, the individual
96.29 receiving services, the case manager, and the guardian, if applicable, will identify
96.30 the transitional service plan fundamental service outcome and anticipated timeline to
96.31 achieve this outcome. Within the first 20 days following a recipient's request for an
96.32 assessment or reassessment, the transitional service planning team must be identified. A
96.33 team leader must be identified who will be responsible for assigning responsibility and
96.34 communicating with team members to ensure implementation of the transition plan and
96.35 ongoing assessment and communication process. The team leader should be an individual,

97.1 such as the case manager or guardian, who has the opportunity to follow the recipient to
97.2 the next level of service.

97.3 Within ten days following an assessment, a comprehensive transitional service plan
97.4 must be developed incorporating elements of a comprehensive functional assessment and
97.5 including short-term measurable outcomes and timelines for achievement of and reporting
97.6 on these outcomes. Functional milestones must also be identified and reported according
97.7 to the timelines agreed upon by the transitional service planning team. In addition, the
97.8 comprehensive transitional service plan must identify additional supports that may assist
97.9 in the achievement of the fundamental service outcome such as the development of greater
97.10 natural community support, increased collaboration among agencies, and technological
97.11 supports.

97.12 The timelines for reporting on functional milestones will prompt a reassessment of
97.13 services provided, the units of services, rates, and appropriate service providers. It is
97.14 the responsibility of the transitional service planning team leader to review functional
97.15 milestone reporting to determine if the milestones are consistent with observable skills
97.16 and that milestone achievement prompts any needed changes to the comprehensive
97.17 transitional service plan.

97.18 For those whose fundamental transitional service outcome involves the need to
97.19 procure housing, a plan for the recipient to seek the resources necessary to secure the least
97.20 restrictive housing possible should be incorporated into the plan, including employment
97.21 and public supports such as housing access and shelter needy funding.

97.22 (c) Counties and other agencies responsible for funding community placement and
97.23 ongoing community supportive services are responsible for the implementation of the
97.24 comprehensive transitional service plans. Oversight responsibilities include both ensuring
97.25 effective transitional service delivery and efficient utilization of funding resources.

97.26 (d) Following one year of transitional services, the transitional services planning
97.27 team will make a determination as to whether or not the individual receiving services
97.28 requires the current level of continuous and consistent support in order to maintain the
97.29 recipient's current level of functioning. Recipients who are determined to have not had
97.30 a significant change in functioning for 12 months must move from a transitional to a
97.31 maintenance service plan. Recipients on a maintenance service plan must be reassessed
97.32 to determine if the recipient would benefit from a transitional service plan at least every
97.33 12 months and at other times when there has been a significant change in the recipient's
97.34 functioning. This assessment should consider any changes to technological or natural
97.35 community supports.

98.1 (e) When a county is evaluating denials, reductions, or terminations of home and
98.2 community-based services under section 256B.49 for an individual, the case manager
98.3 shall offer to meet with the individual or the individual's guardian in order to discuss the
98.4 prioritization of service needs within the individualized service plan, comprehensive
98.5 transitional service plan, or maintenance service plan. The reduction in the authorized
98.6 services for an individual due to changes in funding for waived services may not exceed
98.7 the amount needed to ensure medically necessary services to meet the individual's health,
98.8 safety, and welfare.

98.9 (f) At the time of reassessment, local agency case managers shall assess each
98.10 recipient of community alternatives for disabled individuals or traumatic brain injury
98.11 waived services currently residing in a licensed adult foster home that is not the primary
98.12 residence of the license holder, or in which the license holder is not the primary caregiver,
98.13 to determine if that recipient could appropriately be served in a community-living setting.
98.14 If appropriate for the recipient, the case manager shall offer the recipient, through a
98.15 person-centered planning process, the option to receive alternative housing and service
98.16 options. ~~In the event that the recipient chooses to transfer from the adult foster home,~~
98.17 ~~the vacated bed shall not be filled with another recipient of waiver services and group~~
98.18 ~~residential housing, unless~~ The licensed capacity shall be reduced accordingly, unless the
98.19 savings required by the 2011 licensed bed closure reductions for foster care settings where
98.20 the physical location is not the primary residence of the license holder are met through
98.21 voluntary changes described in section 245A.03, subdivision 7, paragraph (f), or as
98.22 provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), ~~and the~~
98.23 ~~licensed capacity shall be reduced accordingly. If the adult foster home becomes no longer~~
98.24 ~~viable due to these transfers, the county agency, with the assistance of the department,~~
98.25 ~~shall facilitate a consolidation of settings or closure.~~ This reassessment process shall be
98.26 completed by ~~June 30, 2012~~ July 1, 2013.

98.27 Sec. 30. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 23,
98.28 is amended to read:

98.29 Subd. 23. **Community-living settings.** "Community-living settings" means a
98.30 single-family home or apartment where the service recipient or their family owns or rents,
98.31 ~~as demonstrated by a lease agreement,~~ and maintains control over the individual unit: as
98.32 demonstrated by the lease agreement, or has a plan for transition of a lease from a service
98.33 provider to the individual. Within two years of signing the initial lease, the service provider
98.34 shall transfer the lease to the individual. In the event the landlord denies the transfer, the

99.1 commissioner may approve an exception within sufficient time to ensure the continued
 99.2 occupancy by the individual. Community-living settings are subject to the following:

- 99.3 (1) individuals are not required to receive services;
- 99.4 (2) individuals are not required to have a disability or specific diagnosis to live in the
 99.5 community-living setting unless state or federal funding for housing requires it;
- 99.6 (3) individuals may hire service providers of their choice;
- 99.7 (4) individuals may choose whether to share their household and with whom;
- 99.8 (5) the home or apartment must include living, sleeping, bathing, and cooking areas;
- 99.9 (6) individuals must have lockable access and egress;
- 99.10 (7) individuals must be free to receive visitors and leave the settings at times and for
 99.11 durations of their own choosing;
- 99.12 (8) leases must not reserve the right to assign units or change unit assignments; and
- 99.13 (9) access to the greater community must be easily facilitated based on the
 99.14 individual's needs and preferences.

99.15 Sec. 31. Minnesota Statutes 2010, section 256B.49, is amended by adding a
 99.16 subdivision to read:

99.17 Subd. 24. Appeals. A recipient who is adversely affected by the reduction,
 99.18 suspension, denial, or termination of services under this section may appeal the decision
 99.19 according to section 256.045. The notice of the reduction, suspension, denial, or
 99.20 termination of services from the lead agency to the applicant or recipient must be made
 99.21 in plain language and must include a form for written appeal. The commissioner may
 99.22 provide lead agencies with a model form for written appeal. The appeal must be in
 99.23 writing and identify the specific issues the recipient would like to have considered in the
 99.24 appeal hearing and a summary of the basis, with supporting professional documentation
 99.25 if available, for contesting the decision.

99.26 Sec. 32. **[256B.492] HOME AND COMMUNITY-BASED SETTINGS.**

99.27 (a) For purposes of the home and community-based waiver programs under sections
 99.28 256B.092 and 256B.49, home and community-based settings include:

- 99.29 (1) licensed adult or child foster care settings of four or five, if emergency exception
 99.30 criteria are met; and
- 99.31 (2) other settings that meet the definition of "community-living settings" under
 99.32 section 256B.49, subdivision 23:
- 99.33 (i) in addition to this definition, if a single corporation or entity provides both
 99.34 housing and services, there must be a distinct separation between the housing and services;

100.1 (ii) individuals may choose a service provider separate from the housing provider
100.2 without being required to move; and

100.3 (iii) for settings that meet this definition, individuals with disabilities may reside in
100.4 up to four units plus 25 percent of the remaining units in the building unless an exception
100.5 is granted under paragraph (c).

100.6 (b) For purposes of the home and community-based waiver programs under sections
100.7 256B.092 and 256B.49, home and community-based settings must not:

100.8 (1) be located in a building that is also a publicly or privately operated facility that
100.9 provides institutional treatment or custodial care;

100.10 (2) be located in a building on the grounds of, or immediately adjacent to, a public or
100.11 private institution;

100.12 (3) be a housing complex designed expressly around an individual's diagnosis or
100.13 disability;

100.14 (4) be segregated based on disability, either physically or because of setting
100.15 characteristics, from the larger community; or

100.16 (5) have the qualities of an institution which include, but are not limited to:
100.17 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
100.18 agreed to and documented in the person's individual service plan shall not result in a
100.19 residence having the qualities of an institution as long as the restrictions for the person are
100.20 not imposed upon others in the same residence and are the least restrictive alternative,
100.21 imposed for the shortest possible time to meet the person's needs.

100.22 (c) The provisions of this section do not apply to any setting in which residents
100.23 receive services under a home and community-based waiver as of June 30, 2013, and
100.24 which have been delivering those services for at least one year.

100.25 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
100.26 part of a Hennepin County demonstration project by January 1, 2013, is qualified for
100.27 the exception allowed under paragraph (c).

100.28 Sec. 33. Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13,
100.29 is amended to read:

100.30 Subd. 13. **ICF/DD rate decrease effective July 1, ~~2012~~ 2013.** Notwithstanding
100.31 subdivision 12, and if the commissioner has not received federal approval before July 1,
100.32 2013, of the Long-Term Care Realignment Waiver application submitted under Laws
100.33 2011, First Special Session chapter 9, article 7, section 52, for each facility reimbursed
100.34 under this section for services provided from July 1, 2013, through December 31, 2013,
100.35 the commissioner shall decrease operating payments equal to 1.67 percent of the operating

101.1 payment rates in effect on June 30, ~~2012~~ 2013. For each facility, the commissioner shall
101.2 apply the rate reduction based on occupied beds, using the percentage specified in this
101.3 subdivision multiplied by the total payment rate, including the variable rate but excluding
101.4 the property-related payment rate, in effect on the preceding date. The total rate reduction
101.5 shall include the adjustment provided in section 256B.501, subdivision 12.

101.6 Sec. 34. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

101.7 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
101.8 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
101.9 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
101.10 center, or a group residential housing facility.

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

101.18 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

101.19 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
101.20 of thrifty food plan;

101.21 (3) controlled protein diet, less than 40 grams and requires special products, 125
101.22 percent of thrifty food plan;

101.23 (4) low cholesterol diet, 25 percent of thrifty food plan;

101.24 (5) high residue diet, 20 percent of thrifty food plan;

101.25 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

101.26 (7) gluten-free diet, 25 percent of thrifty food plan;

101.27 (8) lactose-free diet, 25 percent of thrifty food plan;

101.28 (9) antidumping diet, 15 percent of thrifty food plan;

101.29 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

101.30 (11) ketogenic diet, 25 percent of thrifty food plan.

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

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

102.5 (d) The county agency shall continue to pay a monthly allowance of \$68 for
102.6 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
102.7 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
102.8 until the person has not received Minnesota supplemental aid for one full calendar month
102.9 or until the person's living arrangement changes and the person no longer meets the criteria
102.10 for the restaurant meal allowance, whichever occurs first.

