A bill for an act

relating to state government; establishing the health and human services budget; making changes to children and family services, Department of Health, miscellaneous provisions, health licensing fees, health care, and continuing care; redesigning service delivery; making changes to chemical and mental health; modifying fee schedules; modifying program eligibility requirements; authorizing rulemaking; requiring reports; appropriating money for the Departments of Health and Human Services and other health-related boards and councils; making forecast adjustments; amending Minnesota Statutes 2010, sections 3.98, by adding a subdivision; 62D.08, subdivision 7; 62E.08, subdivision 1; 62E.14, by adding a subdivision; 62J.04, subdivisions 3, 9; 62J.17, subdivision 4a; 62J.495, by adding a subdivision; 62J.497, by adding a subdivision; 62J.692; 62Q.32; 62U.04, subdivisions 3, 9; 62U.06, subdivision 2; 119B.011, subdivision 13; 119B.035, subdivisions 1, 4; 119B.09, subdivision 10, by adding subdivisions; 119B.13, subdivisions 1, 1a, 7; 144.05, by adding a subdivision; 144.1499; 144.1501, subdivisions 1, 4; 144.98, subdivisions 2a, 7, by adding subdivisions; 144A.102; 144A.61, by adding a subdivision; 144E.123; 145.928, subdivision 2; 145.986, by adding subdivisions; 145A.17, subdivision 3; 148.07, subdivision 1; 148.108, by adding a subdivision; 148.191, subdivision 2; 148.212, subdivision 1; 148.231; 148B.17; 148B.33, subdivision 2; 148B.52; 150A.091, subdivisions 2, 3, 4, 5, 8, by adding a subdivision; 151.07; 151.101; 151.102, by adding a subdivision; 151.12; 151.13, subdivision 1; 151.19; 151.25; 151.47, subdivision 1; 151.48; 152.12, subdivision 3; 157.15, by adding a subdivision; 245.50; 245A.14, subdivision 4; 246B.10; 252.025, subdivision 7; 252.27, subdivision 2a; 253B.212; 254B.03, subdivisions 1, 4; 254B.04, subdivision 1, by adding a subdivision; 254B.06, subdivision 2; 256.01, subdivisions 14b, 24, 29, by adding subdivisions; 256.045, subdivision 4a; 256.969, subdivision 2b, by adding a subdivision; 256B.04, subdivision 18; 256B.05, by adding a subdivision; 256B.055, subdivision 15; 256B.056, subdivisions 3, 4, by adding a subdivision; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8e, 13e, 13h, 17, 17a, 18, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.0644; 256B.0657; 256B.0659, subdivisions 11, 28; 256B.0751, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0753, by adding a subdivision; 256B.0754, by adding a subdivision; 256B.0755, subdivision 4, by adding subdivisions; 256B.0756; 256B.0911, subdivisions 1a, 3a, 4a, 6; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 5, 10; 256B.0916, subdivision 6a; 256B.092, subdivisions 1a, 1b, 1e, 1g, 3, 8; 256B.0945, subdivision 4; 256B.14, by adding a subdivision; 256B.19, by adding a subdivision; 256B.37, subdivision 5;

256B.431, subdivision 2r, by adding a subdivision; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.441, by adding a subdivision; 256B.48, subdivision 1; 256B.49, subdivisions 12, 13, 14, 15; 256B.5012, by adding subdivisions; 256B.69, subdivisions 3a, 4, 5a, 5c, 6, by adding subdivisions; 256B.692, subdivisions 2, 5, 7, by adding a subdivision; 256B.694; 256B.76, subdivision 4; 256D.03, subdivision 3; 256D.031, subdivisions 6, 7, 10; 256D.05, subdivision 1; 256D.06, subdivisions 1, 1b, 2; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.46, subdivision 1; 256D.49, subdivision 3; 256G.02, subdivision 6; 256I.03, by adding a subdivision; 256I.04, subdivision 2b; 256I.05, subdivisions 1a, 1e, by adding a subdivision; 256J.20, subdivision 3; 256J.38, subdivision 1; 256J.53, subdivision 2; 256L.01, subdivision 4a; 256L.02, subdivision 3; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivisions 2, 3a, 5, by adding a subdivision; 256L.07, subdivision 1; 256L.09, subdivision 4; 256L.11, subdivision 7; 256L.12, subdivision 9; 256L.15, subdivision 1a; 260C.157, subdivision 3; 260D.01; 297F.10, subdivision 1; 326B.175; 393.07, subdivisions 10, 10a; 402A.10, subdivisions 4, 5; 402A.15; 402A.18; 402A.20; 518A.51; Laws 2008, chapter 363, article 18, section 3, subdivision 5; Laws 2009, chapter 79, article 8, sections 4, as amended; 51, as amended; article 13, section 3, subdivision 8, as amended; Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6; article 25, section 3, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 62E; 62J; 62U; 137; 144; 145; 148; 151; 256; 256B; 256L; 326B; 402A; repealing Minnesota Statutes 2010, sections 62J.07, subdivisions 1, 2, 3; 62J.17, subdivisions 1, 3, 5a, 6a, 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 144.1464; 145A.14, subdivisions 1, 2; 256.01, subdivision 2b; 256.979, subdivisions 5, 6, 7, 10; 256.9791; 256.9862, subdivision 2; 256B.055, subdivision 15; 256B.057, subdivision 2c; 256D.46, subdivisions 2, 3; 256L.07, subdivision 7; 402A.30; 402A.45; Laws 2008, chapter 358, article 3, sections 8; 9; Laws 2009, chapter 79, article 3, section 18, as amended; article 5, sections 55, as amended; 56; 57; 60; 61; 62; 63; 64; 65; 66; 68; 69; 79; Minnesota Rules, parts 3400.0130, subpart 8; 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, 23; 4651.0110, subparts 2, 2a, 3, 4, 5; 4651.0120; 4651.0130; 4651.0140; 4651.0150; 9500.1243, subpart 3; 9500.1261, subparts 3, items D, E, 4, 5.

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

ARTICLE 1

CHILDREN AND FAMILY SERVICES

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

Subd. 13. **Family.** "Family" means parents, stepparents, guardians and their spouses, or other eligible relative caregivers and their spouses, and their blood related dependent children and adoptive siblings under the age of 18 years living in the same home including children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60

days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents, stepparents, guardians, and their spouses or eligible relative caregivers and their spouses residing in the same household.

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

Sec. 2. Minnesota Statutes 2010, section 119B.035, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, except as provided in subdivision 4, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, and up to available appropriations, the commissioner shall provide assistance under the at-home infant child care program and for administrative costs associated with the program. The commissioner shall set aside two percent of the basic sliding fee child care appropriation under section 119B.03, for purposes of this section. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Sec. 3. Minnesota Statutes 2010, section 119B.035, subdivision 4, is amended to read:

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to ~~90~~ 64 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

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

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2010, section 119B.09, subdivision 10, is amended to read:

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

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

Sec. 6. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

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

(e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care. The

maximum payment to a provider for one day of care must not exceed the daily rate. The maximum payment to a provider for one week of care must not exceed the weekly rate.

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

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

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

EFFECTIVE DATE. This section is effective September 3, 2012, except the amendments to paragraph (e) are effective April 16, 2012.

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

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

(b) The maximum rate paid to legal nonlicensed family child care providers must be ~~80~~ 64 percent of the county maximum hourly rate for licensed family child care providers. In counties where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by ~~0.80~~ 0.64. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

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

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

EFFECTIVE DATE. This section is effective April 16, 2012, except the amendment changing 80 to 64 and 0.80 to 0.64 is effective July 1, 2011.

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

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

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

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

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

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

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

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

Subdivision 1. **Electronic benefit transfer (EBT) card.** Beginning July 1, 2011, cash benefits for the general assistance and Minnesota supplemental aid programs under chapter 256D and programs under chapter 256J must be issued on a separate EBT card with the name of the head of household printed on the card. This card must be issued within 30 calendar days of an eligibility determination. During the initial 30 calendar days of eligibility, a recipient may have cash benefits issued on an EBT card without a name printed on the card. This card may be the same card on which food support benefits are issued and does not need to meet the requirements of this section.

Subd. 2. **EBT card use restricted to Minnesota vendors.** EBT cardholders receiving cash benefits under the general assistance and Minnesota supplemental aid programs under chapter 256D or programs under chapter 256J are prohibited from using their EBT cards at vendors located outside of Minnesota. This subdivision does not apply to food support benefits.

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

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

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than ~~30~~ 90 days and which prevents the person from obtaining or retaining employment;

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

~~(3)~~ (2) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative;

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

~~(5)~~ (4) a person not described in clause (1) or ~~(3)~~ (2) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining employment;

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

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

~~(8)~~ (5) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

~~(9)~~ (6) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to ~~be learning disabled~~ have a condition that qualifies under Minnesota's special education rules as a specific learning disability, provided that ~~if~~ a rehabilitation plan for the person is developed or approved by the county agency, and the person is following the plan;

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

~~(11)~~ (7) a person who is eligible for displaced homemaker services, programs, or assistance under section 116L.96, but only if that person is enrolled as a full-time student;

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

~~(13)~~ (8) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day; or

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

~~(15)~~ (9) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.

(b) As a condition of eligibility under paragraph (a), clauses (1), ~~(3)~~ (2), ~~(5)~~ (4), ~~(8)~~ (5), and ~~(9)~~ (6), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision

5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) As a condition of eligibility under this section, the recipient must complete at least 20 hours per month of volunteer or paid work. The county of residence shall determine what may be included as volunteer work. Recipients must provide monthly proof of volunteer work on the forms established by the county. A person who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity must not be made ineligible for general assistance under this section.

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

Sec. 12. Minnesota Statutes 2010, section 256D.06, subdivision 1, is amended to read:

Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be granted in an amount that when added to the nonexempt income actually available to the assistance unit, the total amount equals the applicable standard of assistance for general assistance. In determining eligibility for and the amount of assistance for an individual or married couple, the county agency shall disregard the first ~~$50~~ $150 of earned income per month.

Sec. 13. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

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

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

Sec. 14. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:

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

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

(c) Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal

years as determined by the commissioner, and may reallocate any unspent amounts to other counties. No county shall be allocated less than $1,000 for a fiscal year.

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

Sec. 15. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent

of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or

controlled by the recipient's service provider. In a multifamily building of more than four ~~or more~~ units, the maximum number of apartments at one address that may be used by recipients of this program shall be 50 percent of the units in a building. This paragraph expires on June 30, ~~2012~~ 2014.

Sec. 16. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

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

Sec. 17. Minnesota Statutes 2010, section 256I.03, is amended by adding a subdivision to read:

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

Sec. 18. Minnesota Statutes 2010, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Group residential housing agreements.** (a) Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to

the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections. Group residential housing agreements may be terminated with or without cause by either the county or the provider with two calendar months prior notice.

(b) Beginning July 1, 2011, counties must not enter into agreements with providers of group residential housing that are licensed as board and lodging with special services and that do not include a residency requirement of at least 20 hours per month of volunteer or paid work. A person who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity must not be made ineligible for group residential housing under this section.

Sec. 19. Minnesota Statutes 2010, section 256I.05, subdivision 1a, is amended to read:

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

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

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

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

(d) Beginning July 1, 2011, counties must not negotiate supplementary service rates with providers of group residential housing that are licensed as board and lodging with special services and that do not enforce a policy of sobriety on their premises.

Sec. 20. Minnesota Statutes 2010, section 256I.05, subdivision 1e, is amended to read:

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

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

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

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

(b) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2011, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for the group residential provider described under paragraph (a), not to exceed an additional 175 beds.

Sec. 21. Minnesota Statutes 2010, section 256I.05, is amended by adding a subdivision to read:

Subd. 1o. **Supplemental rate adjustment.** Notwithstanding any other provision to the contrary, board and lodging with services providers that receive a supplemental service rate in excess of the supplemental service rate established under subdivision 1, shall be reduced no more than $10.42 per bed per month.

Sec. 22. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2010, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the ~~plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation~~

~~rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35~~ participant must be working in unsubsidized employment at least 20 hours per week.

(b) Participants seeking approval of a postsecondary education or training plan must provide documentation that:

(1) the employment goal can only be met with the additional education or training;

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

(c) The hourly unsubsidized employment requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

Sec. 24. Minnesota Statutes 2010, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under ~~this subdivision~~ section 245.487, subdivision 3, and chapters 260C and 260D. Screenings shall be conducted within 15 days of a request for a screening. The team, which may be the team constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability~~. The team shall involve parents or guardians in the screening process as appropriate~~, and the child's parent, guardian, or permanent legal custodian under section 260C.201, subdivision 11. The team may be the same team as defined in section 260B.157, subdivision 3.

(b) The social services agency shall determine whether a child brought to its attention for the purposes described in this section is an Indian child, as defined in section 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child, the team provided in paragraph (a) shall include a designated representative of the Indian child's tribe, unless the child's tribal authority declines to appoint a representative. The

Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12.

(c) If the court, prior to, or as part of, a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a postdispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall ascertain whether the child is an Indian child and shall notify the county welfare agency and, if the child is an Indian child, shall notify the Indian child's tribe. The county's juvenile treatment screening team must either: (i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or (ii) elect not to screen a given case and notify the court of that decision within three working days.

(d) ~~If the screening team has elected to screen and evaluate the child,~~ The child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

(e) When the county's juvenile treatment screening team has elected to screen and evaluate a child determined to be an Indian child, the team shall provide notice to the tribe or tribes that accept jurisdiction for the Indian child or that recognize the child as a

member of the tribe or as a person eligible for membership in the tribe, and permit the tribe's representative to participate in the screening team.

(f) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

Sec. 25. Minnesota Statutes 2010, section 260D.01, is amended to read:

260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

(a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for treatment" provisions of the Juvenile Court Act.

