

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including assessment and support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary institutional admissions. Long-term consultation services must be available to any person regardless of public program eligibility. The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with long-term care options counseling provided under subdivision 4d, section 256.975, subdivisions 7 to 7c, and section 256.01, subdivision 24. The lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

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

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; and

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this sub-

division, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for state plan home care services identified in:

(i) section 256B.0625, subdivisions 7, 19a, and 19c;

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, determination of eligibility for case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, determination of eligibility for family support grants under section 252.32, semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

Subd. 2. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 2a. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 2b. **MnCHOICES certified assessors.** (a) Each lead agency shall use certified assessors who have completed MnCHOICES training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principals and have a common set of skills that must ensure consistency and equitable access to services statewide. A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(b) MnCHOICES certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse with at least two years of home and community-

based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

Subd. 2c. **Assessor training and certification.** The commissioner shall develop and implement a curriculum and an assessor certification process. All existing lead agency staff designated to provide the services defined in subdivision 1a must be certified within timelines specified by the commissioner, but no sooner than six months after statewide availability of the training and certification process. The commissioner must establish the timelines for training and certification in a manner that allows lead agencies to most efficiently adopt the automated process established in subdivision 5. Each lead agency is required to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service. Certified assessors are required to be recertified every three years.

Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation team shall be established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 2b, paragraph (b). Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs. The team of certified assessors must include, at a minimum:

- (1) a social worker; and
- (2) a public health nurse or registered nurse.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

- (1) a summary of assessed needs as defined in paragraphs (c) and (d);
- (2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;
- (3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;
- (4) referral information; and
- (5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

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

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

Subd. 3b. Transition assistance. (a) Lead agency certified assessors shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under

section 256.975, subdivision 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living, Disability Linkage Line, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about transition assistance that is available;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

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

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

(1) the consultation shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:

(i) the resident verbally requests; or

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

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

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

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

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

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

(1) inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for consultation services under this subdivision;

(2) receive a copy of the verification of counseling prior to executing a lease or service contract with the prospective resident, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements; and

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

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

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

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

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

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

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

Subd. 3e. **Consultation at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under section 256.975, subdivision 7. The purpose of the counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive setting.

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

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

Subd. 4. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 4a. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4b. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4c. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 40 calendar days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 40 calendar days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Linkage Line for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (dd).

Subd. 4e. **Determination of institutional level of care.** The determination of the need for nursing facility, hospital, and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective January 1, 2014, for individuals age 21 and older, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner until criteria in section 144.0724, subdivision 11, becomes effective on or after October 1, 2019.

Subd. 5. **Administrative activity.** The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30, 2013, payment for long-term care consultation face-to-face assessment shall be made as described in this subdivision.

(b) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431, 256B.434, or 256B.441.

(d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph (b). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(e) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(f) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(g) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(h) Until the alternative payment methodology in paragraph (i) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(i) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program.

Subd. 6a. [Repealed, 2015 c 78 art 6 s 32]

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under section 256.975, subdivisions 7a to 7c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

Subd. 8. [Repealed, 2001 c 161 s 58]

Subd. 9. [Repealed, 1Sp2001 c 9 art 4 s 34]

History: 1991 c 292 art 7 s 14; 1992 c 513 art 7 s 53-55; 1Sp1993 c 1 art 5 s 56-61,135; 1995 c 207 art 6 s 57-61; 1997 c 203 art 4 s 34; art 9 s 10; 1997 c 225 art 8 s 6; 1998 c 407 art 4 s 33-35; 1999 c 245 art 3 s 12; 1Sp2001 c 9 art 3 s 42; art 4 s 4-14; 2002 c 277 s 32; 2002 c 375 art 2 s 18,19; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 56; art 3 s 29; 2004 c 288 art 5 s 4; 2005 c 56 s 1; 2005 c 98 art 2 s 5; 1Sp2005 c 4 art 8 s 45; 2007 c 147 art 6 s 23-28; art 7 s 13,14; 2009 c 79 art 8 s 32-43; 2009 c 173 art 1 s 28; 2010 c 352 art 1 s 16-20; 1Sp2010 c 1 art 24 s 5; 1Sp2011 c 9 art 7 s 12-15; 2012 c 216 art 11 s 6-15; 2012 c 247 art 4 s 20-23; 2012 c 253 art 3 s 1; 2013 c 63 s 10; 2013 c 108 art 2 s 17-23,44,45; art 15 s 3,4; 2014 c 262 art 5 s 6; 2014 c 275 art 1 s 59; 2014 c 291 art 9 s 5; 2015 c 78 art 6 s 10-13,31