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

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

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

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

103.1 (g) Notwithstanding this subdivision, to access housing and services as provided
 103.2 in paragraph (f), the recipient may choose housing that may be owned, operated, or
 103.3 controlled by the recipient's service provider. In a multifamily building ~~of four or more~~
 103.4 ~~units, the maximum number of apartments that may be used by recipients of this program~~
 103.5 ~~shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012.~~ of
 103.6 more than four units, the maximum number of units that may be used by recipients of this
 103.7 program shall be 50 percent of the units in the building. When housing is controlled by
 103.8 the service provider, the individual may choose the individual's own service provider as
 103.9 provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled
 103.10 by the service provider, the service provider shall implement a plan with the recipient to
 103.11 transition the lease to the recipient's name. Within two years of signing the initial lease,
 103.12 the service provider shall transfer the lease entered into under this subdivision to the
 103.13 recipient. In the event the landlord denies this transfer, the commissioner may approve an
 103.14 exception within sufficient time to ensure the continued occupancy by the recipient. This
 103.15 paragraph expires June 30, 2016.

103.16 Sec. 35. Laws 2011, First Special Session chapter 9, article 7, section 52, is amended to
 103.17 read:

103.18 Sec. 52. **IMPLEMENT NURSING HOME LEVEL OF CARE CRITERIA.**

103.19 The commissioner shall seek any necessary federal approval in order to implement
 103.20 the changes to the level of care criteria in Minnesota Statutes, section 144.0724,
 103.21 subdivision 11, on or after July 1, 2012, for adults and children.

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

103.23 Sec. 36. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to
 103.24 read:

103.25 Sec. 54. **CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

103.26 (a) Notwithstanding any other rate reduction in this article, if the commissioner of
 103.27 human services has not received federal approval before July 1, 2013, of the long-term
 103.28 care realignment waiver application submitted under Laws 2011, First Special Session
 103.29 chapter 9, article 7, section 52, the commissioner of human services shall decrease grants,
 103.30 allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67
 103.31 percent effective July 1, ~~2012~~ 2013, for services rendered ~~on or after those dates~~ from July
 103.32 1, 2013, through December 31, 2013. County or tribal contracts for services specified in
 103.33 this section must be amended to pass through these rate reductions within 60 days of

104.1 the effective date of the decrease, and must be retroactive from the effective date of the
104.2 rate decrease.

104.3 (b) The rate changes described in this section must be provided to:

104.4 (1) home and community-based waived services for persons with developmental
104.5 disabilities or related conditions, including consumer-directed community supports, under
104.6 Minnesota Statutes, section 256B.501;

104.7 (2) home and community-based waived services for the elderly, including
104.8 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

104.9 (3) waived services under community alternatives for disabled individuals,
104.10 including consumer-directed community supports, under Minnesota Statutes, section
104.11 256B.49;

104.12 (4) community alternative care waived services, including consumer-directed
104.13 community supports, under Minnesota Statutes, section 256B.49;

104.14 (5) traumatic brain injury waived services, including consumer-directed
104.15 community supports, under Minnesota Statutes, section 256B.49;

104.16 (6) nursing services and home health services under Minnesota Statutes, section
104.17 256B.0625, subdivision 6a;

104.18 (7) personal care services and qualified professional supervision of personal care
104.19 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

104.20 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
104.21 subdivision 7;

104.22 (9) day training and habilitation services for adults with developmental disabilities
104.23 or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the
104.24 additional cost of rate adjustments on day training and habilitation services, provided as a
104.25 social service under Minnesota Statutes, section 256M.60; and

104.26 (10) alternative care services under Minnesota Statutes, section 256B.0913.

104.27 (c) A managed care plan receiving state payments for the services in this section
104.28 must include these decreases in their payments to providers. To implement the rate
104.29 reductions in this section, capitation rates paid by the commissioner to managed care
104.30 organizations under Minnesota Statutes, section 256B.69, shall reflect a ~~2.34~~ 1.67 percent
104.31 reduction for the specified services for the period of ~~January 1, 2013, through June 30,~~
104.32 ~~2013, and a 1.67 percent reduction for those services on and after July 1, 2013,~~
104.33 through December 31, 2013.

104.34 The above payment rate reduction, allocation rates, and rate limits shall expire for
104.35 services rendered on December 31, 2013.

105.1 Sec. 37. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 105.2 3, is amended to read:

105.3 **Subd. 3. Forecasted Programs**

105.4 The amounts that may be spent from this
 105.5 appropriation for each purpose are as follows:

105.6 **(a) MFIP/DWP Grants**

105.7	Appropriations by Fund		
105.8	General	84,680,000	91,978,000
105.9	Federal TANF	84,425,000	75,417,000

105.10	(b) MFIP Child Care Assistance Grants	55,456,000	30,923,000
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105.11	(c) General Assistance Grants	49,192,000	46,938,000
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105.12 **General Assistance Standard.** The
 105.13 commissioner shall set the monthly standard
 105.14 of assistance for general assistance units
 105.15 consisting of an adult recipient who is
 105.16 childless and unmarried or living apart
 105.17 from parents or a legal guardian at \$203.
 105.18 The commissioner may reduce this amount
 105.19 according to Laws 1997, chapter 85, article
 105.20 3, section 54.

105.21 **Emergency General Assistance.** The
 105.22 amount appropriated for emergency general
 105.23 assistance funds is limited to no more
 105.24 than \$6,689,812 in fiscal year 2012 and
 105.25 \$6,729,812 in fiscal year 2013. Funds
 105.26 to counties shall be allocated by the
 105.27 commissioner using the allocation method
 105.28 specified in Minnesota Statutes, section
 105.29 256D.06.

105.30	(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
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105.31	(e) Group Residential Housing Grants	121,080,000	129,238,000
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105.32	(f) MinnesotaCare Grants	295,046,000	317,272,000
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106.1 This appropriation is from the health care
 106.2 access fund.

106.3 **(g) Medical Assistance Grants** 4,501,582,000 4,437,282,000

106.4 **Managed Care Incentive Payments.** The
 106.5 commissioner shall not make managed care
 106.6 incentive payments for expanding preventive
 106.7 services during fiscal years beginning July 1,
 106.8 2011, and July 1, 2012.

106.9 **Reduction of Rates for Congregate**

106.10 **Living for Individuals with Lower Needs.**

106.11 Beginning October 1, 2011, through June
 106.12 30, 2012, lead agencies must reduce rates in
 106.13 effect on January 1, 2011, by ten percent for
 106.14 individuals with lower needs living in foster
 106.15 care settings where the license holder does
 106.16 not share the residence with recipients on
 106.17 the CADI and DD waivers and customized
 106.18 living settings for CADI. Beginning July
 106.19 1, 2012, lead agencies must reduce rates in
 106.20 effect on January 1, 2011, by ten percent,
 106.21 for individuals living in foster care settings
 106.22 where the license holder does not share the
 106.23 residence with recipients on the CADI and
 106.24 DD waivers and customized living settings
 106.25 for CADI, in a manner that ensures that:
 106.26 (1) an identical percentage of recipients
 106.27 receiving services under each waiver receive
 106.28 a reduction; and (2) the projected savings
 106.29 for this provision for fiscal year 2013 are
 106.30 achieved, notwithstanding whether or not a
 106.31 recipient is an individual with lower needs.

106.32 Lead agencies must adjust contracts within
 106.33 60 days of the effective date.

106.34 **Reduction of Lead Agency Waiver**

106.35 **Allocations to Implement Rate Reductions**

107.1 **for Congregate Living for Individuals**
107.2 **with Lower Needs.** Beginning October 1,
107.3 2011, the commissioner shall reduce lead
107.4 agency waiver allocations to implement the
107.5 reduction of rates for individuals with lower
107.6 needs living in foster care settings where the
107.7 license holder does not share the residence
107.8 with recipients on the CADI and DD waivers
107.9 and customized living settings for CADI.

107.10 **Reduce customized living and 24-hour**
107.11 **customized living component rates.**
107.12 Effective July 1, 2011, the commissioner
107.13 shall reduce elderly waiver customized living
107.14 and 24-hour customized living component
107.15 service spending by five percent through
107.16 reductions in component rates and service
107.17 rate limits. The commissioner shall adjust
107.18 the elderly waiver capitation payment
107.19 rates for managed care organizations paid
107.20 under Minnesota Statutes, section 256B.69,
107.21 subdivisions 6a and 23, to reflect reductions
107.22 in component spending for customized living
107.23 services and 24-hour customized living
107.24 services under Minnesota Statutes, section
107.25 256B.0915, subdivisions 3e and 3h, for the
107.26 contract period beginning January 1, 2012.
107.27 To implement the reduction specified in
107.28 this provision, capitation rates paid by the
107.29 commissioner to managed care organizations
107.30 under Minnesota Statutes, section 256B.69,
107.31 shall reflect a ten percent reduction for the
107.32 specified services for the period January 1,
107.33 2012, to June 30, 2012, and a five percent
107.34 reduction for those services on or after July
107.35 1, 2012.

108.1 **Limit Growth in the Developmental**

108.2 **Disability Waiver.** The commissioner
108.3 shall limit growth in the developmental
108.4 disability waiver to six diversion allocations
108.5 per month beginning July 1, 2011, through
108.6 June 30, 2013, and 15 diversion allocations
108.7 per month beginning July 1, 2013, through
108.8 June 30, 2015. Waiver allocations shall
108.9 be targeted to individuals who meet the
108.10 priorities for accessing waiver services
108.11 identified in Minnesota Statutes, 256B.092,
108.12 subdivision 12. The limits do not include
108.13 conversions from intermediate care facilities
108.14 for persons with developmental disabilities.
108.15 Notwithstanding any contrary provisions in
108.16 this article, this paragraph expires June 30,
108.17 2015.

108.18 **Limit Growth in the Community**

108.19 **Alternatives for Disabled Individuals**

108.20 **Waiver.** The commissioner shall limit
108.21 growth in the community alternatives for
108.22 disabled individuals waiver to 60 allocations
108.23 per month beginning July 1, 2011, through
108.24 June 30, 2013, and 85 allocations per
108.25 month beginning July 1, 2013, through
108.26 June 30, 2015. Waiver allocations must
108.27 be targeted to individuals who meet the
108.28 priorities for accessing waiver services
108.29 identified in Minnesota Statutes, section
108.30 256B.49, subdivision 11a. The limits include
108.31 conversions and diversions, unless the
108.32 commissioner has approved a plan to convert
108.33 funding due to the closure or downsizing
108.34 of a residential facility or nursing facility
108.35 to serve directly affected individuals on
108.36 the community alternatives for disabled

109.1 individuals waiver. Notwithstanding any
 109.2 contrary provisions in this article, this
 109.3 paragraph expires June 30, 2015.

109.4 **Personal Care Assistance Relative**
 109.5 **Care.** The commissioner shall adjust the
 109.6 capitation payment rates for managed care
 109.7 organizations paid under Minnesota Statutes,
 109.8 section 256B.69, to reflect the rate reductions
 109.9 for personal care assistance provided by
 109.10 a relative pursuant to Minnesota Statutes,
 109.11 section 256B.0659, subdivision 11.

109.12 (h) Alternative Care Grants	46,421,000	46,035,000
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109.13 **Alternative Care Transfer.** Any money
 109.14 allocated to the alternative care program that
 109.15 is not spent for the purposes indicated does
 109.16 not cancel but shall be transferred to the
 109.17 medical assistance account.