(b) The juvenile court has original and exclusive jurisdiction over a child in voluntary foster care for treatment upon the filing of a report or petition required under this chapter. All obligations of the agency to a child and family in foster care contained in chapter 260C not inconsistent with this chapter are also obligations of the agency with regard to a child in foster care for treatment under this chapter.

(c) This chapter shall be construed consistently with the mission of the children's mental health service system as set out in section 245.487, subdivision 3, and the duties of an agency under section 256B.092, 260C.157, and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the needs of a child with a developmental disability or related condition. This chapter:

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in foster care to receive necessary treatment for an emotional disturbance or developmental disability or related condition;

(2) establishes court review requirements for a child in voluntary foster care for treatment due to emotional disturbance or developmental disability or a related condition;

(3) establishes the ongoing responsibility of the parent as legal custodian to visit the child, to plan together with the agency for the child's treatment needs, to be available and accessible to the agency to make treatment decisions, and to obtain necessary medical, dental, and other care for the child; and

(4) applies to voluntary foster care when the child's parent and the agency agree that the child's treatment needs require foster care either:

(i) due to a level of care determination by the agency's screening team informed by the diagnostic and functional assessment under section 245.4885; or

(ii) due to a determination regarding the level of services needed by the responsible social services' screening team under section 256B.092, and Minnesota Rules, parts 9525.0004 to 9525.0016.

(d) This chapter does not apply when there is a current determination under section 626.556 that the child requires child protective services or when the child is in foster care for any reason other than treatment for the child's emotional disturbance or developmental disability or related condition. When there is a determination under section 626.556 that the child requires child protective services based on an assessment that there are safety and risk issues for the child that have not been mitigated through the parent's engagement in services or otherwise, or when the child is in foster care for any reason other than the child's emotional disturbance or developmental disability or related condition, the provisions of chapter 260C apply.

(e) The paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of this chapter is:

(1) to ensure a child with a disability is provided the services necessary to treat or ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires it and the child cannot be maintained in the home of the parent; and

(3) to ensure the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, where necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs; and

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply. This chapter shall be construed consistently with the requirements of the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et al., and the provisions of the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 26. Minnesota Statutes 2010, section 393.07, subdivision 10a, is amended to read:

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

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

~~(1) a manual Authorization to Participate (ATP) card; or~~

~~(2)~~ the ~~immediate~~ issuance of food stamp ~~coupons~~ benefits.

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

Sec. 27. Minnesota Statutes 2010, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

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

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

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

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

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

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

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

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

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

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

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

(i) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e). A portion of the nonfederal share of these fees may be retained for expenditures necessary to administer the fees and must be transferred to the child support system special revenue account. ~~The remaining nonfederal share of the federal collections fees and cost recovery fees must be retained by the commissioner and dedicated to the child support general fund county performance-based grant account authorized under sections 256.979 and 256.9791.~~ The commissioner shall distribute the remaining nonfederal share of these fees to the counties quarterly using the methodology specified in section 256.979, subdivision 11. The funds received by the counties must be reinvested in the child support enforcement program, and the counties shall not reduce the funding of their child support programs by the amount of funding distributed.

Sec. 28. **GRANT PROGRAM TO PROMOTE HEALTHY COMMUNITY INITIATIVES.**

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

(b) Specifically, the Search Institute must use a competitive grant process to select four interested communities throughout Minnesota to undertake strong community

mobilization initiatives to support communities wishing to catalyze multiple sectors to create or strengthen a community collaboration to address issues of poverty in their communities. The Search Institute must provide the selected communities with the tools, training, and resources they need for successfully implementing initiatives focused on strengthening the community. The Search Institute also must use a competitive grant process to provide four strong community innovation grants to encourage current community initiatives to bring new innovation approaches to their work to reduce poverty. Finally, the Search Institute must work to strengthen networking and information sharing activities among all healthy community initiatives throughout Minnesota, including sharing best program practices and providing personal and electronic opportunities for peer learning and ongoing program support.

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

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

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

Sec. 29. **CIRCLES OF SUPPORT GRANTS.**

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

Specifically, circles of support initiatives must focus on increasing social capital, income, educational attainment, and individual accountability, while reducing debt, service dependency, and addressing systemic disparities that hold poverty in place. The effort must support the development of local guiding coalitions as the link between the community and circles of support for resource development and funding leverage.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 30. **PILOT PROJECT FOR HOMELESS ADULTS TO BE IN-HOME CARETAKERS OF FORECLOSED HOMES.**

(a) Stepping Stone Emergency Housing may form a partnership with local banks who own foreclosed homes to:

(1) utilize foreclosed homes for graduates of Stepping Stone Emergency Housing to become in-home caretakers of those homes;

(2) provide the security needed by the homes' banking owners and others to help stabilize neighborhoods through carefully maintained homes that will prevent vandalism, squatters, and drug houses;

(3) provide transitional housing to up to four homeless clients per home after they graduate from emergency housing allowing the clients time to find permanent housing in a tight affordable housing market; and

(4) provide management of the project to ensure proper oversight for the homes' owners and support of the caretakers.

(b) This section expires June 30, 2013.

Sec. 31. **HOMELESS SHELTERS; SCHOOL DISTRICTS.**

School districts may coordinate with local units of government and homeless services providers to use empty school buildings as homeless shelters.

Sec. 32. **REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES, GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.**

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

Sec. 33. **MINNESOTA EBT BUSINESS TASK FORCE.**

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

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

(2) two members of the Minnesota senate, one appointed by the senate majority leader and one appointed by the senate minority leader;

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

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

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

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

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

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

Sec. 34. **STREAMLINING CHILDREN AND COMMUNITY SERVICES ACT REPORTING REQUIREMENTS.**

The commissioner of human services and county human services representatives, in consultation with other interested parties, shall develop a streamlined alternative to current reporting requirements related to the Children and Community Services Act service plan. The commissioner shall submit recommendations and draft legislation to the chairs and ranking minority members of the committees having jurisdiction over human services no later than November 15, 2012.

Sec. 35. **REPEALER.**

(a) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10; 256.9791; 256.9862, subdivision 2; and 256D.46, subdivisions 2 and 3, are repealed.

(b) Minnesota Rules, parts 3400.0130, subpart 8; and 9500.1261, subparts 3, items D and E, 4, and 5, are repealed effective September 3, 2012.

ARTICLE 2

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2010, section 62D.08, subdivision 7, is amended to read:

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. The definition of administrative expenses must be consistent with that of the National Association of Insurance Commissioners (NAIC) as provided in the most current NAIC blank. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

Sec. 2. Minnesota Statutes 2010, section 62J.04, subdivision 3, is amended to read:

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

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

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

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

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and

local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 3. Minnesota Statutes 2010, section 62J.17, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 4. Minnesota Statutes 2010, section 62J.495, is amended by adding a subdivision to read:

Subd. 7. **Exemption.** Any clinical practice with a total annual net revenue of less than $500,000, and that has not received a state or federal grant for implementation of electronic health records, is exempt from the requirements of subdivision 1. This subdivision expires December 31, 2020.

Sec. 5. Minnesota Statutes 2010, section 62J.497, is amended by adding a subdivision to read:

Subd. 6. **Additional standards for electronic prescribing.** By January 1, 2012, the commissioner of health, in consultation with the Minnesota e-Health Advisory Committee, must develop a method for incorporation of the following transactions into the requirements and standards for electronic prescribing provided in subdivisions 2 and 3:

(1) submission of requests for a formulary exception based on information required on the form developed according to subdivision 4; and

(2) submission of prior authorization requests based on information required on the form developed according to subdivision 5.

Sec. 6. Minnesota Statutes 2010, section 62J.692, is amended to read:

62J.692 MEDICAL EDUCATION.

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

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and

whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health in consultation with the Medical Education and Research Advisory Committee.

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

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

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

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

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

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

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, advanced dental therapists, chiropractors, or physician assistants is eligible for funds under subdivision 4 or 11, as appropriate, if the program:

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

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

(3) emphasizes primary care ~~or specialties that are in undersupply in Minnesota~~ in rural areas or for racial, ethnic, or cultural populations in the state experiencing health disparities.

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

(b) A clinical medical education program for advanced practice nursing, registered nurses, or licensed practical nurses is eligible for funds under subdivision 4 or 11, as appropriate, if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

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

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

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

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number or National Provider Identification number (NPI) of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

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

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

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

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

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

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

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

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

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

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

(b) ~~$5,350,000~~ $4,900,000 of the available medical education funds in fiscal year 2012 and $3,044,000 beginning in fiscal year 2013 shall be distributed to fund training designed to address health disparities as follows:

(1) ~~$1,475,000~~ $500,000 in fiscal year 2012 and $200,000 beginning in fiscal year 2013 to ~~the University of Minnesota Medical Center-Fairview~~ the White Earth Band of Ojibwe Indians according to section 145.9271;

(2) ~~$2,075,000~~ $600,000 in fiscal year 2012 and $200,000 beginning in fiscal year 2013 to the ~~University of Minnesota School of Dentistry~~ University of Minnesota according to section 137.395; ~~and~~

(3) $500,000 in fiscal year 2012 and $200,000 beginning in fiscal year 2013 shall be distributed to the community health centers development grants program according to section 145.987;

(4) $500,000 in fiscal year 2012 and $200,000 beginning in fiscal year 2013 shall be distributed to the community mental health centers grant program according to section 145.9272;

(5) $1,000,000 in fiscal year 2012 and $444,000 beginning in fiscal year 2013 shall be distributed to the health careers opportunities grant program according to section 144.1499; and

~~(3)~~ (6) $1,800,000 to the Academic Health Center. $150,000 of the funds distributed to the Academic Health Center under this paragraph shall be used for a program to assist internationally trained physicians who are legal residents and who commit to serving underserved Minnesota communities in a health professional shortage area to successfully compete for family medicine residency programs at the University of Minnesota.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) voluntary contributions by employers or other entities;

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

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

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

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

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

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

(4) ~~$1,121,640~~ $1,021,640 shall be distributed by the commissioner to clinical medical education dental innovation grants in accordance with subdivision 7a; ~~and~~

(5) $100,000 shall be distributed to the health careers opportunities grant program according to section 144.1499; and

(6) the remainder of the amount transferred according to section 256B.69, subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a), or subdivision 11, as appropriate.

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

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

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

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

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

~~(5)~~ (3) the priority level of the project in relation to ~~state clinical education, access, and~~ health disparity workforce goals.

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

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

The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a), or 11, as appropriate.

Subd. 9. **Review of eligible providers.** The commissioner and the Medical Education and Research Costs Advisory Committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. ~~The results of any such reviews must be reported to the Legislative Commission on Health Care Access.~~

Subd. 11. **Distribution of funds.** (a) Upon receiving federal approval, the commissioner shall annually distribute the available medical education funds to all qualifying applicants based on the following distribution formula, which supersedes the formula described in subdivision 4, paragraphs (a) and (b):

(1) funds received pursuant to section 297F.10 shall be distributed to eligible clinical training sites using a public program volume factor, which is determined by the total volume of public program revenue received by each eligible training site as a percentage of all public program revenue received by all eligible training sites in the fund pool. Only clinical training that occurs in a hospital that reports financial, utilization, and services data to the commissioner of health, pursuant to sections 144.564 and 144.695 to 144.703 and Minnesota Rules, chapter 4650, is eligible for funding under this clause; and

(2) funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), shall be distributed to eligible training sites based on the total number of eligible trainee FTEs and the total statewide average costs per FTE, by type of trainee, in each clinical medical education program. The number of eligible trainee FTEs for funds distributed under this clause is determined using the following steps:

(i) each FTE trainee from an advanced practice nursing, physician assistant, family medicine, internal medicine, general pediatrics, or psychiatry program is weighted at 1.25. Each FTE trainee from any other eligible training program is weighted at 1.0;

(ii) each FTE trainee at a clinical training site located in an isolated rural area according to the four category classification of the Rural Urban Commuting Area (RUCA) system developed for the United States Health Resources and Services Administration shall be weighted at the weight in item (i) multiplied by 1.5; each FTE trainee at a clinical training site located in a small rural area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.25; each FTE trainee at a clinical training site located in a large rural area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.1; and each FTE trainee at a clinical training site located in an

urban area according to the RUCA system shall be weighted at the weight in item (i) multiplied by 1.0;

(iii) each FTE trainee at a clinical training site that is a hospital eligible for funding under clause (1) shall be weighted at the weight in item (ii) multiplied by 0.85; and each FTE trainee at a clinical training site that is an ambulatory, nursing home, or other eligible nonhospital setting shall be weighted at the weight in item (ii) multiplied by 1.15; and

(iv) grants to hospitals under this item are limited to a percentage share of the total pool of funds available under this item that is no more than 1.5 times the percentage of the hospital's total revenue that comes from public programs. Grants to hospitals in excess of this amount will be redistributed to other sites eligible for funding under this item. Each eligible clinical training site's grant under this item will be calculated by multiplying the training site's adjusted FTE count upon completion of items (i) to (iv) by the statewide average cost per trainee for each provider type to determine an adjusted clinical training cost for each site. The grant to each eligible clinical training site under this item shall equal that site's share of total adjusted clinical training costs for all eligible training sites receiving funding under this item. Any clinical training site with fewer than 0.1 FTE eligible trainees from all programs upon completion of items (i) to (iv) and any clinical training site that would receive less than a cumulative $1,000 under clauses (1) and (2) will be eliminated from the distribution.

(b) Public program revenue for the distribution formula includes revenue for the relevant MERC reporting period from medical assistance, prepaid medical assistance, general assistance medical care, MinnesotaCare, and prepaid general assistance medical care, as reported to the Department of Health pursuant to sections 144.562, 144.564, and 144.695 to 144.703 and Minnesota Rules, chapter 4650, by December 31 of the year in which the MERC application is submitted. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), clause (2), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

Sec. 7. **[62U.15] ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.**

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

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

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

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

(1) earlier identification of Alzheimer's and other dementias;

(2) improved support of family caregivers; and

(3) improved collaboration between medical care management and community-based supports.