109.18 (i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000
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109.19 Sec. 38. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
 109.20 4, is amended to read:

109.21 Subd. 4. **Grant Programs**

109.22 The amounts that may be spent from this
 109.23 appropriation for each purpose are as follows:

109.24 (a) **Support Services Grants**

	Appropriations by Fund		
109.26 General	8,715,000	8,715,000	
109.27 Federal TANF	100,525,000	94,611,000	

109.28 **MFIP Consolidated Fund Grants.** The
 109.29 TANF fund base is reduced by \$10,000,000
 109.30 each year beginning in fiscal year 2012.

109.31 **Subsidized Employment Funding Through**
 109.32 **ARRA.** The commissioner is authorized to
 109.33 apply for TANF emergency fund grants for

110.1 subsidized employment activities. Growth
 110.2 in expenditures for subsidized employment
 110.3 within the supported work program and the
 110.4 MFIP consolidated fund over the amount
 110.5 expended in the calendar year quarters in
 110.6 the TANF emergency fund base year shall
 110.7 be used to leverage the TANF emergency
 110.8 fund grants for subsidized employment and
 110.9 to fund supported work. The commissioner
 110.10 shall develop procedures to maximize
 110.11 reimbursement of these expenditures over the
 110.12 TANF emergency fund base year quarters,
 110.13 and may contract directly with employers
 110.14 and providers to maximize these TANF
 110.15 emergency fund grants.

110.16 **(b) Basic Sliding Fee Child Care Assistance**
 110.17 **Grants**

37,144,000

38,678,000

110.18 **Base Adjustment.** The general fund base is
 110.19 decreased by \$990,000 in fiscal year 2014
 110.20 and \$979,000 in fiscal year 2015.

110.21 **Child Care and Development Fund**

110.22 **Unexpended Balance.** In addition to
 110.23 the amount provided in this section, the
 110.24 commissioner shall expend \$5,000,000
 110.25 in fiscal year 2012 from the federal child
 110.26 care and development fund unexpended
 110.27 balance for basic sliding fee child care under
 110.28 Minnesota Statutes, section 119B.03. The
 110.29 commissioner shall ensure that all child
 110.30 care and development funds are expended
 110.31 according to the federal child care and
 110.32 development fund regulations.

110.33 **(c) Child Care Development Grants**

774,000

774,000

111.1 **Base Adjustment.** The general fund base is
 111.2 increased by \$713,000 in fiscal years 2014
 111.3 and 2015.

111.4 **(d) Child Support Enforcement Grants** 50,000 50,000

111.5 **Federal Child Support Demonstration**

111.6 **Grants.** Federal administrative
 111.7 reimbursement resulting from the federal
 111.8 child support grant expenditures authorized
 111.9 under section 1115a of the Social Security
 111.10 Act is appropriated to the commissioner for
 111.11 this activity.

111.12 **(e) Children's Services Grants**

111.13	Appropriations by Fund		
111.14	General	47,949,000	48,507,000
111.15	Federal TANF	140,000	140,000

111.16 **Adoption Assistance and Relative Custody**

111.17 **Assistance Transfer.** The commissioner
 111.18 may transfer unencumbered appropriation
 111.19 balances for adoption assistance and relative
 111.20 custody assistance between fiscal years and
 111.21 between programs.

111.22 **Privatized Adoption Grants.** Federal
 111.23 reimbursement for privatized adoption grant
 111.24 and foster care recruitment grant expenditures
 111.25 is appropriated to the commissioner for
 111.26 adoption grants and foster care and adoption
 111.27 administrative purposes.

111.28 **Adoption Assistance Incentive Grants.**

111.29 Federal funds available during fiscal year
 111.30 2012 and fiscal year 2013 for adoption
 111.31 incentive grants are appropriated to the
 111.32 commissioner for these purposes.

111.33 **(f) Children and Community Services Grants** 53,301,000 53,301,000

111.34 **(g) Children and Economic Support Grants**

112.1	Appropriations by Fund		
112.2	General	16,103,000	16,180,000
112.3	Federal TANF	700,000	0

112.4 **Long-Term Homeless Services.** \$700,000

112.5 is appropriated from the federal TANF
 112.6 fund for the biennium beginning July
 112.7 1, 2011, to the commissioner of human
 112.8 services for long-term homeless services
 112.9 for low-income homeless families under
 112.10 Minnesota Statutes, section 256K.26. This
 112.11 is a onetime appropriation and is not added
 112.12 to the base.

112.13 **Base Adjustment.** The general fund base is
 112.14 increased by \$42,000 in fiscal year 2014 and
 112.15 \$43,000 in fiscal year 2015.

112.16 **Minnesota Food Assistance Program.**
 112.17 \$333,000 in fiscal year 2012 and \$408,000 in
 112.18 fiscal year 2013 are to increase the general
 112.19 fund base for the Minnesota food assistance
 112.20 program. Unexpended funds for fiscal year
 112.21 2012 do not cancel but are available to the
 112.22 commissioner for this purpose in fiscal year
 112.23 2013.

112.24 **(h) Health Care Grants**

112.25	Appropriations by Fund		
112.26	General	26,000	66,000
112.27	Health Care Access	190,000	190,000

112.28 **Base Adjustment.** The general fund base is
 112.29 increased by \$24,000 in each of fiscal years
 112.30 2014 and 2015.

112.31	(i) Aging and Adult Services Grants	12,154,000	11,456,000
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112.32 **Aging Grants Reduction.** Effective July
 112.33 1, 2011, funding for grants made under
 112.34 Minnesota Statutes, sections 256.9754 and

113.1 256B.0917, subdivision 13, is reduced by
 113.2 \$3,600,000 for each year of the biennium.
 113.3 These reductions are onetime and do
 113.4 not affect base funding for the 2014-2015
 113.5 biennium. Grants made during the 2012-2013
 113.6 biennium under Minnesota Statutes, section
 113.7 256B.9754, must not be used for new
 113.8 construction or building renovation.

113.9 **Essential Community Support Grant**
 113.10 **Delay.** Upon federal approval to implement
 113.11 the nursing facility level of care on July
 113.12 1, 2013, essential community supports
 113.13 grants under Minnesota Statutes, section
 113.14 256B.0917, subdivision 14, are reduced by
 113.15 \$6,410,000 in fiscal year 2013. Base level
 113.16 funding is increased by \$5,541,000 in fiscal
 113.17 year 2014 and \$6,410,000 in fiscal year 2015.

113.18 **Base Level Adjustment.** The general fund
 113.19 base is increased by \$10,035,000 in fiscal
 113.20 year 2014 and increased by \$10,901,000 in
 113.21 fiscal year 2015.

113.22	(j) Deaf and Hard-of-Hearing Grants	1,936,000	1,767,000
113.23	(k) Disabilities Grants	15,945,000	18,284,000

113.24 **Grants for Housing Access Services.** In
 113.25 fiscal year 2012, the commissioner shall
 113.26 make available a total of \$161,000 in housing
 113.27 access services grants to individuals who
 113.28 relocate from an adult foster care home to
 113.29 a community living setting for assistance
 113.30 with completion of rental applications or
 113.31 lease agreements; assistance with publicly
 113.32 financed housing options; development of
 113.33 household budgets; and assistance with
 113.34 funding affordable furnishings and related
 113.35 household matters.

114.1 **HIV Grants.** The general fund appropriation
114.2 for the HIV drug and insurance grant
114.3 program shall be reduced by \$2,425,000 in
114.4 fiscal year 2012 and increased by \$2,425,000
114.5 in fiscal year 2014. These adjustments are
114.6 onetime and shall not be applied to the base.
114.7 Notwithstanding any contrary provision, this
114.8 provision expires June 30, 2014.

114.9 **Region 10.** Of this appropriation, \$100,000
114.10 each year is for a grant provided under
114.11 Minnesota Statutes, section 256B.097.

114.12 **Base Level Adjustment.** The general fund
114.13 base is increased by \$2,944,000 in fiscal year
114.14 2014 and \$653,000 in fiscal year 2015.

114.15 **Local Planning Grants for Creating**
114.16 **Alternatives to Congregate Living for**
114.17 **Individuals with Lower Needs.** Of this
114.18 appropriation, \$100,000 in fiscal year 2013
114.19 is for administrative functions related to the
114.20 need determination and planning process
114.21 required under Minnesota Statutes, sections
114.22 144A.351 and 245A.03, subdivision 7,
114.23 paragraphs (e) and (f). The commissioner
114.24 shall make available a total of ~~\$250,000 per~~
114.25 ~~year~~ \$400,000, \$250,000 of which carries
114.26 forward from fiscal year 2012, in local
114.27 and regional planning grants, beginning
114.28 July 1, ~~2011~~ 2012, to assist lead agencies
114.29 and provider organizations in developing
114.30 alternatives to congregate living within the
114.31 available level of resources for the home
114.32 and community-based services waivers for
114.33 persons with disabilities.

114.34 **Disability Linkage Line.** Of this
114.35 appropriation, \$125,000 in fiscal year 2012

115.1 and \$300,000 in fiscal year 2013 are for
 115.2 assistance to people with disabilities who are
 115.3 considering enrolling in managed care.

115.4 **(l) Adult Mental Health Grants**

115.5	Appropriations by Fund		
115.6	General	70,570,000	70,570,000
115.7	Health Care Access	750,000	750,000
115.8	Lottery Prize	1,508,000	1,508,000

115.9 **Funding Usage.** Up to 75 percent of a fiscal
 115.10 year's appropriation for adult mental health
 115.11 grants may be used to fund allocations in that
 115.12 portion of the fiscal year ending December
 115.13 31.

115.14 **Base Adjustment.** The general fund base is
 115.15 increased by \$200,000 in fiscal years 2014
 115.16 and 2015.

115.17	(m) Children's Mental Health Grants	16,457,000	16,457,000
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115.18 **Funding Usage.** Up to 75 percent of a fiscal
 115.19 year's appropriation for children's mental
 115.20 health grants may be used to fund allocations
 115.21 in that portion of the fiscal year ending
 115.22 December 31.

115.23 **Base Adjustment.** The general fund base is
 115.24 increased by \$225,000 in fiscal years 2014
 115.25 and 2015.

115.26	(n) Chemical Dependency Nonentitlement		
115.27	Grants	1,336,000	1,336,000

115.28 **Sec. 39. INDEPENDENT LIVING SERVICES BILLING.**

115.29 The commissioner shall allow for daily rate and 15-minute increment billing for
 115.30 independent living services under the brain injury (BI) and CADI waivers. If necessary to
 115.31 comply with this requirement, the commissioner shall submit a waiver amendment to the
 115.32 state plan no later than December 31, 2012.

115.33 **Sec. 40. COMMUNITY FIRST CHOICE OPTION.**

116.1 (a) If the final federal regulations under Community First Choice Option are
116.2 determined by the commissioner, after consultation with interested stakeholders in
116.3 paragraph (d), to be compatible with Minnesota's fiscal neutrality and policy requirements
116.4 for redesigning and simplifying the personal care assistance program, assistance at home
116.5 and in the community provided through the home and community-based services with
116.6 waivers, state-funded grants, and medical assistance-funded services and programs, the
116.7 commissioner shall develop and request a state plan amendment to establish services,
116.8 including self-directed options, under section 1915k of the Social Security Act by January
116.9 15, 2013, for implementation on July 1, 2013.

116.10 (b) The commissioner shall develop and provide to the chairs of the health and
116.11 human services policy and finance committees, legislation needed to reform and simplify
116.12 home care, home and community-based services waivers, and other community support
116.13 services under the Community First Choice Option by February 15, 2013.

116.14 (c) Any savings generated by this option shall accrue to the commissioner for
116.15 development and implementation of community support services under the Community
116.16 First Choice Option.

116.17 (d) The commissioner shall consult with stakeholders, including persons with
116.18 disabilities and seniors, who represent a range of disabilities, ages, cultures, and
116.19 geographic locations, their families and guardians, as well as representatives of advocacy
116.20 organizations, lead agencies, direct support staff, labor unions, and a variety of service
116.21 provider groups.

116.22 Sec. 41. **COMMISSIONER AUTHORITY TO REDUCE 2011 CONGREGATE**
116.23 **CARE LOW NEED RATE CUT.**

116.24 During fiscal years 2013 and 2014, the commissioner shall reduce the 2011 reduction
116.25 of rates for congregate living for individuals with lower needs to the extent actions taken
116.26 under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (f), produce savings
116.27 beyond the amount needed to meet the licensed bed closure savings requirements of
116.28 Minnesota Statutes, section 245A.03, subdivision 7, paragraph (e). Each February 1, the
116.29 commissioner shall report to the chairs of the legislative committees with jurisdiction over
116.30 health and human services finance on any reductions provided under this section. This
116.31 section is effective on July 1, 2012, and expires on June 30, 2014.

116.32 Sec. 42. **HOME AND COMMUNITY-BASED SERVICES WAIVERS**
116.33 **AMENDMENT FOR EXCEPTION.**

117.1 By September 1, 2012, the commissioner of human services shall submit
117.2 amendments to the home and community-based waiver plans consistent with the definition
117.3 of home and community-based settings under Minnesota Statutes, section 256B.492,
117.4 including a request to allow an exception for those settings that serve persons with
117.5 disabilities under a home and community-based service waiver in more than 25 percent
117.6 of the units in a building as of January 1, 2012, but otherwise meet the definition under
117.7 Minnesota Statutes, section 256B.492.

117.8 Sec. 43. **COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION**
117.9 **TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
117.10 **METHODOLOGY.**

117.11 By July 1, 2012, the commissioner shall request an amendment to the home and
117.12 community-based services waivers authorized under Minnesota Statutes, sections
117.13 256B.092 and 256B.49, to establish an exception to the consumer-directed community
117.14 supports budget methodology to provide up to 20 percent more funds for those
117.15 participants who have their 21st birthday and graduate from high school during 2013 and
117.16 are authorized for more services under consumer-directed community supports prior to
117.17 graduation than what they are eligible to receive under the current consumer-directed
117.18 community supports budget methodology. The exception is limited to those who can
117.19 demonstrate that they will have to leave consumer-directed community supports and use
117.20 other waiver services because their need for day or employment supports cannot be met
117.21 within the consumer-directed community supports budget limits. The commissioner
117.22 shall consult with the stakeholder group authorized under Minnesota Statutes, section
117.23 256B.0657, subdivision 11, to implement this provision. The exception process shall be
117.24 effective upon federal approval for persons eligible during 2013 and 2014.

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

117.26 Sec. 44. **DIRECTION TO OMBUDSMAN FOR LONG-TERM CARE.**

117.27 The ombudsman for long-term care shall:

117.28 (1) research the existence of differential treatment based on source of payment in
117.29 assisted living settings;

117.30 (2) convene stakeholders to provide technical assistance and expertise in studying
117.31 and addressing these issues, including but not limited to consumers, health care and
117.32 housing providers, advocates representing seniors and younger persons with disabilities or
117.33 mental health challenges, county representatives, and representatives of the Departments
117.34 of Health and Human Services; and

118.1 (3) submit a report of findings to the legislature no later than January 31, 2013,
118.2 with recommendations for the development of policies and procedures to prevent and
118.3 remedy instances of discrimination based on participation in or potential eligibility for
118.4 medical assistance.

118.5 ARTICLE 5

118.6 MINNESOTA CHILDREN AND FAMILY INVESTMENT PROGRAM

118.7 Section 1. CITATION.

118.8 Sections 2 to 8 may be cited as the "Minnesota Children and Family Investment
118.9 Program Act."

118.10 Sec. 2. Minnesota Statutes 2010, section 256J.08, is amended by adding a subdivision
118.11 to read:

118.12 Subd. 11b. **Child well-being.** "Child well-being" means a child's developmental
118.13 progress relative to the child's age, including cognitive, physical, emotional, and social
118.14 development as measured through developmental screening tools, school achievement,
118.15 health status, and other relevant standardized measures of development.

118.16 Sec. 3. Minnesota Statutes 2010, section 256J.45, subdivision 2, is amended to read:

118.17 Subd. 2. **General information.** (a) The MFIP orientation must consist of a
118.18 presentation that informs caregivers of:

118.19 (1) the necessity to obtain immediate employment;

118.20 (2) the work incentives under MFIP, including the availability of the federal earned
118.21 income tax credit and the Minnesota working family tax credit;

118.22 (3) the requirement to comply with the employment plan and other requirements
118.23 of the employment and training services component of MFIP, including a description
118.24 of the range of work and training activities that are allowable under MFIP to meet the
118.25 individual needs of participants;

118.26 (4) the consequences for failing to comply with the employment plan and other
118.27 program requirements, and that the county agency may not impose a sanction when failure
118.28 to comply is due to the unavailability of child care or other circumstances where the
118.29 participant has good cause under subdivision 3;

118.30 (5) the rights, responsibilities, and obligations of participants;

118.31 (6) the types and locations of child care services available through the county agency;

118.32 (7) the availability and the benefits of the early childhood health and developmental
118.33 screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

119.1 (8) the caregiver's eligibility for transition year child care assistance under section
119.2 119B.05;

119.3 (9) the availability of all health care programs, including transitional medical
119.4 assistance;

119.5 (10) the caregiver's option to choose an employment and training provider and
119.6 information about each provider, including but not limited to, services offered, program
119.7 components, job placement rates, job placement wages, and job retention rates;

119.8 (11) the caregiver's option to request approval of an education and training plan
119.9 according to section 256J.53;

119.10 (12) the work study programs available under the higher education system; ~~and~~

119.11 (13) information about the 60-month time limit exemptions under the family
119.12 violence waiver and referral information about shelters and programs for victims of family
119.13 violence; and

119.14 (14) the availability and benefits of early childhood health and developmental
119.15 screening and other early childhood resources and programs.

119.16 (b) For MFIP caregivers who are exempt from attending the orientation under
119.17 subdivision 1, the county agency must provide the information required under paragraph
119.18 (a), clause (14), via other means.

119.19 Sec. 4. Minnesota Statutes 2011 Supplement, section 256J.49, subdivision 13, is
119.20 amended to read:

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

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

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

119.30 (3) unpaid work experience, including community service, volunteer work,
119.31 the community work experience program as specified in section 256J.67, unpaid
119.32 apprenticeships or internships, and supported work when a wage subsidy is not provided.
119.33 Unpaid work experience is only an option if the participant has been unable to obtain or
119.34 maintain paid employment in the competitive labor market, and no paid work experience
119.35 programs are available to the participant. Prior to placing a participant in unpaid work,

120.1 the county must inform the participant that the participant will be notified if a paid work
120.2 experience or supported work position becomes available. Unless a participant consents in
120.3 writing to participate in unpaid work experience, the participant's employment plan may
120.4 only include unpaid work experience if including the unpaid work experience in the plan
120.5 will meet the following criteria:

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

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

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

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

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

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

120.24 (8) activities included in the employment plan that is developed under section
120.25 256J.521, subdivision 3; ~~and~~

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

120.29 (10) attending a child's early childhood activities, including developmental
120.30 screenings and subsequent referral and follow-up services. MFIP employment and training
120.31 providers must coordinate with county social service agencies and health plans to assist
120.32 recipients in arranging referrals indicated by screening results.

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

121.1 Sec. 5. Minnesota Statutes 2010, section 256J.50, is amended by adding a subdivision
121.2 to read:

121.3 Subd. 13. **Child development information.** MFIP employment and training
121.4 providers and county agencies shall post information regarding child development in areas
121.5 easily accessible to families participating in MFIP.

121.6 Sec. 6. Minnesota Statutes 2010, section 256J.521, subdivision 2, is amended to read:

121.7 Subd. 2. **Employment plan; contents.** (a) Based on the assessment under
121.8 subdivision 1, the job counselor and the participant must develop an employment plan
121.9 that includes participation in activities and hours that meet the requirements of section
121.10 256J.55, subdivision 1. The purpose of the employment plan is to identify for each
121.11 participant the most direct path to unsubsidized employment and any subsequent steps that
121.12 support long-term economic stability. The employment plan should be developed using
121.13 the highest level of activity appropriate for the participant. Activities must be chosen from
121.14 clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of
121.15 preference for activities, priority must be given for activities related to a family violence
121.16 waiver when developing the employment plan. The employment plan must also list the
121.17 specific steps the participant will take to obtain employment, including steps necessary
121.18 for the participant to progress from one level of activity to another, and a timetable for
121.19 completion of each step. Levels of activity include:

121.20 (1) unsubsidized employment;

121.21 (2) job search;

121.22 (3) subsidized employment or unpaid work experience;

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

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

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

121.27 (b) Participants who are determined to possess sufficient skills such that the
121.28 participant is likely to succeed in obtaining unsubsidized employment must job search at
121.29 least 30 hours per week for up to six weeks and accept any offer of suitable employment.
121.30 The remaining hours necessary to meet the requirements of section 256J.55, subdivision
121.31 1, may be met through participation in other work activities under section 256J.49,
121.32 subdivision 13. The participant's employment plan must specify, at a minimum: (1)
121.33 whether the job search is supervised or unsupervised; (2) support services that will
121.34 be provided; and (3) how frequently the participant must report to the job counselor.
121.35 Participants who are unable to find suitable employment after six weeks must meet

122.1 with the job counselor to determine whether other activities in paragraph (a) should be
122.2 incorporated into the employment plan. Job search activities which are continued after six
122.3 weeks must be structured and supervised.

122.4 (c) Participants who are determined to have barriers to obtaining or maintaining
122.5 suitable employment that will not be overcome during six weeks of job search under
122.6 paragraph (b) must work with the job counselor to develop an employment plan that
122.7 addresses those barriers by incorporating appropriate activities from paragraph (a), clauses
122.8 (1) to (6). The employment plan must include enough hours to meet the participation
122.9 requirements in section 256J.55, subdivision 1, unless a compelling reason to require
122.10 fewer hours is noted in the participant's file.

122.11 (d) The job counselor and the participant must sign the employment plan to indicate
122.12 agreement on the contents.