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

Sec. 8. **[137.395] EDUCATION AND TRAINING FOR HEALTH DISPARITY POPULATIONS.**

Subdivision 1. **Condition.** If the Board of Regents accepts the amount transferred under section 62J.692, subdivision 4, paragraph (b), clause (2), then it must be used for the purposes provided in this section.

Subd. 2. **Purpose.** The Board of Regents, through the Academic Health Center, is required to implement a scholarship program in order to increase the number of graduates of the Academic Health Center programs who are from racial, ethnic, or cultural populations in the state that experience health disparities.

Subd. 3. **Scholarships.** The Board of Regents is required to provide full scholarships to Academic Health Center programs for students who are from racial, ethnic, or cultural populations that experience health disparities. One-third of the scholarship funding available under this program must go to students at the University of Minnesota, Medical School, Duluth.

Sec. 9. Minnesota Statutes 2010, section 144.05, is amended by adding a subdivision to read:

Subd. 6. **Elimination of certain provider reporting requirements; sunset of new requirements.** (a) Notwithstanding any other law, rule, or provision to the contrary, effective July 1, 2012, the commissioner shall cease collecting from health care providers and purchasers all reports and data related to health care costs, quality, utilization, access, patient encounters, and disease surveillance and public health, and related to provider licensure, monitoring, finances, and regulation, unless the reports or data are necessary for federal compliance. For purposes of this subdivision, the term "health care providers and purchasers" has the meaning provided in section 62J.03, subdivision 8, except that it also includes nursing homes, health plan companies as defined in section 62Q.01, subdivision 4, and managed care and county-based purchasing plans delivering services under sections 256B.69 and 256B.692.

(b) The commissioner shall present to the 2012 legislature draft legislation to repeal, effective July 1, 2012, the provider reporting requirements identified under paragraph (a) that are not necessary for federal compliance.

(c) The commissioner may establish new provider reporting requirements to take effect on or after July 1, 2012. These new reporting requirements must sunset five years from their effective date, unless they are renewed by the commissioner. All new provider reporting requirements and requests for their renewal shall not take effect unless they are enacted in state law.

Sec. 10. Minnesota Statutes 2010, section 144.1499, is amended to read:

144.1499 ~~PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS~~ HEALTH CAREERS OPPORTUNITIES GRANT PROGRAM.

Subdivision. 1. **Program.** The commissioner of health, ~~in consultation with an organization representing health care employers, long-term care employers, and educational institutions,~~ may make grants to ~~qualifying consortia as defined in section 116L.11, subdivision 4, for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. To qualify for a grant under this section, a consortium shall:~~ health care employers, educational institutions, and related organizations for eligible activities intended to increase the number of people from racial, ethnic, or cultural populations that experience health disparities who are entering health careers in Minnesota.

~~(1) develop a health and long-term care careers curriculum that provides career exploration and training in national skill standards for health care and long-term care and that is consistent with Minnesota graduation standards and other related requirements;~~

~~(2) offer programs for high school students that provide training in health and long-term care careers with credits that articulate into postsecondary programs; and~~

~~(3) provide technical support to the participating health care and long-term care employer to enable the use of the employer's facilities and programs for kindergarten to grade 12 health and long-term care careers education.~~

Subd. 2. **Eligible activities.** Eligible activities must focus on students from racial, ethnic, or cultural populations experiencing health disparities. Eligible activities include the following:

(1) health careers exploration activities for students from racial, ethnic, or cultural populations experiencing health disparities;

(2) elementary, secondary, and postsecondary education activities to improve the academic readiness to enter health professions education programs for students from racial, ethnic, or cultural populations experiencing health disparities;

(3) health careers mentoring for students from racial, ethnic, or cultural populations experiencing health disparities, including support for faculty involved in mentoring these students enrolled in or interested in entering health professions education programs;

(4) secondary and postsecondary summer health care internships that provide students from racial, ethnic, or cultural populations experiencing health disparities with formal exposure to a health care profession in an employment setting;

(5) health careers preparation, guidance, and support for students from racial, ethnic, or cultural populations experiencing health disparities who are interested in entering health professions education programs;

(6) health careers preparation, guidance, and support for students from racial, ethnic, or cultural populations experiencing health disparities who are enrolled in health

professions education programs and other activities to improve retention of these students in health professions education programs; or

(7) other activities the commissioner has reason to believe will prepare, attract, and educate for health careers students from racial, ethnic, or cultural populations experiencing health disparities.

Subd. 3. **Applications.** Applicants seeking a grant must apply to the commissioner. Applications must include the following:

(1) a description of the need, challenges, or barriers that the proposed project will address;

(2) a detailed description of the project and how it proposes to address the challenges or barriers;

(3) a budget detailing all sources of funds for the project and how project funds will be used;

(4) baseline data showing the current percentage of program applicants and current students who are from racial, ethnic, or cultural populations experiencing health disparities;

(5) a description of achievable objectives that demonstrate how the project will contribute to increasing the number of students from racial, ethnic, or cultural populations experiencing health disparities who are entering health professions in Minnesota;

(6) a timeline for completion of the project;

(7) roles and capabilities of responsible individuals and organizations, including partner organizations;

(8) a plan to evaluate project outcomes; and

(9) other information the commissioner believes necessary to evaluate the application.

Subd. 4. **Consideration of applications.** The commissioner must review each application to determine whether or not the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner must evaluate each application based on the following:

(1) the extent to which the applicant has demonstrated that its project is likely to contribute to increasing the number of American Indians and underrepresented populations of color entering health professions in Minnesota;

(2) the application's clarity and thoroughness in describing the challenges and barriers it is addressing;

(3) the extent to which the applicant appears likely to coordinate project efforts with other organizations;

(4) the reasonableness of the project budget; and

(5) the organizational capacity of the applicant and its partners.

The commissioner may also take into account other relevant factors. During application review the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible applicant based on the relative strength of each eligible application and the funds available to the commissioner. The commissioner may collect from grantees any information necessary to evaluate the program.

Sec. 11. Minnesota Statutes 2010, section 144.1501, subdivision 1, is amended to read:

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

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

(c) "Designated rural area" means~~:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2010, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants <u>from racial, ethnic, or cultural populations experiencing health disparities who are</u> closest to completing their training <u>and who agree to serve in settings in Minnesota that provide health care services to at least 50 percent American Indian or other populations of color, such as a federally recognized</u>

Native American reservation. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 13. **[144.1503] HEALTH PROFESSIONS OPPORTUNITIES SCHOLARSHIP PROGRAM.**

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

(a) "Certified clinical nurse specialist" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a clinical nurse specialist.

(b) "Certified nurse midwife" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a nurse midwife.

(c) "Certified nurse practitioner" means an individual licensed in Minnesota as a registered nurse and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a nurse practitioner.

(d) "Chiropractor" means an individual licensed and regulated under sections 148.02 to 148.108.

(e) "Dental therapist" means an individual licensed in the state and includes advanced dental therapists certified under section 150A.106.

(f) "Dentist" means an individual licensed in Minnesota as a dentist under chapter 150A.

(g) "Eligible scholarship placement site" means a nonprofit, private, or public entity located in Minnesota that provides at least 50 percent of its health care services to

American Indian or other populations of color, such as federally recognized American Indian reservations.

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

(i) "Participant" means an individual receiving a scholarship under this program.

(j) "Physician assistant" means a person licensed in Minnesota under chapter 147A.

(k) "Primary care physician" means an individual licensed in Minnesota as a physician and board-certified in family practice, internal medicine, obstetrics and gynecology, pediatrics, geriatrics, emergency medicine, hospital medicine, or psychiatry.

(l) "Registered nurse" means an individual licensed by the Minnesota Board of Nursing to practice professional nursing.

Subd. 2. **Establishment and purpose.** The commissioner shall establish a health professions opportunities scholarship program. The purpose of the program is to increase the number of students from racial, ethnic, or cultural populations experiencing health disparities who enter health professions.

Subd. 3. **Eligible students.** To be eligible to apply to the commissioner for the scholarship program, an applicant must be:

(1) accepted for full-time study in a program of study that will result in licensure as a primary care physician, certified nurse practitioner, certified nurse midwife, certified clinical nurse specialist, chiropractor, physician assistant, registered nurse, dentist, or dental therapist;

(2) a Minnesota resident; and

(3) an individual from a racial, ethnic, or cultural population experiencing health disparities in the state.

Subd. 4. **Scholarship.** The commissioner may award a scholarship for the cost of full tuition, fees, and living expenses up to $40,000 per year to eligible students. The commissioner will subtract the amount of other scholarship, grant, and gift awards to the participant from the award made by this program. Scholarship awards will be limited to the number of years for full-time enrollment in the applicant's program of study but will not include any years completed prior to applying. The commissioner shall determine the number of new scholarship awards made per fiscal year based on availability of state funding. Scholarship awards will be paid by the commissioner directly to the participant's educational institution after full-time enrollment is verified. Appropriations made to the scholarship program do not cancel and are available until expended.

Subd. 5. **Obligated service.** A participant shall agree in contract to fulfill a three-year service obligation at an eligible scholar placement site upon completion of training, including residency, and obtaining Minnesota licensure. Participants must provide at least 32 hours of direct patient care per week for at least 45 weeks per year. Obligated service must start by March 31 of the year following completion of required training.

Subd. 6. **Affidavit of service required.** Before starting a service obligation and annually thereafter, participants shall submit to the commissioner an affidavit of practice signed by a representative of their eligible scholar placement site verifying employment status and the number of weekly hours of direct patient care provided by the participant. Participants must also provide written notice to the commissioner within 30 days of:

(1) a change in name or address;

(2) a decision not to fulfill a service obligation; or

(3) cessation of obligated practice.

Subd. 7. **Penalty for nonfulfillment.** If a participant does not complete the educational program, successfully obtain licensure, or fulfill the required minimum commitment of service according to subdivision 6, the commissioner of health shall collect from the participant the total amount awarded to the participant under the scholarship program plus interest at a rate established according to section 270C.40. Funds collected for nonfulfillment shall be credited to the health professions opportunities scholarship program. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty due to emergency circumstances.

Sec. 14. **[144.586] PATIENT SAFETY SURVEY.**

Hospitals licensed under section 144.55 must submit necessary information to the Leapfrog Group patient safety survey on an annual basis in order to publicly report patient safety information and track the progress of each hospital to improve quality, safety, and efficiency of care delivery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144E.123 PREHOSPITAL CARE DATA.

Subdivision 1. **Collection and maintenance.** Until July 1, 2014, a licensee ~~shall~~ may collect and provide prehospital care data to the board in a manner prescribed by the board. At a minimum, the data must include items identified by the board that are part of the National Uniform Emergency Medical Services Data Set. A licensee shall maintain prehospital care data for every response.

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

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

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

Subd. 5. **Working group.** By October 1, 2011, the board must convene a working group composed of six members, three of which must be appointed by the board and three of which must be appointed by the Minnesota Ambulance Association, to redesign the board's policies related to collection of data from licenses. The issues to be considered include, but are not limited to, the following: user-friendly reporting requirements; data sets; improved accuracy of reported information; appropriate use of information gathered through the reporting system; and methods for minimizing the financial impact of data reporting on licenses, particularly for rural volunteer services. The working group must report its findings and recommendations to the board no later than January 1, 2014.

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

Sec. 22. **[145.9271] WHITE EARTH BAND URBAN CLINIC.**

Subdivision 1. **Condition.** If the White Earth Band of Ojibwe Indians accepts the amount transferred under section 62J.692, subdivision 4, paragraph (b), clause (1), then it must use the funds for purposes of this section.

Subd. 2. **Establish urban clinic.** The White Earth Band of Ojibwe Indians shall establish and operate one or more health care clinics in the Minneapolis area or greater Minnesota to serve members of the White Earth Tribe and may use funds received under section 62J.692, subdivision 4, paragraph (b), clause (1), for application to qualify as a federally qualified health center.

Subd. 3. **Grant agreements.** Before receiving the funds to be transferred under section 62J.692, subdivision 4, paragraph (b), clause (1), the White Earth Band of Ojibwe Indians is requested to submit to the commissioner of health a work plan and budget that describes its annual plan for the funds. The commissioner will incorporate the work plan and budget into a grant agreement between the commissioner and the White Earth Band of Ojibwe Indians. Before each successive disbursement, the White Earth Band of Ojibwe Indians is requested to submit a narrative progress report and an expenditure report to the commissioner.

Sec. 23. **[145.9272] COMMUNITY MENTAL HEALTH CENTER GRANTS.**

Subdivision 1. **Definitions.** For purposes of this section, "community mental health center" means an entity that is eligible for payment under section 256B.0625, subdivision 5.

Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute, from money appropriated for this purpose, grants to community mental health centers operating in the state on July 1 of the year 2011 and each subsequent year for community mental health center services to low-income consumers and patients with mental illness. The amount of each grant shall be in proportion to each community mental health center's revenues received from state health care programs in the most recent calendar year for which data is available.

Sec. 24. Minnesota Statutes 2010, section 145.928, subdivision 2, is amended to read:

Subd. 2. **State-community partnerships; plan.** The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Council on Affairs of Chicano/Latino People under section 3.9223; the Council on Black Minnesotans under section 3.9225; the Council on Asian-Pacific Minnesotans under section 3.9226; the Alliance for Racial and Cultural Health Equity; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Sec. 25. **[145.929] PROFESSIONALS FROM POPULATIONS WITH HEALTH DISPARITIES.**

The commissioner of health shall survey the diversity of the work force for health-related professions and compare proportions in the allied health professions among populations experiencing health disparities, including cultural, racial, ethnic, and geographic factors, compared to the population of the state. Based on this survey, the commissioner shall determine on an annual basis the ratio of training and residency positions needed versus those available based on funding capacity.