122.13 (e) Except as provided under paragraph (f), failure to develop or comply with
122.14 activities in the plan, or voluntarily quitting suitable employment without good cause, will
122.15 result in the imposition of a sanction under section 256J.46.

122.16 (f) When a participant fails to meet the agreed-upon hours of participation in paid
122.17 employment because the participant is not eligible for holiday pay and the participant's
122.18 place of employment is closed for a holiday, the job counselor shall not impose a sanction
122.19 or increase the hours of participation in any other activity, including paid employment, to
122.20 offset the hours that were missed due to the holiday.

122.21 (g) Employment plans must be reviewed at least every three months to determine
122.22 whether activities and hourly requirements should be revised. At the time of the
122.23 employment plan review, the job counselor must provide information to participants
122.24 regarding early childhood development and resources for families. The job counselor
122.25 is encouraged to allow participants who are participating in at least 20 hours of work
122.26 activities to also participate in education and training activities in order to meet the federal
122.27 hourly participation rates.

122.28 Sec. 7. **DIRECTION TO COMMISSIONER.**

122.29 The commissioner of human services may phase in the change in terminology from
122.30 "Minnesota Family Investment Program" to "Minnesota Children and Family Investment
122.31 Program" as the commissioner exhausts supplies of printed materials.

122.32 Sec. 8. **REVISOR INSTRUCTION.**

123.1 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall substitute
 123.2 the terms "Minnesota Children and Family Investment Program" for "Minnesota Family
 123.3 Investment Program" and "MCFIP" for "MFIP" wherever they appear.

123.4 **ARTICLE 6**

123.5 **MISCELLANEOUS**

123.6 Section 1. Minnesota Statutes 2010, section 245.697, subdivision 1, is amended to read:

123.7 Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created.
 123.8 The council must have ~~30~~ 31 members appointed by the governor in accordance with
 123.9 federal requirements. In making the appointments, the governor shall consider appropriate
 123.10 representation of communities of color. The council must be composed of:

123.11 (1) the assistant commissioner of mental health for the department of human services;

123.12 (2) a representative of the Department of Human Services responsible for the
 123.13 medical assistance program;

123.14 (3) one member of each of the ~~four~~ five core mental health professional disciplines
 123.15 (psychiatry, psychology, social work, nursing, and marriage and family therapy);

123.16 (4) one representative from each of the following advocacy groups: Mental Health
 123.17 Association of Minnesota, NAMI-MN, Mental Health Consumer/Survivor Network of
 123.18 Minnesota, and Minnesota Disability Law Center;

123.19 (5) providers of mental health services;

123.20 (6) consumers of mental health services;

123.21 (7) family members of persons with mental illnesses;

123.22 (8) legislators;

123.23 (9) social service agency directors;

123.24 (10) county commissioners; and

123.25 (11) other members reflecting a broad range of community interests, including
 123.26 family physicians, or members as the United States Secretary of Health and Human
 123.27 Services may prescribe by regulation or as may be selected by the governor.

123.28 (b) The council shall select a chair. Terms, compensation, and removal of members
 123.29 and filling of vacancies are governed by section 15.059. Notwithstanding provisions
 123.30 of section 15.059, the council and its subcommittee on children's mental health do not
 123.31 expire. The commissioner of human services shall provide staff support and supplies
 123.32 to the council.

123.33 Sec. 2. Minnesota Statutes 2010, section 254A.19, is amended by adding a subdivision
 123.34 to read:

124.1 Subd. 4. **Civil commitments.** A Rule 25 assessment, under Minnesota Rules,
124.2 part 9530.6615, does not need to be completed for an individual being committed as a
124.3 chemically dependent person, as defined in section 253B.02, and for the duration of a civil
124.4 commitment under section 253B.065, 253B.09, or 253B.095 in order for a county to
124.5 access consolidated chemical dependency treatment funds under section 254B.04. The
124.6 county must determine if the individual meets the financial eligibility requirements for
124.7 the consolidated chemical dependency treatment funds under section 254B.04. Nothing
124.8 in this subdivision shall prohibit placement in a treatment facility or treatment program
124.9 governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.

124.10 Sec. 3. Minnesota Statutes 2010, section 256B.0943, subdivision 9, is amended to read:

124.11 **Subd. 9. Service delivery criteria.** (a) In delivering services under this section, a
124.12 certified provider entity must ensure that:

124.13 (1) each individual provider's caseload size permits the provider to deliver services
124.14 to both clients with severe, complex needs and clients with less intensive needs. The
124.15 provider's caseload size should reasonably enable the provider to play an active role in
124.16 service planning, monitoring, and delivering services to meet the client's and client's
124.17 family's needs, as specified in each client's individual treatment plan;

124.18 (2) site-based programs, including day treatment and preschool programs, provide
124.19 staffing and facilities to ensure the client's health, safety, and protection of rights, and that
124.20 the programs are able to implement each client's individual treatment plan;

124.21 (3) a day treatment program is provided to a group of clients by a multidisciplinary
124.22 team under the clinical supervision of a mental health professional. The day treatment
124.23 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
124.24 Commission on Accreditation of Health Organizations and licensed under sections 144.50
124.25 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity
124.26 that is ~~under contract with the county board~~ certified under subdivision 4 to operate a
124.27 program that meets the requirements of ~~section 245.4712, subdivision 2, or 245.4884,~~
124.28 ~~subdivision 2, and~~ Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment
124.29 program must stabilize the client's mental health status while developing and improving
124.30 the client's independent living and socialization skills. The goal of the day treatment
124.31 program must be to reduce or relieve the effects of mental illness and provide training to
124.32 enable the client to live in the community. The program must be available at least one day
124.33 a week for a two-hour time block. The two-hour time block must include at least one hour
124.34 of individual or group psychotherapy. The remainder of the structured treatment program
124.35 may include individual or group psychotherapy, and individual or group skills training, if

125.1 included in the client's individual treatment plan. Day treatment programs are not part of
125.2 inpatient or residential treatment services. A day treatment program may provide fewer
125.3 than the minimally required hours for a particular child during a billing period in which
125.4 the child is transitioning into, or out of, the program; and

125.5 (4) a therapeutic preschool program is a structured treatment program offered
125.6 to a child who is at least 33 months old, but who has not yet reached the first day of
125.7 kindergarten, by a preschool multidisciplinary team in a day program licensed under
125.8 Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available two
125.9 hours per day, five days per week, and 12 months of each calendar year. The structured
125.10 treatment program may include individual or group psychotherapy and individual or
125.11 group skills training, if included in the client's individual treatment plan. A therapeutic
125.12 preschool program may provide fewer than the minimally required hours for a particular
125.13 child during a billing period in which the child is transitioning into, or out of, the program.

125.14 (b) A provider entity must deliver the service components of children's therapeutic
125.15 services and supports in compliance with the following requirements:

125.16 (1) individual, family, and group psychotherapy must be delivered as specified in
125.17 Minnesota Rules, part 9505.0323;

125.18 (2) individual, family, or group skills training must be provided by a mental health
125.19 professional or a mental health practitioner who has a consulting relationship with a
125.20 mental health professional who accepts full professional responsibility for the training;

125.21 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
125.22 through arrangements for direct intervention and support services to the child and the
125.23 child's family. Crisis assistance must utilize resources designed to address abrupt or
125.24 substantial changes in the functioning of the child or the child's family as evidenced by
125.25 a sudden change in behavior with negative consequences for well being, a loss of usual
125.26 coping mechanisms, or the presentation of danger to self or others;

125.27 (4) mental health behavioral aide services must be medically necessary treatment
125.28 services, identified in the child's individual treatment plan and individual behavior plan,
125.29 which are performed minimally by a paraprofessional qualified according to subdivision
125.30 7, paragraph (b), clause (3), and which are designed to improve the functioning of the
125.31 child in the progressive use of developmentally appropriate psychosocial skills. Activities
125.32 involve working directly with the child, child-peer groupings, or child-family groupings
125.33 to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph
125.34 (p), as previously taught by a mental health professional or mental health practitioner
125.35 including:

- 126.1 (i) providing cues or prompts in skill-building peer-to-peer or parent-child
 126.2 interactions so that the child progressively recognizes and responds to the cues
 126.3 independently;
- 126.4 (ii) performing as a practice partner or role-play partner;
- 126.5 (iii) reinforcing the child's accomplishments;
- 126.6 (iv) generalizing skill-building activities in the child's multiple natural settings;
- 126.7 (v) assigning further practice activities; and
- 126.8 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
 126.9 behavior that puts the child or other person at risk of injury.

126.10 A mental health behavioral aide must document the delivery of services in written
 126.11 progress notes. The mental health behavioral aide must implement treatment strategies
 126.12 in the individual treatment plan and the individual behavior plan. The mental health
 126.13 behavioral aide must document the delivery of services in written progress notes. Progress
 126.14 notes must reflect implementation of the treatment strategies, as performed by the mental
 126.15 health behavioral aide and the child's responses to the treatment strategies; and

126.16 (5) direction of a mental health behavioral aide must include the following:

- 126.17 (i) a clinical supervision plan approved by the responsible mental health professional;
- 126.18 (ii) ongoing on-site observation by a mental health professional or mental health
 126.19 practitioner for at least a total of one hour during every 40 hours of service provided
 126.20 to a child; and
- 126.21 (iii) immediate accessibility of the mental health professional or mental health
 126.22 practitioner to the mental health behavioral aide during service provision.

126.23 Sec. 4. Minnesota Statutes 2011 Supplement, section 256M.40, subdivision 1, is
 126.24 amended to read:

126.25 Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated
 126.26 under this chapter to each county board on a calendar year basis in an amount determined
 126.27 according to the formula in paragraphs (a) to ~~(e)~~ (f).

126.28 (a) For calendar years 2011 ~~and~~, 2012, and 2013, the commissioner shall allocate
 126.29 available funds to each county in proportion to that county's share in calendar year 2010.

126.30 (b) For calendar year ~~2013~~ 2014, the commissioner shall allocate available funds to
 126.31 each county as follows:

126.32 (1) ~~75~~ 80 percent must be distributed on the basis of the county share in calendar
 126.33 year ~~2012~~ 2013;

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

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

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

127.7 (2) 20 percent must be distributed as follows:

127.8 (i) 25 percent must be allocated to cover infrastructure costs for grant implementation
127.9 which includes a guaranteed floor and an amount based on the county's population size
127.10 as determined by the commissioner; and

127.11 (ii) 75 percent must be allocated based on the need for vulnerable children and
127.12 adult services as follows:

127.13 (A) 70 percent shall be allocated to counties based on the county's average three-year
127.14 count of vulnerable children who are subjects of family assessments or subjects of
127.15 accepted reports under sections 626.556 and 626.5561 per 1,000 county child population
127.16 as determined by the most recent data of the commissioner; and

127.17 (B) 30 percent shall be allocated to counties based on the county's average three-year
127.18 count of vulnerable adults who are subjects of reports accepted for county investigation or
127.19 emergency protective services under section 626.557 per 1,000 county adult population
127.20 determined by the most recent data of the commissioner.

127.21 (c) For calendar year ~~2014~~ 2015, the commissioner shall allocate available funds to
127.22 each county as follows:

127.23 (1) ~~50~~ 60 percent must be distributed on the basis of the county share in calendar
127.24 year ~~2012~~ 2013; and

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

127.27 ~~(3) 20 percent must be distributed on the basis of the number of vulnerable children~~
127.28 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
127.29 ~~county as determined by the most recent data of the commissioner; and~~

127.30 ~~(4) 20 percent must be distributed on the basis of the number of vulnerable adults~~
127.31 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
127.32 ~~recent data of the commissioner.~~

127.33 (2) 40 percent must be distributed as follows:

127.34 (i) 25 percent must be allocated to cover infrastructure costs for grant implementation
127.35 which includes a guaranteed floor and an amount based on the county's population size
127.36 as determined by the commissioner; and

128.1 (ii) 75 percent must be allocated based on the need for vulnerable children and
128.2 adult services as follows:

128.3 (A) 70 percent shall be allocated to counties based on the county's average three-year
128.4 count of vulnerable children who are subjects of family assessments or subjects of
128.5 accepted reports under sections 626.556 and 626.5561 per 1,000 county child population
128.6 as determined by the most recent data of the commissioner; and

128.7 (B) 30 percent shall be allocated to counties based on the county's average three-year
128.8 count of vulnerable adults who are subjects of reports accepted for county investigation or
128.9 emergency protective services under section 626.557 per 1,000 county adult population
128.10 determined by the most recent data of the commissioner.

128.11 (d) For calendar year ~~2015~~ 2016, the commissioner shall allocate available funds to
128.12 each county as follows:

128.13 (1) ~~25~~ 40 percent must be distributed on the basis of the county share in calendar
128.14 year ~~2012~~ 2013; and

128.15 ~~(2) 15 percent must be distributed on the basis of the number of persons residing in~~
128.16 ~~the county as determined by the most recent data of the state demographer;~~

128.17 ~~(3) 30 percent must be distributed on the basis of the number of vulnerable children~~
128.18 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
128.19 ~~county as determined by the most recent data of the commissioner; and~~

128.20 ~~(4) 30 percent must be distributed on the basis of the number of vulnerable adults~~
128.21 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
128.22 ~~recent data of the commissioner.~~

128.23 (2) 60 percent must be distributed as follows:

128.24 (i) 25 percent must be allocated to cover infrastructure costs for grant implementation
128.25 which includes a guaranteed floor and an amount based on the county's population size
128.26 as determined by the commissioner; and

128.27 (ii) 75 percent must be allocated based on the need for vulnerable children and
128.28 adult services as follows:

128.29 (A) 70 percent shall be allocated to counties based on the county's average three-year
128.30 count of vulnerable children who are subjects of family assessments or subjects of
128.31 accepted reports under sections 626.556 and 626.5561 per 1,000 county child population
128.32 as determined by the most recent data of the commissioner; and

128.33 (B) 30 percent shall be allocated to counties based on the county's average three-year
128.34 count of vulnerable adults who are subjects of reports accepted for county investigation or
128.35 emergency protective services under section 626.557 per 1,000 county adult population
128.36 determined by the most recent data of the commissioner.

129.1 (e) For calendar year ~~2016 and each calendar year thereafter~~ 2017, the commissioner
129.2 shall allocate available funds to each county as follows:

129.3 (1) ~~20 percent must be distributed on the basis of the number of persons residing~~
129.4 ~~in the county as determined by the most recent data of the state demographer~~ county
129.5 share in calendar year 2013; and

129.6 (2) ~~40 percent must be distributed on the basis of the number of vulnerable children~~
129.7 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
129.8 ~~county as determined by the most recent data of the commissioner; and~~

129.9 (3) ~~40 percent must be distributed on the basis of the number of vulnerable adults~~
129.10 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
129.11 ~~recent data of the commissioner.~~

129.12 (2) 80 percent must be distributed as follows:

129.13 (i) 25 percent must be allocated to cover infrastructure costs for grant implementation
129.14 which includes a guaranteed floor and an amount based on the county's population size
129.15 as determined by the commissioner; and

129.16 (ii) 75 percent must be allocated based on the need for vulnerable children and
129.17 adult services as follows:

129.18 (A) 70 percent shall be allocated to counties based on the county's average three-year
129.19 count of vulnerable children who are subjects of family assessments or subjects of
129.20 accepted reports under sections 626.556 and 626.5561 per 1,000 county child population
129.21 as determined by the most recent data of the commissioner; and

129.22 (B) 30 percent shall be allocated to counties based on the county's average three-year
129.23 count of vulnerable adults who are subjects of reports accepted for county investigation or
129.24 emergency protective services under section 626.557 per 1,000 county adult population
129.25 determined by the most recent data of the commissioner.

129.26 (f) For calendar year 2018 and each calendar year thereafter, the commissioner shall
129.27 allocate available funds to each county as follows:

129.28 (1) 25 percent must be allocated to cover infrastructure costs for grant
129.29 implementation which includes a guaranteed floor and an amount based on the county's
129.30 population size as determined by the commissioner; and

129.31 (2) 75 percent must be allocated based on the need for vulnerable children and
129.32 adult services as follows:

129.33 (i) 70 percent shall be allocated to counties based on the county's average three-year
129.34 count of vulnerable children that are subject of family assessments or subjects of accepted
129.35 reports under sections 626.556 and 626.5561 per 1,000 county child population as
129.36 determined by the most recent data of the commissioner; and

130.1 (ii) 30 percent shall be allocated to counties based on the county's average three-year
 130.2 count of vulnerable adults that are subjects of reports accepted for county investigation or
 130.3 emergency protective services under section 626.557 per 1,000 county adult population
 130.4 determined by the most recent data of the commissioner.

130.5 Sec. 5. Minnesota Statutes 2010, section 462A.29, is amended to read:

130.6 **462A.29 INTERAGENCY COORDINATION ON HOMELESSNESS.**

130.7 (a) The agency shall coordinate services and activities of all state agencies relating
 130.8 to homelessness. The agency shall coordinate an investigation and review of the current
 130.9 system of service delivery to the homeless. The agency may request assistance from other
 130.10 agencies of state government as needed for the execution of the responsibilities under this
 130.11 section and the other agencies shall furnish the assistance upon request.

130.12 (b) The Interagency Council on Homelessness established to assist with the
 130.13 execution of the duties of this section shall give priority to improving the coordination
 130.14 of services and activities that reduce the number of children and military veterans who
 130.15 experience homelessness and improve the economic, health, social, and education
 130.16 outcomes for children and military veterans who experience homelessness.

130.17 Sec. 6. Minnesota Statutes 2010, section 518A.40, subdivision 4, is amended to read:

130.18 Subd. 4. **Change in child care.** (a) When a court order provides for child care
 130.19 expenses, and child care support is not assigned under section 256.741, the public
 130.20 authority, if the public authority provides child support enforcement services, ~~must~~ may
 130.21 suspend collecting the amount allocated for child care expenses when:

130.22 ~~(1)~~ either party informs the public authority that no child care costs are being
 130.23 incurred; and;

130.24 ~~(2)~~ (1) the public authority verifies the accuracy of the information with the obligee;
 130.25 or

130.26 (2) the obligee fails to respond within 30 days of the date of a written request
 130.27 from the public authority for information regarding child care costs. A written or oral
 130.28 response from the obligee that child care costs are being incurred is sufficient for the
 130.29 public authority to continue collecting child care expenses.

130.30 The suspension is effective as of the first day of the month following the date that the
 130.31 public authority ~~received the verification~~ either verified the information with the obligee
 130.32 or the obligee failed to respond. The public authority will resume collecting child care
 130.33 expenses when either party provides information that child care costs ~~have resumed~~ are
 130.34 incurred, or when a child care support assignment takes effect under section 256.741,

131.1 subdivision 4. The resumption is effective as of the first day of the month after the date
131.2 that the public authority received the information.

131.3 (b) If the parties provide conflicting information to the public authority regarding
131.4 whether child care expenses are being incurred, ~~or if the public authority is unable to~~
131.5 ~~verify with the obligee that no child care costs are being incurred,~~ the public authority will
131.6 continue or resume collecting child care expenses. Either party, by motion to the court,
131.7 may challenge the suspension, continuation, or resumption of the collection of child care
131.8 expenses under this subdivision. If the public authority suspends collection activities
131.9 for the amount allocated for child care expenses, all other provisions of the court order
131.10 remain in effect.

131.11 (c) In cases where there is a substantial increase or decrease in child care expenses,
131.12 the parties may modify the order under section 518A.39.

131.13 Sec. 7. Laws 2011, First Special Session chapter 9, article 9, section 18, is amended to
131.14 read:

131.15 Sec. 18. **WHITE EARTH BAND OF OJIBWE HUMAN SERVICES**
131.16 **PROJECT.**

131.17 (a) The commissioner of human services, in consultation with the White Earth Band
131.18 of Ojibwe, shall transfer legal responsibility to the tribe for providing human services to
131.19 tribal members and their families who reside on or off the reservation in Mahnomen
131.20 County. The transfer shall include:

131.21 (1) financing, including federal and state funds, grants, and foundation funds; and

131.22 (2) services to eligible tribal members and families defined as it applies to state
131.23 programs being transferred to the tribe.

131.24 (b) The determination as to which programs will be transferred to the tribe and
131.25 the timing of the transfer of the programs shall be made by a consensus decision of the
131.26 governing body of the tribe and the commissioner. The commissioner shall waive existing
131.27 rules and seek all federal approvals and waivers as needed to carry out the transfer.

131.28 (c) When the commissioner approves transfer of programs and the tribe assumes
131.29 responsibility under this section, Mahnomen County is relieved of responsibility for
131.30 providing program services to tribal members and their families who live on or off the
131.31 reservation while the tribal project is in effect and funded, except that a family member
131.32 who is not a White Earth member may choose to receive services through the tribe or the
131.33 county. The commissioner shall have authority to redirect funds provided to Mahnomen
131.34 County for these services, including administrative expenses, to the White Earth Band
131.35 of Ojibwe Indians.

132.1 (d) Upon the successful transfer of legal responsibility for providing human services
132.2 for tribal members and their families who reside on and off the reservation in Mahnomen
132.3 County, the commissioner and the White Earth Band of Ojibwe shall develop a plan to
132.4 transfer legal responsibility for providing human services for tribal members and their
132.5 families who reside on or off reservation in Clearwater and Becker Counties.

132.6 (e) No later than January 15, 2012, the commissioner shall submit a written
132.7 report detailing the transfer progress to the chairs and ranking minority members of the
132.8 legislative committees with jurisdiction over health and human services. If legislation is
132.9 needed to fully complete the transfer of legal responsibility for providing human services,
132.10 the commissioner shall submit proposed legislation along with the written report.

132.11 (f) Upon receipt of 100 percent match for health care costs from the Indian Health
132.12 Service, the first \$500,000 of savings to the state in tribal health care costs shall be
132.13 distributed to the White Earth Band of Ojibwe to offset the band's cost of implementing
132.14 the human services project. The remainder of the state savings shall be distributed to the
132.15 White Earth Band of Ojibwe to supplement services to off-reservation tribal members.