Sec. 26. Minnesota Statutes 2010, section 145.986, is amended by adding a subdivision to read:

Subd. 7. **Consultation and engagement of consumers and communities with poorer health and outcomes.** Communities who receive state and federal health grants must demonstrate to the commissioner that the applicant or grantee consulted with and engaged local consumers, community organizations, and leaders representing the subgroups of the community that experience the greatest health disparities in the development of the local plan and that the plan incorporates components and activities that reflect the needs and preferences of these communities. The plan must also include

a process for ongoing consultation and engagement of these consumers, community organizations, and leaders in the implementation of the plan and activities funded by state grants.

Sec. 27. Minnesota Statutes 2010, section 145.986, is amended by adding a subdivision to read:

Subd. 8. **Coordination with payment reform demonstration projects.** A community who received a health improvement plan grant under this section and a payment reform demonstration project authorized under section 256B.0755 shall coordinate activities to improve the health of the communities and patients served by both the health improvement plan and the demonstration project provider.

Sec. 28. **[145.987] COMMUNITY HEALTH CENTERS DEVELOPMENT GRANTS FOR UNDERSERVED COMMUNITIES.**

(a) The commissioner of health shall award grants from money appropriated for this purpose to expand community health centers, as defined in section 145.9269, subdivision 1, in the state through the establishment of new community health centers or sites in areas defined as small rural areas or isolated rural areas according to the four category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration or serving underserved patient populations who experience the greatest disparities in health outcomes.

(b) Grant funds may be used to pay for:

(1) costs for an organization to develop and submit a proposal to the federal government for the designation of a new community health center or site;

(2) costs of engaging underserved communities, health care providers, local government agencies, or businesses in a process of developing a plan for a new center or site to serve people in that community; and

(3) costs of planning, designing, remodeling, constructing, or purchasing equipment for a new center or site.

Funds may not be used for operating costs.

(d) A proposal must demonstrate that racial and ethnic communities to be served by the community health center were consulted with and participated in the development of the proposal.

(e) The commissioner shall award grants on a competitive basis based on the following criteria:

(1) the unmet need in the underserved community;

(2) the degree of disparities in health outcomes in the underserved community; and

(3) the extent to which people from the underserved community participated in the development of the proposal.

Sec. 29. Minnesota Statutes 2010, section 145A.17, subdivision 3, is amended to read:

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

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

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

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

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

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

(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or

family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision to read:

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

Sec. 31. Minnesota Statutes 2010, section 297F.10, subdivision 1, is amended to read:

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

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

(2) $8,553,000 for fiscal year 2006 ~~and~~, $8,550,000 for fiscal year 2007 ~~and~~, $8,337,000 for fiscal year 2012, and $6,781,000 each year thereafter must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4 or 11, as appropriate; and

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

Sec. 32. **TRANSFER OF HEALTH QUALITY DATA COLLECTION.**

Subdivision 1. **Transfer.** The duties and activities of the commissioner of health conducted pursuant to Minnesota Statutes, chapter 62U, are transferred to the commissioner of human services.

Subd. 2. **Effect of transfer.** Minnesota Statutes, section 15.039 applies to the transfer required in subdivision 1.

Subd. 3. **Effective date.** The transfer required in subdivision 1 is effective July 1, 2011.

Subd. 4. **Suspended data collection.** Data collection under Minnesota Statutes, section 62U.04, subdivision 4, is suspended, effective July 1, 2011.

Subd. 5. **Commissioner of human services.** (a) During the 2012 legislative session, the commissioner of human services, in consultation with the revisor of statutes, shall submit to the legislature a bill making all statutory changes required by the reorganization required under subdivision 1.

(b) By July 1, 2013, the commissioner must make recommendations to the legislature for collection of encounter data for state health care programs, including SEGIP, through a mechanism that allows a third-party contractor to capture data as it is transmitted through existing claims processing mechanisms.

Sec. 33. **PATIENT AND COMMUNITY ENGAGEMENT IN PAYMENT REFORM AND HEALTH CARE PROGRAM REFORMS.**

Subdivision 1. **Implementation of data system improvements.** The commissioners of health and human services shall implement the recommendations regarding data on health disparities that were contained in the report prepared under Laws 2010, First Special Session chapter 1, article 19, section 23, in consultation with an advisory work group representing racial and ethnic groups and representatives of government and private sector health care organizations. Among other activities, the commissioners shall:

(1) continue engagement with diverse communities on collection of and access to racial and ethnic data from state agencies, health care providers, and health plans;

(2) develop a plan to make data more accessible to communities;

(3) develop consistent data elements across programs when feasible; and

(4) develop consistent policies on data sampling.

Subd. 2. **Patient and community engagement.** The commissioner of health, in cooperation with the commissioners of human services and commerce, shall consult with an advisory committee representing racial and ethnic groups regarding the implementation of subdivision 1 and major agency activities related to state and federal health care reform, payment reform demonstration projects, state health care program reforms, improvements

in quality and patient satisfaction measures, and major changes in state public health priorities and strategies. At the request of the advisory committee established under Laws 2010, First Special Session chapter 1, article 19, section 23, the commissioner shall designate a private sector organization of multiple racial and ethnic groups to serve as the advisory committee under this subdivision.

Sec. 34. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

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

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

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

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

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

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

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

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

Sec. 35. **TRANSFER OF THE HEALTH ECONOMICS PROGRAM.**

Subdivision 1. **Transfer.** The duties and activities of the health economics program at the Minnesota Department of Health conducted pursuant to Minnesota Statutes, chapter 62J, are transferred to the commissioner of commerce.

Subd. 2. **Effect of transfer.** Minnesota Statutes, section 15.039, applies to the transfer required in subdivision 1.

Subd. 3. **Commissioner of commerce.** During the 2012 legislative session, the commissioner of commerce, in consultation with the revisor of statutes, shall submit to the legislature a bill making all statutory changes required by the reorganization required under subdivision 1.

Subd. 4. **Effective date.** The transfer required in subdivision 1 is effective July 1, 2011.

Sec. 36. **STUDY OF FOR-PROFIT HEALTH MAINTENANCE ORGANIZATIONS.**

The commissioner of health shall contract with an entity with expertise in health economics and health care delivery and quality to study the efficiency, costs, service quality, and enrollee satisfaction of for-profit health maintenance organizations, relative to not-for-profit health maintenance organizations operating in Minnesota and other states. The study findings must address whether the state of Minnesota could: (1) reduce medical assistance and MinnesotaCare costs and costs of providing coverage to state employees; and (2) maintain or improve the quality of care provided to state health care program enrollees and state employees if for-profit health maintenance organizations were allowed to operate in the state. The commissioner shall require the entity under contract to report study findings to the commissioner and the legislature by January 15, 2012.

Sec. 37. **MINNESOTA TASK FORCE ON PREMATURITY.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 38. **NURSING HOME REGULATORY EFFICIENCY.**

The commissioner of health shall work with stakeholders to review, develop, implement, and recommend legislative changes in the nursing home licensure process that address efficiency, eliminate duplication, and ensure positive resident clinical outcomes. The commissioner shall ensure that the changes are cost-neutral.

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; and 144.1464, are repealed.

(b) Minnesota Statutes 2010, section 145A.14, subdivisions 1 and 2, are repealed effective January 1, 2012.

(c) Minnesota Rules, parts 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, and 23; 4651.0110, subparts 2, 2a, 3, 4, and 5; 4651.0120; 4651.0130; 4651.0140; and 4651.0150, are repealed effective July 1, 2011.

ARTICLE 3

MISCELLANEOUS

Section 1. Minnesota Statutes 2010, section 3.98, is amended by adding a subdivision to read:

Subd. 5. **Health note.** The commissioner of health, in consultation with other state agencies, shall develop a report and recommendations for the legislature for a process through which a health impact review of proposed legislation may be requested by a legislative committee chair and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services finance and policy issues to estimate the impact of the proposed legislation on costs of health care for public employees, state health care programs, private employers, local governments, or Minnesota individuals and families, including costs related to the impact of the legislation on the health status of the state or a community. The commissioner may consult with local and private public health organizations and other persons or organizations in the development of the report and recommendations. The report and recommendations shall be provided to the legislature by January 15, 2012.

Sec. 2. Minnesota Statutes 2010, section 245A.14, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 33. **Combined application form; referral of veterans.** The commissioner shall modify the combined application form to add a question asking applicants: "Are you a United States military veteran?" The commissioner shall ensure that all applicants who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any benefits for which they may be eligible.

Sec. 4. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision to read:

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

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

(2) "community spouse" means the spouse, who lives in the community, of an individual receiving long-term care services in a long-term care facility or home care services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913. A community spouse does not

include a spouse living in the community who receives a monthly income allowance under section 256B.058, subdivision 2, or who receives home care services or home and community-based services under section 256B.0915, 256B.092, or 256B.49, or the alternative care program under section 256B.0913;

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

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

(5) "disabled child" means a blind or permanently and totally disabled son or daughter of any age as defined in the Supplemental Security Income program or the state medical review team;

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

(7) "long-term care spouse" means the spouse who is receiving long-term care services in a long-term care facility or home care services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913.

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

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

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

(e) For a community spouse with an income equal to or greater than 750 percent of the federal poverty guidelines for a family of two and less than 975 percent of the federal

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

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

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

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

(i) The spousal contribution shall be reviewed at least once every 12 months and when there is a loss or gain in income in excess of ten percent. Thirty days prior to a review or redetermination, written notice must be provided to the community spouse and must contain the amount the spouse is required to contribute, notice of the right to redetermination and appeal, and the telephone number of the division at the department that is responsible for redetermination and review. If, after review, the contribution amount is to be adjusted, the commissioner shall mail a written notice to the community spouse 30 days in advance of the effective date of the change in the amount of the contribution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) If the commissioner finds that notice of the payment obligation was given to the community spouse and the spouse was determined to be able to pay, but that the spouse failed or refused to pay, a cause of action exists against the community spouse for that portion of medical assistance payment of long-term care services or alternative care services granted after notice was given to the community spouse. The action may be brought by the commissioner in the county where assistance was granted for the assistance together with the costs of disbursements incurred due to the action. In addition to granting the commissioner a money judgment, the court may, upon a motion or order to

show cause, order continuing contributions by a community spouse found able to repay the commissioner. The order shall be effective only for the period of time during which a contribution shall be assessed.

Sec. 5. Minnesota Statutes 2010, section 326B.175, is amended to read:

326B.175 ELEVATORS, ENTRANCES SEALED.

Except as provided in section 326B.188, it shall be the duty of the department and the licensing authority of any municipality which adopts any such ordinance whenever it finds any such elevator under its jurisdiction in use in violation of any provision of sections 326B.163 to 326B.178 to seal the entrances of such elevator and attach a notice forbidding the use of such elevator until the provisions thereof are complied with.

Sec. 6. **[326B.188] COMPLIANCE WITH ELEVATOR CODE CHANGES.**

(a) This section applies to code requirements for existing elevators and related devices under Minnesota Rules, chapter 1307, where the deadline set by law for meeting the code requirements is January 29, 2012, or later.

(b) If the department or municipality conducting elevator inspections within its jurisdiction notifies the owner of an existing elevator or related device of the code requirements before the effective date of this section, the owner may submit a compliance plan by December 30, 2011. If the department or municipality does not notify the owner of an existing elevator or related device of the code requirements before the effective date of this section, the department or municipality shall notify the owner of the code requirements and permit the owner to submit a compliance plan by December 30, 2011, or within 60 days after the date of notification, whichever is later.

(c) Any compliance plan submitted under this section must result in compliance with the code requirements by the later of January 29, 2012, or three years after submission of the compliance plan. Elevators and related devices that are not in compliance with the code requirements by the later of January 29, 2012, or three years after the submission of the compliance plan may be taken out of service as provided in section 326B.175.

Sec. 7. **DEVELOPMENTAL DISABILITY WAIVERED SERVICES.**

Subdivision 1. **Purpose.** All individuals in the state of Minnesota who are eligible for developmental disability waivered services are entitled to receive adequate services, within the limits of available funding, to ensure their basic needs for housing, food, health, and safety are met.

Subd. 2. **Instructions to commissioner.** (a) No later than November 1, 2011, the commissioner of human services shall convene a workgroup to define the essential services required to adequately meet the needs of individuals who receive developmental disability waivered services. The commissioner shall identify the essential services in each of the following tiers:

(1) tier 1, services and costs associated with safety, food, housing, and health care;

(2) tier 2, services and costs associated with enhancements toward self-sufficiency; and

(3) tier 3, services and costs associated with quality of life improvements.

(b) The commissioner, or designee, and a representative designated by the counties shall cochair the workgroup. The workgroup shall consider Tier 1 services to be the most important and of highest priority for available funds, and may choose to implement a policy that all waiver-eligible individuals receive Tier 1 services within the limits of available funding before services from Tier 2 or 3 are offered to waiver-eligible individuals.

Sec. 8. **ANALYSIS OF PROGRAMS AND THEIR EFFECT ON MARRIAGES; REPORT.**

(a) The commissioner of human services shall conduct an analysis of how current human services programs affect the motivation and capacity of individuals to form and sustain marriages in which to raise children. Programs to be examined in this marriage impact analysis may include, but are not limited to, medical assistance, MinnesotaCare, Minnesota family investment program, child protection, child support enforcement, and child welfare services.

(b) Before January 1, 2012, the commissioner shall submit a report to the legislature describing the results of this analysis and outline proposals to improve the ability of human services programs to help people who are interested in marriage to form and sustain marriages in which to raise children. The commissioner shall ensure that experts on marriage are consulted on the process of conducting the analysis and writing the report.

Sec. 9. **INSTRUCTIONS TO COMMISSIONER.**

To offset the cost of implementing Minnesota Statutes, section 256B.14, subdivision 3a, the commissioner of human services shall collect from each county its proportionate share of the cost based on population of the county. At the end of each fiscal year, the commissioner shall divide ten percent of all collections made under Minnesota Statutes, section 256B.14, subdivision 3a, between the counties based on the population of the county.

Sec. 10. **LEGISLATIVE APPROVAL FOR FEDERAL FUNDS.**

The commissioners of human services and health shall not expend any funding received through federal grants or subsequent renewal of federal grants without the approval of three of the four chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance.

ARTICLE 4

HEALTH LICENSING FEES

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

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

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

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

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

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

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

Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine, license, and renew the license of duly qualified applicants. It shall hold examinations at least once in each year at such time and place as it may determine. It shall by rule adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for registration and renewal of registration as defined in section 148.231. It shall maintain a record of all persons licensed by the board to practice professional or practical nursing and all registered nurses who hold Minnesota licensure and registration and are certified as

advanced practice registered nurses. It shall cause the prosecution of all persons violating sections 148.171 to 148.285 and have power to incur such necessary expense therefor. It shall register public health nurses who meet educational and other requirements established by the board by rule, including payment of a fee. ~~Prior to the adoption of rules, the board shall use the same procedures used by the Department of Health to certify public health nurses.~~ It shall have power to issue subpoenas, and to compel the attendance of witnesses and the production of all necessary documents and other evidentiary material. Any board member may administer oaths to witnesses, or take their affirmation. It shall keep a record of all its proceedings.

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

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

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

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

Subdivision 1. **Issuance.** Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation or disciplinary action, nor disqualified for any other reason, under the following circumstances:

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

~~nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days whichever occurs first.~~

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

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

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

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

148.231 REGISTRATION; FAILURE TO REGISTER; REREGISTRATION; VERIFICATION.

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

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

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

Subd. 5. **Reregistration.** A person whose registration has lapsed desiring to resume practice shall make application for reregistration, submit satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the ~~registration~~ reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, ~~the~~ registration ~~certificate~~ shall be issued to the person who shall immediately be placed on the practicing list as a registered nurse or licensed practical nurse.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148B.17 FEES.

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

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

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

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

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

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

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

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

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

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

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

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

(11) fee for emeritus status is $125.

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

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

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

(3) duplicate license fee is $25;

(4) duplicate renewal card fee is $10;

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

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

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

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

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

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

148B.52 DUTIES OF THE BOARD.

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

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

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

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

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

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

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

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

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

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

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

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

(1) dentist, $140;

(2) full faculty dentist, $140;

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

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

(5) advanced dental therapist, $100;

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) limited faculty dentist, $168; and

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

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

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

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

(2) dental therapist, $180;

(3) dental hygienist, $118;

(4) licensed dental assistant, $80; and

(5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $24.

Sec. 15. Minnesota Statutes 2010, section 150A.091, subdivision 8, is amended to read:

Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request for issuance of a duplicate of the original license, or of an annual or biennial renewal certificate for a license or permit, a fee in the following amounts:

(1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant license, $35; and

(2) annual or biennial renewal certificates, $10.

Sec. 16. Minnesota Statutes 2010, section 150A.091, is amended by adding a subdivision to read:

Subd. 16. **Failure of professional development portfolio audit.** A licensee shall submit a fee as established by the board not to exceed the amount of $250 after failing two consecutive professional development portfolio audits and, thereafter, for each failed professional development portfolio audit under Minnesota Rules, part 3100.5300.

Sec. 17. **[151.065] FEE AMOUNTS.**

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, $130;

(2) pharmacist licensed by reciprocity, $225;

(3) pharmacy intern, $30;

(4) pharmacy technician, $30;

(5) pharmacy, $190;

(6) drug wholesaler, legend drugs only, $200;

(7) drug wholesaler, legend and nonlegend drugs, $200;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $175;

(9) drug wholesaler, medical gases, $150;

(10) drug wholesaler, also licensed as a pharmacy in Minnesota, $125;

(11) drug manufacturer, legend drugs only, $200;

(12) drug manufacturer, legend and nonlegend drugs, $200;

(13) drug manufacturer, nonlegend or veterinary legend drugs, $175;

(14) drug manufacturer, medical gases, $150;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, $125;

(16) medical gas distributor, $75;

(17) controlled substance researcher, $50; and

(18) pharmacy professional corporation, $100.

Subd. 2. **Original license fee.** The pharmacist original licensure fee, $130.

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, $130;

(2) pharmacy technician, $30;

(3) pharmacy, $190;

(4) drug wholesaler, legend drugs only, $200;

(5) drug wholesaler, legend and nonlegend drugs, $200;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $175;

(7) drug wholesaler, medical gases, $150;

(8) drug wholesaler, also licensed as a pharmacy in Minnesota, $125;

(9) drug manufacturer, legend drugs only, $200;

(10) drug manufacturer, legend and nonlegend drugs, $200;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, $175;

(12) drug manufacturer, medical gases, $150;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, $125;

(14) medical gas distributor, $75;

(15) controlled substance researcher, $50; and

(16) pharmacy professional corporation, $45.

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, $15;

(2) duplicate small license, $15; and

(3) duplicate large certificate, $25.

Subd. 5. **Late fees.** All annual renewal fees are subject to a 50 percent late fee if the renewal fee and application are not received by the board prior to the date specified by the board.

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $90.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical gas distributor who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 18. Minnesota Statutes 2010, section 151.07, is amended to read:

151.07 MEETINGS; EXAMINATION FEE.

The board shall meet at times as may be necessary and as it may determine to examine applicants for licensure and to transact its other business, giving reasonable notice of all examinations by mail to known applicants therefor. The secretary shall record the names of all persons licensed by the board, together with the grounds upon which the right of each to licensure was claimed. The fee for examination shall be in ~~such~~ the

amount ~~as the board may determine~~ specified in section 151.065, which fee may in the discretion of the board be returned to applicants not taking the examination.

Sec. 19. Minnesota Statutes 2010, section 151.101, is amended to read:

151.101 INTERNSHIP.

Upon payment of the fee specified in section 151.065, the board may ~~license~~ register as an intern any natural persons who have satisfied the board that they are of good moral character, not physically or mentally unfit, and who have successfully completed the educational requirements for intern ~~licensure~~ registration prescribed by the board. The board shall prescribe standards and requirements for interns, pharmacist-preceptors, and internship training but may not require more than one year of such training.

The board in its discretion may accept internship experience obtained in another state provided the internship requirements in such other state are in the opinion of the board equivalent to those herein provided.

Sec. 20. Minnesota Statutes 2010, section 151.102, is amended by adding a subdivision to read:

Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy technician unless all applicable fees specified in section 151.065 have been paid.

Sec. 21. Minnesota Statutes 2010, section 151.12, is amended to read:

151.12 RECIPROCITY; LICENSURE.

The board may in its discretion grant licensure without examination to any pharmacist licensed by the Board of Pharmacy or a similar board of another state which accords similar recognition to licensees of this state; provided, the requirements for licensure in such other state are in the opinion of the board equivalent to those herein provided. The fee for licensure shall be in ~~such~~ the amount ~~as the board may determine by rule~~ specified in section 151.065.

Sec. 22. Minnesota Statutes 2010, section 151.13, subdivision 1, is amended to read:

Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist shall pay to the board ~~a~~ the annual renewal fee ~~to be fixed by it~~ specified in section 151.065. The board may ~~promulgate by rule a~~ charge ~~to be assessed for the delinquent payment of a fee.~~ the late fee specified in section 151.065 if the renewal fee and application are not received by the board prior to the date specified by the board. It shall be unlawful for any person licensed as a pharmacist who refuses or fails to pay ~~such~~ any

applicable renewal or late fee to practice pharmacy in this state. Every certificate and license shall expire at the time therein prescribed.

Sec. 23. Minnesota Statutes 2010, section 151.19, is amended to read:

151.19 REGISTRATION; FEES.

Subdivision 1. **Pharmacy registration.** The board shall require and provide for the annual registration of every pharmacy now or hereafter doing business within this state. Upon the payment of ~~a~~ any applicable fee ~~to be set by the board~~ specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such persons as may be qualified by law to conduct a pharmacy. Such certificate shall be displayed in a conspicuous place in the pharmacy for which it is issued and expire on the 30th day of June following the date of issue. It shall be unlawful for any person to conduct a pharmacy unless such certificate has been issued to the person by the board.

Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an annual nonresident special pharmacy registration for all pharmacies located outside of this state that regularly dispense medications for Minnesota residents and mail, ship, or deliver prescription medications into this state. Nonresident special pharmacy registration shall be granted by the board upon payment of any applicable fee specified in section 151.065 and the disclosure and certification by a pharmacy:

(1) that it is licensed in the state in which the dispensing facility is located and from which the drugs are dispensed;

(2) the location, names, and titles of all principal corporate officers and all pharmacists who are dispensing drugs to residents of this state;

(3) that it complies with all lawful directions and requests for information from the Board of Pharmacy of all states in which it is licensed or registered, except that it shall respond directly to all communications from the board concerning emergency circumstances arising from the dispensing of drugs to residents of this state;

(4) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(5) that it cooperates with the board in providing information to the Board of Pharmacy of the state in which it is licensed concerning matters related to the dispensing of drugs to residents of this state;

(6) that during its regular hours of operation, but not less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has

access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(7) that, upon request of a resident of a long-term care facility located within the state of Minnesota, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with the provisions of section 151.415, subdivision 5.

Subd. 3. **Sale of federally restricted medical gases.** The board shall require and provide for the annual registration of every person or establishment not licensed as a pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted medical gases. Upon the payment of ~~a~~ any applicable fee ~~to be set by the board~~ specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to those persons or places that may be qualified to sell or distribute federally restricted medical gases. The certificate shall be displayed in a conspicuous place in the business for which it is issued and expire on the date set by the board. It is unlawful for a person to sell or distribute federally restricted medical gases unless a certificate has been issued to that person by the board.

Sec. 24. Minnesota Statutes 2010, section 151.25, is amended to read:

151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.

The board shall require and provide for the annual registration of every person engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes, now or hereafter doing business with accounts in this state. Upon a payment of ~~a~~ any applicable fee ~~as set by the board~~ specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such manufacturer. Such registration certificate shall be displayed in a conspicuous place in such manufacturer's or wholesaler's place of business for which it is issued and expire on the date set by the board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals, or poisons for medicinal purposes unless such a certificate has been issued to the person by the board. It shall be unlawful for any person engaged in the manufacture of drugs, medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell legend drugs to other than a pharmacy, except as provided in this chapter.

Sec. 25. Minnesota Statutes 2010, section 151.47, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** All wholesale drug distributors are subject to the requirements in paragraphs (a) to (f).

(a) No person or distribution outlet shall act as a wholesale drug distributor without first obtaining a license from the board and paying ~~the required~~ any applicable fee specified in section 151.065.

(b) No license shall be issued or renewed for a wholesale drug distributor to operate unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board.

(c) The board may require a separate license for each facility directly or indirectly owned or operated by the same business entity within the state, or for a parent entity with divisions, subsidiaries, or affiliate companies within the state, when operations are conducted at more than one location and joint ownership and control exists among all the entities.

(d) As a condition for receiving and retaining a wholesale drug distributor license issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has and will continuously maintain:

(1) adequate storage conditions and facilities;

(2) minimum liability and other insurance as may be required under any applicable federal or state law;

(3) a viable security system that includes an after hours central alarm, or comparable entry detection capability; restricted access to the premises; comprehensive employment applicant screening; and safeguards against all forms of employee theft;

(4) a system of records describing all wholesale drug distributor activities set forth in section 151.44 for at least the most recent two-year period, which shall be reasonably accessible as defined by board regulations in any inspection authorized by the board;

(5) principals and persons, including officers, directors, primary shareholders, and key management executives, who must at all times demonstrate and maintain their capability of conducting business in conformity with sound financial practices as well as state and federal law;

(6) complete, updated information, to be provided to the board as a condition for obtaining and retaining a license, about each wholesale drug distributor to be licensed, including all pertinent corporate licensee information, if applicable, or other ownership, principal, key personnel, and facilities information found to be necessary by the board;

(7) written policies and procedures that assure reasonable wholesale drug distributor preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or product shipping and receiving, outdated product

or other unauthorized product control, appropriate disposition of returned goods, and product recalls;

(8) sufficient inspection procedures for all incoming and outgoing product shipments; and

(9) operations in compliance with all federal requirements applicable to wholesale drug distribution.

(e) An agent or employee of any licensed wholesale drug distributor need not seek licensure under this section.

(f) A wholesale drug distributor shall file with the board an annual report, in a form and on the date prescribed by the board, identifying all payments, honoraria, reimbursement or other compensation authorized under section 151.461, clauses (3) to (5), paid to practitioners in Minnesota during the preceding calendar year. The report shall identify the nature and value of any payments totaling $100 or more, to a particular practitioner during the year, and shall identify the practitioner. Reports filed under this provision are public data.

Sec. 26. Minnesota Statutes 2010, section 151.48, is amended to read:

151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.

(a) It is unlawful for an out-of-state wholesale drug distributor to conduct business in the state without first obtaining a license from the board and paying ~~the required~~ any applicable fee specified in section 151.065.

(b) Application for an out-of-state wholesale drug distributor license under this section shall be made on a form furnished by the board.

(c) No person acting as principal or agent for any out-of-state wholesale drug distributor may sell or distribute drugs in the state unless the distributor has obtained a license.

(d) The board may adopt regulations that permit out-of-state wholesale drug distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state wholesale drug distributor:

(1) possesses a valid license granted by another state under legal standards comparable to those that must be met by a wholesale drug distributor of this state as prerequisites for obtaining a license under the laws of this state; and

(2) can show that the other state would extend reciprocal treatment under its own laws to a wholesale drug distributor of this state.