132.16 Sec. 8. **FOSTER CARE FOR INDIVIDUALS WITH AUTISM.**

132.17 The commissioner of human services shall identify and coordinate with one or more
132.18 counties that agree to issue a foster care license and authorize funding for people with
132.19 autism who are currently receiving home and community-based services under Minnesota
132.20 Statutes, section 256B.092 or 256B.49. Children eligible under this section must be in an
132.21 out-of-home placement approved by the lead agency that has legal responsibility for the
132.22 placement. Nothing in this section must be construed as restricting an individual's choice
132.23 of provider. The commissioner will assist the interested county or counties with obtaining
132.24 necessary capacity within the moratorium under Minnesota Statutes, section 245A.03,
132.25 subdivision 7. The commissioner shall coordinate with the interested counties and issue a
132.26 request for information to identify providers who have the training and skills to meet the
132.27 needs of the individuals identified in this section.

132.28 Sec. 9. **DIRECTION TO COMMISSIONER.**

132.29 The commissioner shall develop an optional certification for providers of home
132.30 and community-based services waivers under Minnesota Statutes, section 256B.092
132.31 or 256B.49, that demonstrates competency in working with individuals with autism.
132.32 Recommended language and an implementation plan will be provided to the chairs and
132.33 ranking minority members of the legislative committees with jurisdiction over health and

133.1 human services policy and finance by February 15, 2013, as part of the Quality Outcome
133.2 Standards required under Laws 2010, chapter 352, article 1, section 24.

133.3 **Sec. 10. CHEMICAL HEALTH NAVIGATOR PROGRAM.**

133.4 (a) The commissioner of human services, in partnership with the counties, tribes,
133.5 and stakeholders, shall develop a community-based integrated model of care to improve
133.6 the effectiveness and efficiency of the service continuum for chemically dependent
133.7 individuals. The plan shall identify methods to reduce duplication of efforts, promote
133.8 scientifically supported practices, and improve efficiency. This plan shall consider the
133.9 potential for geographically or demographically disparate impact on individuals who need
133.10 chemical dependency services.

133.11 (b) The commissioner shall provide the chairs and ranking minority members of the
133.12 legislative committees with jurisdiction over health and human services a report detailing
133.13 necessary statutory and rule changes and a proposed pilot project to implement the plan no
133.14 later than March 15, 2013.

133.15 **Sec. 11. BIENNIAL BUDGET REQUEST; UNIVERSITY OF MINNESOTA.**

133.16 Beginning in 2013, as part of the biennial budget request submitted to the Office
133.17 of Management and Budget, the Board of Regents of the University of Minnesota must
133.18 include a request for funding for an investment in rural primary care training to be
133.19 delivered by family practice residence programs to prepare doctors for the practice of
133.20 primary care medicine in rural areas of the state. The funding request must provide for
133.21 ongoing support of rural primary care training through the University of Minnesota's
133.22 general operation and maintenance funding or through dedicated health science funding.

133.23 **Sec. 12. RELEASE OF MEDICAL ASSISTANCE LIEN.**

133.24 Notwithstanding Minnesota Statutes, section 514.981, the commissioner of human
133.25 services shall release and discharge the medical assistance lien in full, pursuant to
133.26 Minnesota Statutes, section 514.981, subdivision 5, for any person who:

133.27 (1) purchased a home in St. Louis County that was subject to a medical assistance
133.28 lien;

133.29 (2) hired Scenic Title and Abstract, Inc. in Duluth to handle the closing on the home;

133.30 (3) satisfied the purchase price of the home by securing a mortgage; and

133.31 (4) obtained a warranty deed for the home that was signed and notarized on

133.32 December 3, 2007, and recorded in St. Louis County on December 28, 2007.

ARTICLE 7

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. SUMMARY OF APPROPRIATIONS.

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	<u>2012</u>	<u>2013</u>	<u>Total</u>
<u>General</u>	\$ <u>301,000</u> \$	<u>(301,000)</u> \$	<u>-0-</u>
<u>Federal TANF</u>	<u>-0-</u>	<u>3,996,000</u>	<u>3,996,000</u>
<u>State Government Special Revenue</u>	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>Total</u>	\$ <u>301,000</u> \$	<u>3,695,000</u> \$	<u>3,996,000</u>

Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2012, are effective the day following final enactment unless a different effective date is explicit.

APPROPRIATIONS
Available for the Year
Ending June 30
2012 **2013**

Sec. 3. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation \$ 301,000 \$ 3,484,000

Appropriations by Fund

	<u>2012</u>	<u>2013</u>
<u>General</u>	<u>301,000</u>	<u>(512,000)</u>
<u>Federal TANF</u>	<u>-0-</u>	<u>3,996,000</u>

Subd. 2. Central Office Operations

135.1	<u>Appropriations by Fund</u>		
135.2	<u>General</u>	<u>-0-</u>	<u>1,049,000</u>
135.3	<u>Federal TANF</u>	<u>-0-</u>	<u>81,000</u>

135.4 **Return On Taxpayer Investment**

135.5 **Implementation Study.** \$64,000 is
 135.6 appropriated in fiscal year 2013 from the
 135.7 general fund to the commissioner of human
 135.8 services for a grant to the commissioner
 135.9 of management and budget to develop
 135.10 recommendations for implementing a
 135.11 return on taxpayer investment (ROTI)
 135.12 methodology and practice related to
 135.13 human services and corrections programs
 135.14 administered and funded by state and county
 135.15 government. The scope of the study shall
 135.16 include assessments of ROTI initiatives
 135.17 in other states, design implications for
 135.18 Minnesota, and identification of one or
 135.19 more Minnesota institutions of higher
 135.20 education capable of providing rigorous
 135.21 and consistent nonpartisan institutional
 135.22 support for ROTI. The commissioner
 135.23 shall consult with representatives of other
 135.24 state agencies, counties, legislative staff,
 135.25 Minnesota institutions of higher education,
 135.26 and other stakeholders in developing
 135.27 recommendations. The commissioner shall
 135.28 report findings and recommendations to the
 135.29 governor and legislature by November 30,
 135.30 2012. This appropriation is added to the base.

135.31 **Minnesota Specialty Health Services -**
 135.32 **Willmar.** \$549,000 in fiscal year 2012
 135.33 and \$2,713,000 in fiscal year 2013 is
 135.34 appropriated from the account established
 135.35 under Minnesota Statutes, section 246.18,
 135.36 subdivision 8, for continued operation of

136.1 the Minnesota Specialty Health Services -
 136.2 Willmar. These appropriations are onetime.
 136.3 Closure of the facility shall not occur prior
 136.4 to June 30, 2013.

136.5 **Subd. 3. Forecasted Programs**

136.6	<u>Appropriations by Fund</u>		
136.7	<u>General</u>	<u>301,000</u>	<u>(1,821,000)</u>
136.8	<u>Federal TANF</u>	<u>-0-</u>	<u>-0-</u>

136.9 **(a) Group Residential Housing Grants**

136.10 **Managing Residential Settings. If**
 136.11 the commissioner's efforts to implement
 136.12 Minnesota Statutes, section 256B.492, results
 136.13 in general fund savings as compared to base
 136.14 level costs in the February 2012 Department
 136.15 of Management and Budget forecast of
 136.16 revenues and expenditures, the savings
 136.17 shall be applied to reduce the reductions
 136.18 to congregate care rates for low-needs
 136.19 individuals specified in Laws 2011, First
 136.20 Special Session chapter 9, effective July 1,
 136.21 2013.

136.22 **(b) Medical Assistance Grants**

136.23 **PCA Relative Care Payment Recovery.**
 136.24 Notwithstanding any law to the contrary, and
 136.25 if, at the conclusion of the HealthStar Home
 136.26 Health, Inc et al v. Commissioner of Human
 136.27 Services litigation, the PCA relative rate
 136.28 reduction under Minnesota Statutes, section
 136.29 256B.0659, subdivision 11, paragraph (c),
 136.30 is upheld, the commissioner is prohibited
 136.31 from recovering the difference between the
 136.32 100 percent rate paid to providers and the
 136.33 80 percent rate, during the period of the
 136.34 temporary injunction issued on October 26,
 136.35 2011. This section does not prohibit the

137.1 commissioner from recovering any other
137.2 overpayments from providers.

137.3 **Long-Term Care Realignment Waiver**
137.4 **Conformity.** Notwithstanding Minnesota
137.5 Statutes, section 256B.0916, subdivision 14,
137.6 and upon federal approval of the long-term
137.7 care realignment waiver application,
137.8 essential community support grants must be
137.9 made available in a manner that is consistent
137.10 with the state's long-term care realignment
137.11 waiver application submitted on February
137.12 13, 2012. The commissioner is authorized
137.13 to use increased federal matching funds
137.14 resulting from approval of the long-term care
137.15 realignment waiver as necessary to meet
137.16 the fiscal year 2013 demand for essential
137.17 community support grants administered in a
137.18 manner that is consistent with the terms and
137.19 conditions of the long-term care realignment
137.20 waiver, and that amount of federal funds is
137.21 appropriated to the commissioner for this
137.22 purpose.

137.23 **Managing Corporate Foster Care.** The
137.24 commissioner of human services shall
137.25 manage foster care beds under Minnesota
137.26 Statutes, section 245A.03, subdivision 7,
137.27 in order to reduce costs by \$4,149,000 in
137.28 fiscal year 2013 as compared to base level
137.29 costs in the February 2012 Department of
137.30 Management and Budget forecast of revenues
137.31 and expenditures. If the department's efforts
137.32 to implement this provision results in savings
137.33 greater than \$4,149,000 in fiscal year 2014,
137.34 the additional savings shall be applied to
137.35 reduce the reductions to congregate care
137.36 rates for low-needs individuals specified in

138.1 Laws 2011, First Special Session chapter 9,
138.2 effective July 1, 2013.

138.3 **Continuing Care Provider Payment**

138.4 **Delay.** The commissioner of human services
138.5 shall delay the last payment or payments
138.6 in fiscal year 2013 to providers listed in
138.7 Minnesota Statutes 2011 Supplement,
138.8 section 256B.5012, subdivision 13, and
138.9 Laws 2011, First Special Session chapter
138.10 9, article 7, section 54, paragraph (b),
138.11 by up to \$22,854,000. In calculating the
138.12 actual payment amounts to be delayed, the
138.13 commissioner must reduce the \$22,854,000
138.14 figure by any cash basis state share
138.15 savings to be realized in fiscal year 2013
138.16 from implementing the long-term care
138.17 realignment waiver before July 1, 2013.

138.18 The commissioner shall make the delayed
138.19 payments in July 2013. Notwithstanding
138.20 any contrary provision in this article, this
138.21 provision expires on August 1, 2013.