Sec. 27. Minnesota Statutes 2010, section 152.12, subdivision 3, is amended to read:

Subd. 3. **Research project use of controlled substances.** Any qualified person may use controlled substances in the course of a bona fide research project but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed and administered by a person lawfully authorized to do so. Every person who engages in research involving the use of such substances shall apply annually for registration by the state Board of Pharmacy and shall pay any applicable fee specified in section 151.065, provided that such registration shall not be required if the person is covered by and has complied with federal laws covering such research projects.

ARTICLE 5

HEALTH CARE

Section 1. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) the premium for the number one qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $1,000 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $1,000 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(b) the premium for the number two qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $500 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $500 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(c) the premiums for the plans with a $2,000, $5,000, or $10,000 annual deductible shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $2,000, $5,000, or $10,000 annual deductible individual plans, respectively, in force in Minnesota; and

(2) individual health maintenance organization contracts of coverage with a $2,000, $5,000, or $10,000 annual deductible, respectively, which are in force in Minnesota; or

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(d) the premium for each type of Medicare supplement plan required to be offered by the association pursuant to section 62E.12 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) Medicare supplement plans in force in Minnesota;

(2) health maintenance organization Medicare supplement contracts of coverage which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles; ~~and~~

(e) the charge for health maintenance organization coverage shall be based on generally accepted actuarial principles~~.~~; and

(f) the premium for a high-deductible, basic plan offered under section 62E.121 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations offering comparable plans outside of the Minnesota Comprehensive Health Association.

The list of insurers and health maintenance organizations whose rates are used to establish the premium for coverage offered by the association pursuant to paragraphs (a) to (d) and (f) shall be established by the commissioner on the basis of information which shall be provided to the association by all insurers and health maintenance organizations annually at the commissioner's request. This information shall include the number of individuals covered by each type of plan or contract specified in paragraphs (a) to (d) and (f) that is sold, issued, and renewed by the insurers and health maintenance organizations, including those plans or contracts available only on a renewal basis. The information shall also include the rates charged for each type of plan or contract.

In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles, provided that the association shall not discriminate in charging premiums based upon sex. In order to compute a weighted average for each type of plan or contract specified under paragraphs (a) to (d) and (f), the association shall, using the information collected pursuant to this subdivision, list insurers and health maintenance organizations in rank order of the total number of individuals covered by

each insurer or health maintenance organization. The association shall then compute a weighted average of the rates charged for coverage by all the insurers and health maintenance organizations by:

(1) multiplying the numbers of individuals covered by each insurer or health maintenance organization by the rates charged for coverage;

(2) separately summing both the number of individuals covered by all the insurers and health maintenance organizations and all the products computed under clause (1); and

(3) dividing the total of the products computed under clause (1) by the total number of individuals covered.

The association may elect to use a sample of information from the insurers and health maintenance organizations for purposes of computing a weighted average. In no case, however, may a sample used by the association to compute a weighted average include information from fewer than the two insurers or health maintenance organizations highest in rank order.

Sec. 2. **[62E.121] HIGH-DEDUCTIBLE, BASIC PLAN.**

Subdivision 1. **Required offering.** The Minnesota Comprehensive Health Association shall offer a high-deductible, basic plan that meets the requirements specified in this section. The high-deductible, basic plan is a one-person plan. Any dependents must be covered separately.

Subd. 2. **Annual deductible; out-of-pocket maximum.** (a) The plan shall provide the following in-network annual deductible options: $3,000, $6,000, $9,000, and $12,000. The in-network annual out-of-pocket maximum for each annual deductible option shall be $1,000 greater than the amount of the annual deductible.

(b) The deductible is subject to an annual increase based on the change in the Consumer Price Index (CPI).

Subd. 3. **Office visits for nonpreventive care.** The following co-payments shall apply for each of the first three office visits per calendar year for nonpreventive care:

(1) $30 per visit for the $3,000 annual deductible option;

(2) $40 per visit for the $6,000 annual deductible option;

(3) $50 per visit for the $9,000 annual deductible option; and

(4) $60 per visit for the $12,000 annual deductible option.

For the fourth and subsequent visits during the calendar year, 80 percent coverage is provided under all deductible options, after the deductible is met.

Subd. 4. **Preventive care.** One hundred percent coverage is provided for preventive care, and no co-payment, coinsurance, or deductible requirements apply.

Subd. 5. **Prescription drugs.** A $10 co-payment applies to preferred generic drugs. Preferred brand-name drugs require an enrollee payment of 100 percent of the health plan's discounted rate.

Subd. 6. **Convenience care center visits.** A $20 co-payment applies for the first three convenience care center visits during a calendar year. For the fourth and subsequent visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 7. **Urgent care center visits.** A $100 co-payment applies for the first urgent care center visit during a calendar year. For the second and subsequent visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 8. **Emergency room visits.** A $200 co-payment applies for the first emergency room visit during a calendar year. For the second and subsequent visits during a calendar year, 80 percent coverage is provided after the deductible is met.

Subd. 9. **Lab and x-ray; hospital services; ambulance; surgery.** Lab and x-ray services, hospital services, ambulance services, and surgery are covered at 80 percent after the deductible is met.

Subd. 10. **Eyewear.** The health plan pays up to $50 per calendar year for eyewear.

Subd. 11. **Maternity.** Maternity, labor and delivery, and postpartum care are not covered. One hundred percent coverage is provided for prenatal care and no deductible applies.

Subd. 12. **Other eligible health care services.** Other eligible health care services are covered at 80 percent after the deductible is met.

Subd. 13. **Option to remove mental health and substance abuse coverage.** Enrollees have the option of removing mental health and substance abuse coverage in exchange for a reduced premium.

Subd. 14. **Option to upgrade prescription drug coverage.** Enrollees have the option to upgrade prescription drug coverage to include coverage for preferred brand-name drugs with a $50 co-payment and coverage for nonpreferred drugs with a $100 co-payment in exchange for an increased premium.

Subd. 15. **Out-of-network services.** (a) The out-of-network annual deductible is double the in-network annual deductible.

(b) There is no out-of-pocket maximum for out-of-network services.

(c) Benefits for out-of-network services are covered at 60 percent after the deductible is met.

(d) The lifetime maximum benefit for out-of-network services is $1,000,000.

Subd. 16. **Services not covered.** Services not covered include: custodial care or rest care; most dental services; cosmetic services; refractive eye surgery; infertility

services; and services that are investigational, not medically necessary, or received while on military duty.

Sec. 3. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision to read:

Subd. 4f. **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** A person may enroll in the comprehensive plan with a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for the healthy Minnesota contribution program, and has been denied coverage as described under section 256L.031, subdivision 6.

Sec. 4. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

Subd. 9. **Growth limits; federal programs.** The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk-based contracting with health plan companies that is consistent with statewide growth limits. ~~The methodology shall be presented for review by the Minnesota Health Care Commission and the Legislative Commission on Health Care Access prior to the submission of a waiver request to the Centers for Medicare and Medicaid Services and subsequent implementation of the methodology.~~

Sec. 5. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

Subd. 9. **Review of eligible providers.** The commissioner and the Medical Education and Research Costs Advisory Committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the ~~Legislative Commission on Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

Sec. 6. **[62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL ERRORS PROHIBITED.**

A health care provider shall not bill a patient, and shall not be reimbursed, for any operation, treatment, or other care that is provided to reverse, correct, or otherwise minimize the affects of an adverse health care event, as described in section 144.7065, subdivisions 2 to 7, for which that health care provider is responsible.

Sec. 7. Minnesota Statutes 2010, section 62Q.32, is amended to read:

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed. ~~The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the Legislative Commission on Health Care Access by January 15, 1996.~~

Sec. 8. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) By no later than October 15, 2010, the commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(c) By no later than January 1, 2011, the commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use,

condition-specific quality of care, and the condition-specific results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:

(1) clearly indicate the reason they believe the data used to calculate the peer group system results are not accurate;

(2) provide evidence and documentation to support the reason that data was not accurate; and

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

If a provider does not meet the requirements of this paragraph, a provider's appeal shall be considered withdrawn. The commissioner shall not publish results for a specific provider under paragraph (e) or (f) while that provider has an unresolved appeal.

(e) Beginning January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing information under paragraph (e) or (f), the commissioner shall ensure the scientific validity and reliability of the results according to the standards described in paragraph (h). If additional time is needed to establish the scientific validity and reliability of the results, the commissioner may delay the dissemination of data to providers under paragraph (b) or (c), or the publication of information under paragraph (e) or (f). If the delay is more than 60 days, the commissioner shall report in writing to the ~~Legislative Commission on~~

~~Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance the following information:

(1) the reason for the delay;

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

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

If there is a delay under this paragraph, the commissioner must disseminate the information to providers under paragraph (b) or (c) at least 90 days before publishing results under paragraph (e) or (f).

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

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

(2) establishment of an explicit minimum reliability threshold developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

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

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

Subd. 9. **Uses of information.** (a) ~~By no later~~ As coverage is offered, sold, issued, or renewed, but not less than 12 months after the commissioner publishes the information in subdivision 3, paragraph (e):

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

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

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

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

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.

Sec. 10. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:

Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner of health shall submit to the ~~Legislative Commission on Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0754.

Sec. 11. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 33. **Contingency contract fees.** When the commissioner enters into a contingency-based contract for the purpose of recovering medical assistance or MinnesotaCare funds, the commissioner may retain that portion of the recovered funds equal to the amount of the contingency fee.

Sec. 12. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 34. **Elimination of certain provider reporting requirements; sunset of new requirements.** (a) Notwithstanding any other law, rule, or provision to the contrary, effective July 1, 2012, the commissioner shall cease collecting from health care providers and purchasers all reports and data related to health care costs, quality, utilization, access, patient encounters, and disease surveillance and public health, and related to provider licensure, monitoring, finances, and regulation, unless the reports or data are necessary for federal compliance. For purposes of this subdivision, the term "health care providers and purchasers" has the meaning provided in section 62J.03, subdivision 8, except that it also includes nursing homes, health plan companies as defined in section 62Q.01, subdivision

4, and managed care and county-based purchasing plans delivering services under sections 256B.69 and 256B.692.

(b) The commissioner shall present to the 2012 legislature draft legislation to repeal, effective July 1, 2012, the provider reporting requirements identified under paragraph (a) that are not necessary for federal compliance.

(c) The commissioner may establish new provider reporting requirements to take effect on or after July 1, 2012. These new reporting requirements must sunset five years from their effective date, unless they are renewed by the commissioner. All new provider reporting requirements and requests for their renewal shall not take effect unless they are enacted in state law.

Sec. 13. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009. For the first 24 months of the rebased period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent rate setting periods in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. ~~Effective January 1, 2013, rates shall be rebased at full value~~ Rates must not be rebased to more current data for the first six months of the rebased period beginning January 1, 2013. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 14. Minnesota Statutes 2010, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Initiatives to reduce incidence of low birth-weight.** The commissioner shall require hospitals located in the seven-county metropolitan area, as a condition of contract, to implement strategies to reduce the incidence of low birth-weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth-weight, with special emphasis on areas within a one-mile radius of the hospital. These strategies may focus on smoking prevention and cessation, ensuring that pregnant women get adequate nutrition, and addressing demographic, social, and environmental risk factors. The strategies must coordinate health care with social services and the local public health system, and offer patient education through appropriate means. The commissioner shall require hospitals to submit proposed initiatives for approval to the commissioner by January 1, 2012, and the commissioner shall require hospitals to implement approved initiatives by July 1, 2012. The commissioner shall evaluate the strategies adopted to reduce low birth-weight, and shall require hospitals to submit outcome and other data necessary for the evaluation.

Sec. 15. Minnesota Statutes 2010, section 256B.04, subdivision 18, is amended to read:

Subd. 18. **Applications for medical assistance.** (a) The state agency may take applications for medical assistance and conduct eligibility determinations for MinnesotaCare enrollees.

(b) The commissioner of human services shall modify the Minnesota health care programs application form to add a question asking applicants: "Are you a United States military veteran?"

Sec. 16. Minnesota Statutes 2010, section 256B.05, is amended by adding a subdivision to read:

Subd. 5. **Technical assistance.** The commissioner shall provide technical assistance to county agencies in processing complex medical assistance applications, including but not limited to applications for long-term care services. The commissioner shall provide this technical assistance using existing financial resources.

Sec. 17. Minnesota Statutes 2010, section 256B.055, subdivision 15, is amended to read:

Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a person who is:

(1) at least age 21 and under age 65;

(2) not pregnant;

(3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII of the Social Security Act;

(4) not an adult in a family with children as defined in section 256L.01, subdivision 3a; and

(5) not described in another subdivision of this section.

(b) If the federal government eliminates the federal Medicaid match or reduces the federal Medicaid matching rate beyond any adjustment required as part of the annual recalculation of the state's overall Medicaid matching rate for persons eligible under this subdivision, the commissioner shall eliminate coverage for persons enrolled under this subdivision and suspend new enrollment under this subdivision effective on the date of the elimination or reduction.

EFFECTIVE DATE. The amendments to this section are effective the day following final enactment and expire January 1, 2014.

Sec. 18. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts

or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; and

(5) effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (c).

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

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

Sec. 19. Minnesota Statutes 2010, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

~~(d) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size.~~

~~(c)~~ (d) In computing income to determine eligibility of persons under paragraphs (a) to ~~(d)~~ (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

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

Sec. 20. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this

chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(i) refugees admitted to the United States according to United States Code, title 8, section 1157;

(ii) persons granted asylum according to United States Code, title 8, section 1158;

(iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(iv) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(v) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or (e), are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully present in the United States, as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the United States Citizenship and Immigration Services to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this

subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition~~, except for organ transplants and related care and services and routine prenatal care~~.

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i)(1) Notwithstanding paragraph (h), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and that are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ and stem cell transplants and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) dialysis;

(ix) chemotherapy or therapeutic radiation services;

(x) rehabilitation services;

(xi) physical, occupational, or speech therapy;

(xii) transportation services;

(xiii) case management;

(xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xv) dental services;

(xvi) hospice care;

(xvii) audiology services and hearing aids;

(xviii) podiatry services;

(xix) chiropractic services;

(xx) immunizations;

(xxi) vision services and eyeglasses;

(xxii) waiver services;

(xxiii) individualized education programs; or

(xxiv) chemical dependency treatment.

~~(i)~~ (j) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present as designated in paragraph (e) and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

~~(j)~~ (k) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

~~(k)~~ (l) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

Sec. 21. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 1b. **Care coordination services provided through pediatric hospitals.** (a) Medical assistance covers care coordination services provided by certain pediatric hospitals to children with high-cost medical conditions and children at risk of recurrent hospitalization for acute or chronic illnesses. There must be Level I and Level II pediatric care coordination services.

(b) Level I pediatric care coordination services are provided by advanced practice nurses employed by or under contract with pediatric hospitals that have a neonatal intensive care unit and are either recipients of payments to support the training of residents from an approved graduate medical residency program under United States Code, title 42, section 256e, or the major pediatric teaching hospital affiliate of the University of Minnesota Medical School, and that meet the criteria in this subdivision.

(c) The services in paragraph (b) must be available through in-home video telehealth management and other methods, and must be designed to improve patient outcomes and reduce unnecessary hospital and emergency room utilization. The services must streamline communication, reduce redundancy, and eliminate unnecessary documentation through the use of a Web-accessible, uniform document that contains critical patient care management information, and which is accessible to all providers with patient consent. The commissioner shall develop the uniform document and associated Web site and shall implement procedures to assess patient outcomes and evaluate the effectiveness of the care coordination services provided under this subdivision.

(d) Medical assistance also covers, as durable medical equipment, computers, webcams, and other technology necessary to allow in-home video telehealth management.

(e) For purposes of paragraph (b), a child has a high-cost medical condition if inpatient hospital expenses for that child related to complex or chronic illnesses or conditions for the most recent calendar year exceeded $100,000, or if the expenses for that child are projected to exceed $100,000 for the current calendar year. For purposes of this subdivision, a child is at risk of recurrent hospitalization if the child was hospitalized three or more times for acute or chronic illness in the most recent calendar year.

(f) For purposes of paragraph (b), "care coordination" means collaboration between the advanced practice nurse and primary care physicians and specialists to manage care and reduce hospitalizations, patient case management, development of medical management plans for chronic illnesses and recurrent acute illnesses, oversight and coordination of all aspects of care in partnership with families, organization of medical information into a summary of critical information, coordination and appropriate sequencing of tests and multiple appointments, information and assistance with accessing resources, and telephone triage for acute illnesses or problems.

(g) The commissioner shall adjust managed care and county-based purchasing plan capitation rates to reflect savings from the coverage of this service.

(h) Level II pediatric care coordination services are provided by registered nurses employed by or under contract with a pediatric hospital that has been designated as an essential community provider under section 62Q.19, subdivision 1, clause (4), and has been a recipient of payments to support the training of residents from an approved graduate medical residency program pursuant to United States Code, title 42, section 256e, and that meets the following criteria:

(1) the services must be provided through telehealth management and other methods, be available on a regular schedule seven days per week, and be designed to provide collaboration in patient care as provided by the patient's family, primary care providers, and the hospital and specialized physicians;

(2) for purposes of this paragraph, a child has a high-cost medical condition if the child has a serious chronic physical disability caused by a congenital anomaly, birth injury or traumatic injury, complications which can be expected to cause further injury, hospitalization, or death, but that can be effectively addressed through ongoing family and primary care supported by communication of ongoing care information and care coordination; and

(3) for purposes of this paragraph, "care coordination" means the ready availability of telehealth management services to support collaboration through a registered nurse between a child's family, the primary care professional that is available to care for the child, and appropriate professionals to address urgent questions about and minimize the consequences of medical complications, develop medical management plans for complex conditions, and avoid serious health consequences and hospitalizations to treat such complications.

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

Sec. 22. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3q. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the

use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

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

Sec. 23. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to read:

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater number of visits is obtained.

Sec. 24. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

Sec. 25. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. ~~Effective July 1, 2009,~~ The actual acquisition cost of a drug shall be estimated by the commissioner~~,~~ at ~~average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent.~~ wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Wholesale acquisition cost is defined as

the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be on the basis of the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or ~~the amount established for Medicare by the~~ 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider or the wholesale acquisition cost.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may

require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective July 1, 2011, or upon federal approval, whichever is later.

Sec. 26. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking ~~four~~ three or more prescriptions to treat or prevent ~~two~~ one or more chronic medical conditions~~, or~~, a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, ~~excluding~~ including long-term care ~~and~~ settings, group homes, ~~if the service is ordered by the provider-directed care coordination team~~ and facilities providing assisted living services; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the

requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 27. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) an ambulance, as defined in section 144E.001, subdivision 2;

(2) special transportation; or

(3) common carrier including, but not limited to, bus, taxicab, other commercial carrier, or private automobile.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation providers shall perform driver-assisted services for eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the most direct route. The minimum medical assistance reimbursement rates for special transportation services are:

(1) (i) $17 for the base rate and $1.35 per mile for special transportation services to eligible persons who need a wheelchair-accessible van;

(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to eligible persons who do not need a wheelchair-accessible van; and

(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for special transportation services to eligible persons who need a stretcher-accessible vehicle;

(2) the base rates for special transportation services in areas defined under RUCA to be super rural shall be equal to the reimbursement rate established in clause (1) plus 11.3 percent; and

(3) for special transportation services in areas defined under RUCA to be rural or super rural areas:

(i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125 percent of the respective mileage rate in clause (1); and

(ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to 112.5 percent of the respective mileage rate in clause (1).

(c) For purposes of reimbursement rates for special transportation services under paragraph (b), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(d) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(e) Effective for services provided on or after July 1, 2011, nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, are reduced 4.5 percent. Payments made to managed care plans and county-based

purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 28. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2011, ambulance services payment rates are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to read:

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers ~~costs of~~ the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Sec. 30. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party payer. A good faith effort is established by supplying with the authorization request to the commissioner the following:

(1) a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

(2) the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available for the service.

(c) Authorization is not required if a third-party payer has made payment that is equal to or greater than 60 percent of the maximum payment amount for the service allowed under medical assistance.

Sec. 31. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to read:

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

(b) ~~Until the volume of systems purchased increases to allow a discount price, the commissioner shall reimburse augmentative and alternative communication manufacturers and vendors at the manufacturer's suggested retail price for augmentative and alternative communication systems and related components. The commissioner shall separately reimburse providers for purchasing and integrating individual communication systems which are unavailable as a package from an augmentative and alternative communication vendor.~~ Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

Sec. 32. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Payment for multiple services provided on same day.** The commissioner shall not prohibit payment, including any supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health services or dental services were provided on the same day as other covered health care services furnished by the same provider.

Sec. 33. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56. **Medical care coordination.** (a) Medical assistance covers in-reach community-based care coordination that is performed in a hospital emergency department as an eligible procedure under a state health care program or private insurance for a frequent user.

(b) Reimbursement must be made in 15-minute increments under current Medicaid mental health social work reimbursement methodology and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. A frequent user who is participating in care coordination within a health care home framework is ineligible for reimbursement under this subdivision. Eligible in-reach care coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) A frequent user is defined as an individual who:

(1) has frequented the hospital emergency department for services three or more times in the previous six consecutive months;

(2) would benefit from the provision of in-reach community-based services; and

(3) has two or more of the following risk factors:

(i) on one or more occasions within the last 24 months, the individual was diagnosed with a chronic or life-threatening condition that requires management of symptoms, medications, health care, or changes in lifestyle or risk-related behaviors that may include, but are not limited to, HIV/AIDS, hepatitis, diabetes, heart disease, hypertension, emphysema, asthma, or cancer;

(ii) on one or more occasions within the last 24 months, the individual was diagnosed or, in the judgment of an emergency department physician, would likely be diagnosed,

if provided a mental assessment, with an Axis I or II mental disorder identified in the Diagnostic and Statistical Manual of Mental Disorders;

(iii) on one or more occasions within the last 24 months, the individual was diagnosed or, in the judgment of an emergency department physician, would likely be diagnosed, if provided an assessment, with a substance use problem that interferes with the individual's health or appropriate utilization of health services; or

(iv) the individual is currently experiencing homelessness. "Homelessness" means lacking a fixed, regular, or adequate nighttime residence or a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations or a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings.

(d) Any hospital choosing to participate in medical care coordination under this subdivision must, upon request by the commissioner of human services, make available program utilization data. Frequent users who are enrolled in a program must track:

(1) the total number of program participants in the frequent user program for a defined period of time established by the commissioner;

(2) the total number of program participants and what form of health care coverage they had at the time of enrollment and the number of beneficiaries who did not remain enrolled in the program for at least two months;

(3) the frequency of emergency department visits during the 12 months prior to enrollment in the program and associated costs to the hospital;

(4) the frequency of emergency department visits during the 12 months after program enrollment and the associated costs to the hospital;

(5) the total number of inpatient admissions during the 12 months immediately preceding enrollment and the associated costs to the hospital;

(6) the total number of inpatient admissions during the 12 months after enrollment in the program and the associated costs to the hospital;

(7) the total number of inpatient days during the 12 months immediately preceding enrollment and the associated costs to the hospital; and

(8) the total number of inpatient days during the 12 months after program enrollment and the associated costs to the hospital.

(e) For the purposes of this subdivision, "in-reach community-based care coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working with an organization's staff to transition an individual back into the individual's living

environment. In-reach community-based care coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

Sec. 34. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

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

Sec. 35. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 36. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 59. **Services provided by advanced dental therapists and dental therapists.** Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

Sec. 37. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60. **Payment for noncovered services.** (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long-term care per diem;

(5) the recipient is enrolled in the restricted recipient program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescriptive drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service.

Sec. 38. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. ~~**Co-payments**~~ **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing for all recipients, effective for services provided on or after ~~October 1, 2003, and before January 1, 2009~~ July 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (c). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) ~~$6~~ $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval; ~~and~~

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.;

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

~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:~~

~~(1) $3.50 for nonemergency visits to a hospital-based emergency room;~~

~~(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(3)~~ (6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly ~~co-payments~~ cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on ~~co-payments~~ cost-sharing.

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

(c) Effective January 1, 2012, or upon federal approval, whichever is later, the following co-payments for nonpreventive visits shall apply to providers included in provider peer grouping:

(1) $3 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is at the 60th percentile or lower for providers of the same type;

(2) $6 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) $10 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county-based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph using a methodology approved by the commissioner. The commissioner shall develop a

methodology for calculating the average, risk-adjusted, total annual cost of care for fee-for-service providers.

(d) The commissioner shall seek any federal waivers and approvals necessary to increase the co-payment for nonemergency visits to a hospital-based emergency room under paragraph (a), clause (3), and to implement paragraph (c).

Sec. 39. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Sec. 40. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum ~~or the $7 per month maximum effective January 1, 2009,~~ for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent ~~co-payment~~ cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

Sec. 41. Minnesota Statutes 2010, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic

disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers.

(e) A provider described in section 256B.76, subdivision 5, may limit the eligibility of new medical assistance, general assistance medical care, and MinnesotaCare patients for specific categories of rehabilitative services, if medical assistance, general assistance medical care, and MinnesotaCare patients served by the provider in the aggregate exceed 30 percent of the provider's overall patient population.

Sec. 42. Minnesota Statutes 2010, section 256B.0751, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant licensed and practicing under chapter 147A, ~~or~~ a mental health professional licensed under section 245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6), or an advanced practice nurse licensed and registered to practice under chapter 148.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Sec. 43. Minnesota Statutes 2010, section 256B.0751, subdivision 2, is amended to read:

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, ~~and~~ mental health professionals, and physician assistants as personal clinicians but permitting multidisciplinary teams of other health professionals;

(2) focus on delivering high-quality, efficient, and effective health care services and providing, arranging, or coordinating related social and public health services and other services that directly affect an individual's health, access to services, quality and outcomes, and patient satisfaction;

(3) encourage patient-centered care and services, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of ~~clinical~~ professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care and wellness plans for their patients with complex or chronic conditions, including an assessment of health risks ~~and~~, chronic conditions, and socioeconomic factors affecting health and treatment;

(6) enable and encourage utilization of a range of qualified health care professionals and other professionals or services related to the health and treatment of the patient, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience, with appropriate adjustments for socioeconomic factors;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment and service options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Sec. 44. Minnesota Statutes 2010, section 256B.0751, subdivision 3, is amended to read:

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician ~~or~~, a primary care clinic, or community mental health center eligible for payment under section 256B.0625, subdivision 5, may be certified as a health care home. If a primary care clinic or mental health center is certified, all of the primary care clinic's or mental health center's clinicians who may provide care to persons enrolled with the health care home must meet the criteria of a health care home. In order to be certified as a health care home, a clinician ~~or~~, clinic, or community mental health center must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians ~~or~~, clinics, or mental health centers certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Sec. 45. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to read:

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner of health shall modify the health care homes application for certification to add an item allowing an applicant to indicate status as a federally qualified health center or a federally qualified health center look-alike, as defined in section 145.9269, subdivision 1. Effective July 1, 2012, the commissioner shall certify as a health care home each applicant that indicates this status on a completed application for certification, without requiring the applicant to meet the standards in Minnesota Rules, part 4764.0040. In order to retain certification, a federally qualified health center or federally qualified health center look-alike certified under this paragraph must seek annual recertification by submitting a letter of intent stating its desire to be recertified but is not required to meet the standards for recertification in Minnesota Rules, part 4764.0040.