138.22 **Contingent Managed Care Provider**

138.23 **Payment Increases.** Any money received
138.24 by the state as a result of the cap on
138.25 earnings in the 2011 contract or 2011
138.26 contract amendments for services provided
138.27 under Minnesota Statutes, sections
138.28 256B.69 and 256L.12, shall be used to
138.29 retroactively increase medical assistance
138.30 and MinnesotaCare capitation payments to
138.31 managed care plans for calendar year 2011.
138.32 The commissioner of human services shall
138.33 require managed care plans to use the entire
138.34 amount of any increase in capitation rates
138.35 provided under this provision to retroactively
138.36 increase calendar year 2011 payment rates for

139.1 health care providers employed by or under
 139.2 contract with the plan, including nursing
 139.3 facilities that provide services to emergency
 139.4 medical assistance recipients, but excluding
 139.5 payments to hospitals and other institutional
 139.6 providers for facility, administrative, and
 139.7 other operating costs not related to direct
 139.8 patient care. Increased payments must be
 139.9 distributed in proportion to each provider's
 139.10 share of total plan payments received for
 139.11 services provided to medical assistance and
 139.12 MinnesotaCare enrollees. Any increase in
 139.13 provider payment rates under this provision
 139.14 is onetime and shall not increase base
 139.15 provider payment rates.

139.16 **Subd. 4. Grant Programs**

139.17	<u>Appropriations by Fund</u>		
139.18	<u>General</u>	<u>-0-</u>	<u>260,000</u>
139.19	<u>Federal TANF</u>	<u>-0-</u>	<u>2,900,000</u>

139.20 **(a) Support Services Grants**

139.21 **Northern Connections. \$300,000 is**
 139.22 **appropriated from the TANF fund in fiscal**
 139.23 **year 2013 to the commissioner of human**
 139.24 **services for a grant to Northern Connections**
 139.25 **in Perham for a workforce program that**
 139.26 **provides one-stop supportive services**
 139.27 **to individuals as they transition into the**
 139.28 **workforce. This appropriation must be used**
 139.29 **for families with incomes below 200 percent**
 139.30 **of the federal poverty guidelines and with**
 139.31 **minor children in the household. This is a**
 139.32 **onetime appropriation and is available until**
 139.33 **expended.**

139.34 **(b) Children and Economic Support Grants**

140.1 **Long-Term Homeless Supportive Services.**

140.2 \$500,000 is appropriated in fiscal year 2013
140.3 from the TANF fund for long-term homeless
140.4 supportive services for low-income families
140.5 under Minnesota Statutes, section 256K.26.

140.6 This is a onetime appropriation and is not
140.7 added to the base.

140.8 **Healthy Community Initiatives. \$300,000**

140.9 in fiscal year 2013 is appropriated from the
140.10 TANF fund to the commissioner of human
140.11 services for contracting with the Search
140.12 Institute to promote healthy community
140.13 initiatives. The commissioner may expend
140.14 up to five percent of the appropriation
140.15 to provide for the program evaluation.

140.16 This appropriation must be used to serve
140.17 families with incomes below 200 percent
140.18 of the federal poverty guidelines and minor
140.19 children in the household. This is a onetime
140.20 appropriation and is available until expended.

140.21 **Circles of Support. \$400,000 in fiscal year**

140.22 2013 is appropriated from the TANF fund
140.23 to the commissioner of human services for
140.24 the purpose of providing grants to three
140.25 community action agencies for circles of
140.26 support initiatives. This appropriation must
140.27 be used to serve families with incomes below
140.28 200 percent of the federal poverty guidelines
140.29 and minor children in the household. This
140.30 is a onetime appropriation and is available
140.31 until expended.

140.32 **Transitional Housing Services. \$1,000,000**

140.33 is appropriated in fiscal year 2013 to the
140.34 commissioner of human services from the
140.35 TANF fund for transitional housing services,

141.1 including the provision of up to four months
141.2 of rental assistance under Minnesota Statutes,
141.3 section 256E.33. This appropriation must be
141.4 used for homeless families with children with
141.5 incomes below 115 percent of the federal
141.6 poverty guidelines, and must be coordinated
141.7 with family stabilization services under
141.8 Minnesota Statutes, section 256J.575.

141.9 **Community Action Agencies. \$250,000**
141.10 is appropriated in fiscal year 2013 from the
141.11 TANF fund for grants to community action
141.12 agencies under Minnesota Statutes, section
141.13 256E.30. This appropriation must be used
141.14 to serve families with income below 200
141.15 percent of the federal poverty guidelines and
141.16 minor children in the household. This is a
141.17 onetime appropriation and is available until
141.18 expended.

141.19 **MFIP Mentoring Pilot Program. \$150,000**
141.20 is appropriated to the commissioner of
141.21 human services from the TANF fund in
141.22 fiscal year 2013 for the purpose of providing
141.23 grants to help five local communities to
141.24 train and support volunteers mentoring
141.25 families receiving MFIP. Each pilot program
141.26 may receive a grant of up to \$30,000.
141.27 Organizations must apply for grant funds
141.28 according to the timelines and on the
141.29 forms prescribed by the commissioner.
141.30 Organizations receiving grant funding must
141.31 model their project on the circles of support
141.32 model. Projects must focus on reducing
141.33 parents' and their children's isolation and
141.34 supporting families in making connections
141.35 within their local communities.

- 142.1 **(c) Basic Sliding Fee Child Care Grants**
- 142.2 **TANF Transfer to Federal Child Care**
- 142.3 **and Development Fund.** (a) In addition
- 142.4 to the amount provided in this section, the
- 142.5 commissioner shall transfer TANF funds to
- 142.6 basic sliding fee child care assistance under
- 142.7 Minnesota Statutes, section 119B.03:
- 142.8 (1) fiscal year 2013, \$436,000; and
- 142.9 (2) fiscal year 2014 and ongoing, \$1,135,000.
- 142.10 (b) The commissioner shall authorize the
- 142.11 transfer of sufficient TANF funds to the
- 142.12 federal child care and development fund to
- 142.13 meet this appropriation and shall ensure that
- 142.14 all transferred funds are expended according
- 142.15 to federal child care and development fund
- 142.16 regulations.
- 142.17 **(d) Disabilities Grants**
- 142.18 **Living Skills Training for Persons**
- 142.19 **with Intractable Epilepsy.** \$65,000 is
- 142.20 appropriated in fiscal year 2013 from the
- 142.21 general fund to the commissioner of human
- 142.22 services for living skills training programs
- 142.23 for persons with intractable epilepsy
- 142.24 who need assistance in the transition to
- 142.25 independent living under Laws 1988, chapter
- 142.26 689, article 2, section 251. This is a onetime
- 142.27 appropriation and is available until expended.
- 142.28 **Self-advocacy Network for Persons with**
- 142.29 **Disabilities.**
- 142.30 (1) \$95,000 is appropriated from the general
- 142.31 fund in fiscal year 2013 to the commissioner
- 142.32 of human services to establish and maintain
- 142.33 a statewide self-advocacy network for
- 142.34 persons with intellectual and developmental

143.1 disabilities. This is a onetime appropriation
 143.2 and is available until expended.
 143.3 (2) The self-advocacy network must focus on
 143.4 ensuring that persons with disabilities are:
 143.5 (i) informed of and educated about their legal
 143.6 rights in the areas of education, employment,
 143.7 housing, transportation, and voting; and
 143.8 (ii) educated and trained to self-advocate for
 143.9 their rights under law.
 143.10 (3) Self-advocacy network activities under
 143.11 this section include but are not limited to:
 143.12 (i) education and training, including
 143.13 preemployment and workplace skills;
 143.14 (ii) establishment and maintenance of a
 143.15 communication and information exchange
 143.16 system for self-advocacy groups; and
 143.17 (iii) financial and technical assistance to
 143.18 self-advocacy groups.
 143.19 **Aliveness Project.** \$100,000 in fiscal year
 143.20 2013 is for a grant to the Aliveness Project,
 143.21 a statewide nonprofit, for providing the
 143.22 health and wellness services it has provided
 143.23 to individuals throughout Minnesota since
 143.24 its inception in 1985. The activities and
 143.25 proposed outcomes supported by this
 143.26 onetime appropriation must further the
 143.27 comprehensive plan of the Department of
 143.28 Human Services, HIV/AIDS program. This
 143.29 is a onetime appropriation and is available
 143.30 until expended.

143.31 **Sec. 4. COMMISSIONER OF HEALTH**

143.32 <u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>423,000</u>
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144.1	<u>Appropriations by Fund</u>		
144.2		<u>2012</u>	<u>2013</u>
144.3	<u>General</u>	<u>-0-</u>	<u>-0-</u>

144.4 **Subd. 2. Community and Family Health**
 144.5 **Promotions**

144.6 **Autism Study.** \$200,000 is for the
 144.7 commissioner of health, in partnership with
 144.8 the University of Minnesota, to conduct a
 144.9 qualitative study focused on cultural and
 144.10 resource-based aspects of autism spectrum
 144.11 disorders (ASD) that are unique to the
 144.12 Somali community. By February 15,
 144.13 2014, the commissioner shall report the
 144.14 findings of this study to the legislature. The
 144.15 report must include recommendations as to
 144.16 establishment of a population-based public
 144.17 health surveillance system for ASD. This
 144.18 appropriation is available until June 30, 2014.

144.19 **Subd. 3. Policy Quality and Compliance**

144.20	<u>Appropriations by Fund</u>		
144.21	<u>General</u>	<u>-0-</u>	<u>-0-</u>

144.22 **Web Site Changes.** \$36,000 from the
 144.23 general fund is for Web site changes required
 144.24 in article 2, section 17. This is a onetime
 144.25 appropriation and must be shared with the
 144.26 Department of Human Services through an
 144.27 interagency agreement.

144.28 **Management and Budget.** \$100,000 from
 144.29 the general fund is for the commissioner to
 144.30 transfer to the commissioner of management
 144.31 and budget for the evaluation and report
 144.32 required in article 2, section 17. This is a
 144.33 onetime appropriation.

144.34 **For-Profit HMO Study.** \$79,000 is for
 144.35 a study of for-profit health maintenance

145.1 organizations. This is onetime and available
145.2 until expended.

145.3 **Nursing Facility Moratorium Exceptions.**

145.4 (a) Beginning in fiscal year 2013, the
145.5 commissioner of health may approve
145.6 moratorium exception projects under
145.7 Minnesota Statutes, section 144A.073, for
145.8 which the full annualized state share of
145.9 medical assistance costs does not exceed
145.10 \$1,500,000.

145.11 (b) In fiscal year 2013, \$8,000 is for
145.12 administrative costs related to review of
145.13 moratorium exception projects.

145.14 Sec. 5. **EXPIRATION OF UNCODIFIED LANGUAGE.**

145.15 All uncodified language contained in this article expires on June 30, 2013, unless a
145.16 different expiration date is explicit.

145.17 Sec. 6. **EFFECTIVE DATE.**

145.18 The provisions in this article are effective July 1, 2012, unless a different effective
145.19 date is explicit.

APPENDIX
Article locations in H2294-2

ARTICLE 1	HEALTH CARE	Page.Ln 2.2
ARTICLE 2	DEPARTMENT OF HEALTH	Page.Ln 19.3
ARTICLE 3	CHILDREN AND FAMILY SERVICES	Page.Ln 37.23
ARTICLE 4	CONTINUING CARE	Page.Ln 61.5
	MINNESOTA CHILDREN AND FAMILY INVESTMENT	
ARTICLE 5	PROGRAM	Page.Ln 118.5
ARTICLE 6	MISCELLANEOUS	Page.Ln 123.4
ARTICLE 7	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 134.1