(c) The commissioner of health shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

Sec. 46. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical or socioeconomic needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and health care home.

Sec. 47. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 9. **Patient choice of health care home.** Notwithstanding section 256B.69, subdivisions 4 and 23, and subject to any necessary federal approval, the commissioner may require a patient enrolled in a state health care program through a managed care plan, county-based purchasing plan, fee-for-service, or demonstration project under section 256B.0755 to select a health care home and agree to receive primary care and care coordination services through the health care home as a condition of enrollment in the state health care program. The patient must be allowed to choose from among all available qualified health care providers, including an essential community provider as defined in section 62Q.19, if the provider is certified as a health care home and agrees to accept the terms, conditions, and payment rates for participation in the managed care plan, county-based purchasing plan, fee-for-service program, or demonstration project, except that reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must comply with federal law.

Sec. 48. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 10. **Engagement of patients and communities in health care home.** The commissioner of health shall require health care homes to demonstrate that their health care home patients, and the racial and ethnic communities of current or potential patients, participate in evaluating the health care home and recommending improvements and changes to the health care home's methods and procedures in order to improve health, quality, and patient satisfaction for patients from those communities. The commissioner shall consult with racial and ethnic communities to determine whether the requirements of this section and rules adopted under it are barriers to effective health care home methods and procedures for serving patients of racial and ethnic communities.

Sec. 49. Minnesota Statutes 2010, section 256B.0753, is amended by adding a subdivision to read:

Subd. 4. **Waiver recipients.** A health care home shall receive the highest care coordination payment established under section 256B.0753 for providing services to an enrollee receiving home and community-based waiver services.

Sec. 50. Minnesota Statutes 2010, section 256B.0754, is amended by adding a subdivision to read:

Subd. 3. **Primary care provider tiering.** (a) The commissioner shall establish a tiering system for all providers participating in Minnesota health care programs.

The tiering system must differentiate providers on the basis of their ability to provide cost-effective, quality care and must incorporate the provider peer grouping measures established under section 62U.04. The tier assignments must be established annually based on the most recent peer grouping measures available. Differentiation of tier assignments must be statistically valid. The commissioner may set specific quality standards for providers designated as high-performing providers under this subdivision.

(b) The commissioner may adjust the rates paid to providers within each tier group established under paragraph (a) on an annual basis. Adjustments to rates shall not include the rate paid for care coordination services to certified health care homes under section 256B.0753. Providers designated high-performing providers under paragraph (c) are not eligible for rate increases unless the provider also meets the cost and quality criteria associated with that tier level.

(c) Health care homes certified under section 256B.0751, rural health clinics, and federally qualified health care clinics are designated as high-performing providers under this subdivision.

(d) Providers reimbursed on a cost basis are subject to rate adjustments under this section.

(e) The commissioner may phase in the tiering system by service type.

EFFECTIVE DATE. This section is effective one year from the public release of provider peer grouping measures under Minnesota Statutes, section 62U.04, or upon federal approval, whichever is later.

Sec. 51. Minnesota Statutes 2010, section 256B.0755, subdivision 4, is amended to read:

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The total cost of care benchmark for demonstration projects must be no greater than the capitation rate that would have been paid to a managed care plan for a substantially similar enrollee population based on the per-member per-month rate in

effect on December 31, 2010. The commissioner shall adjust benchmark payment rates for demonstration projects as necessary to reflect the higher level of service and cost necessary to serve a patient population with a higher incidence of socioeconomic barriers and complexity, and shall make corresponding reductions in payment rates for projects with a lower concentration of patients with socioeconomic barriers and complexity.

Sec. 52. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled in a demonstration project who have complex medical or socioeconomic needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, or housing. The coordination of care and services must be as provided in the plan established by the patient and primary care provider or health care home.

Sec. 53. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 9. **Rural demonstration projects.** For demonstration projects serving rural areas, the commissioner shall consult with rural hospitals, primary care providers, county boards, health plans, and other key stakeholders primarily domiciled in the service area regarding the development and approval of alternative rural health care delivery demonstration projects under this section. In addition to organizations eligible to establish a demonstration project under subdivision 1, a rural demonstration project may be established by a county public health or social services agency or a county-based purchasing plan. In a rural area where multiple, competing provider-based demonstration projects are not possible, the commissioner shall not approve more than one demonstration project to serve the primary geographic area and shall follow the applicable procedures and requirements in section 256B.692 regarding participation of county boards in reviewing and approving demonstration project proposals.

Sec. 54. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 10. **Patient choice of qualified provider.** The commissioner shall implement and approve demonstration projects in a manner that allows a patient to choose a primary care provider and health care home from among all available qualified options. The

commissioner may require the patient to remain with the chosen provider, health care home, or demonstration project organization for a period of time determined by the commissioner. The commissioner shall implement the demonstration projects in a manner that ensures that a patient has the option of receiving services, including health care home services, through a provider designated as an essential community provider under section 62Q.19. Demonstration projects and essential community providers must comply with section 62Q.19, subdivisions 3 to 7, for purposes of participation of providers in the demonstration project, except that reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must be in compliance with federal law.

Sec. 55. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 11. **Patient and community engagement.** As a condition of approval of a demonstration project, the commissioner shall require the applicant to demonstrate that consumers and communities to be served under the project were consulted with and engaged in the process of developing the project proposal. The proposal must identify the needs and preferences of consumers and communities that were identified through this process of consultation and engagement. The consumers and communities consulted with and engaged in the development of the proposal must generally reflect the demographics, race, and ethnicity of those likely to be served under the demonstration project, with a special focus on those who experience the greatest health disparities. The commissioner shall require that demonstration project providers continue to consult with and engage consumers and communities during implementation and operation of the demonstration project.

Sec. 56. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 12. **Care coordination system.** The commissioner of human services, in consultation with the commissioner of health, shall convene an advisory committee of small, independent, rural, and safety net primary care clinics, community hospitals, mental health centers, dental clinics, and other providers to advise the commissioner on the establishment of a system that will allow providers participating in payment reform demonstration projects established under this section and section 256B.0756 to effectively coordinate and deliver care to patients. In consultation with the advisory committee, the commissioner shall develop a plan for the care coordination system, issue a

request for proposals, and contract with a vendor or vendors to establish and maintain the technology for the care coordination system. Using appropriations made for this purpose, the commissioner shall fund the planning, development, and establishment of the system. Ongoing costs must be covered by payments made by the providers who use the system.

Sec. 57. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 13. **Approval and implementation.** Beginning January 1, 2012, the commissioner of human services shall approve payment reform projects authorized under this section for medical assistance and MinnesotaCare. The commissioner may approve projects for persons enrolled in fee-for-service programs and may require managed care plans and county-based purchasing plans to contract with a demonstration project provider on the same terms, conditions, and payment arrangements as are established by the commissioner for fee-for-service programs.

Sec. 58. Minnesota Statutes 2010, section 256B.0756, is amended to read:

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals

the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

(h) A demonstration project established under this section must meet the requirements of section 256B.0755, subdivisions 8, 9, 10, and 11.

Sec. 59. **[256B.0758] PREGNANCY CARE HOMES.**

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

(b) "Pregnancy care home" means a health care home certified by the commissioner of health under section 256B.0751 that provides pregnancy care services in a way that is patient-centered, outcome-driven, comprehensive, and coordinated, and meets the standards specified and developed under subdivision 3.

(c) "Pregnancy care services" means prenatal care, consultative perinatal services, intrapartum and postpartum care, and well-baby care for the first week.

(d) "State health care program" means the medical assistance and MinnesotaCare programs.

Subd. 2. **Development and implementation of standards.** (a) The commissioners of human services and health shall develop and implement standards of certification of pregnancy care homes for state health care programs. In developing standards, the commissioners shall consult with representatives of the American College of Nurse Midwives, the American Congress of OB/GYN, the American Academy of Family Practice, the American Academy of Pediatrics, and relevant local consumer groups.

Subd. 3. **Criteria for development of standards.** (a) A pregnancy care home must meet the general health care home standards developed by the commissioners under section 256B.0751, subdivision 2, paragraph (a), clauses (1) to (4), (6), and (8) to (10), and must also meet specific standards for pregnancy care homes. The specific standards for

pregnancy care homes developed by the commissioners must meet the criteria specified in this subdivision.

(b) A pregnancy care home must provide pregnancy care services. Nonpregnancy complications, such as preexisting illness, shall be covered by medical assistance outside of the pregnancy care home. During a pregnancy episode, the pregnancy care home must coordinate necessary nonpregnancy health care services with the mother's primary care provider or another appropriate provider.

(c) Each pregnancy care home must have adequate malpractice insurance that meets the standards specified by the commissioners.

(d) A pregnancy care home may provide pregnancy services through any health care professional licensed to provide the service in Minnesota, including but not limited to licensed traditional midwives, certified nurse midwives, family practitioners, obstetricians, perinatologists, neonatologists, and other advanced practice registered nurses.

(e) Pregnancy care within a pregnancy care home may be provided at any Minnesota facility licensed to provide pregnancy care and birth, including but not limited to freestanding birth centers, integrated birth centers, and hospitals. Each pregnancy care home must offer the option of midwife-directed pregnancy care services in a licensed integrated or freestanding birth center.

(f) A pregnancy care home must have a governing board comprised of at least eight members. One-half of the governing board members must be providers licensed to attend births.

(g) Each pregnancy care home must have a formal consultative relationship with at least one level III perinatal center to provide care for mothers and babies who develop pregnancy complications.

(h) Each pregnancy care home must comply with state and federal requirements for the use of interoperable electronic medical records.

(i) Each pregnancy care home must submit annual reports to the commissioners of human services and health that document:

(1) all relevant pregnancy care outcomes and patient satisfaction measures; and

(2) the financial status of the pregnancy care home.

All reports are public data under section 13.02.

(j) Each pregnancy care home must offer culturally competent care coordination services in a manner that is consistent with health care home requirements.

(k) For the purposes of developing and implementing the standards in this subdivision, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 4. **Certification process.** Providers seeking certification as a pregnancy care home must apply to the commissioner of health. Providers certified by the commissioner of health may provide pregnancy care services through pregnancy care homes beginning July 1, 2012. Certification as a pregnancy care home is voluntary, except that beginning July 1, 2014, all nonemergency pregnancy care services covered under state health care programs must be provided through providers certified as pregnancy care homes.

Subd. 5. **Payments to pregnancy care homes.** (a) The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides a single per-person payment to pregnancy care homes to cover all pregnancy care services provided to each mother and infant enrolled in a state health care program. Pregnancy care homes receiving payments under this subdivision remain eligible for care coordination payments under section 256B.0753.

(b) Payment amounts for pregnancy care homes shall be uniform statewide and determined annually by the commissioner, based initially upon a specified percentage of the calculated average cost of care for mothers and infants under state health care programs for the three most recent fiscal years for which cost information is available. Beginning July 1, 2014, statewide payment amounts for pregnancy care homes shall be determined annually by the commissioner by adjusting the current payment amount by a measure of medical inflation selected by the commissioner that best represents the change in the cost of pregnancy-related services provided to patients covered by private sector health coverage.

(c) Pregnancy care home payments must initially be made for pregnancy care services provided to pregnant women who are not high risk, beginning July 1, 2012. Beginning January 1, 2013, the commissioner shall phase in higher payments for high-risk pregnancy categories so that beginning July 1, 2014, pregnancy care services for all low-risk and high-risk pregnancies are reimbursed under this subdivision.

Sec. 60. **[256B.0759] CARE COORDINATION FOR ENROLLEES.**

Subdivision 1. **Qualified enrollee.** For purposes of this section, a "qualified enrollee" means: (1) a medical assistance enrollee eligible under this chapter; or (2) a MinnesotaCare enrollee eligible under chapter 256L.

Subd. 2. **Selection of primary care provider.** The commissioner shall require qualified enrollees who do not have a designated medical condition to select a primary care provider and agree to receive primary care services from that provider as a condition of medical assistance or MinnesotaCare enrollment.

Subd. 3. **Selection of health care home; care coordination.** (a) The commissioner shall require qualified enrollees who have a medical condition designated by the commissioner to select a health care home certified under section 256B.0751 and agree to receive primary care and care coordination services through that health care home as a condition of medical assistance or MinnesotaCare enrollment. For purposes of this subdivision, the commissioner shall designate medical conditions with a high likelihood of inappropriate inpatient hospital admissions for which care coordination and prior authorization of admissions are expected to improve the quality of care and lead to costs savings for state health care programs.

(b) The commissioner shall include on Minnesota health care program enrollment cards a designation as to whether an enrollee meets the criteria in paragraph (a). In order to receive medical assistance or MinnesotaCare payment for nonemergency inpatient hospital admissions for enrollees meeting the criteria in paragraph (a), a hospital must receive prior authorization from the enrollee's health care home.

EFFECTIVE DATE. This section is effective January 1, 2012, for MinnesotaCare enrollees not eligible for a federal match, and is effective January 1, 2012, or upon federal approval, whichever is later, for medical assistance enrollees and for MinnesotaCare enrollees eligible for a federal match.

Sec. 61. **[256B.0760] ELECTIVE SURGERY.**

Subdivision 1. **Payment prohibition.** The commissioner, in consultation with health care providers, health care homes certified under section 256B.0751, managed care plans providing services under section 256B.69, and county-based purchasing plans providing services under section 256B.692, shall identify elective or nonemergency surgical procedures for which less invasive and less costly alternative treatment methods are available, and shall prohibit payment for these elective or nonemergency surgical procedures if the alternative treatment methods have not first been evaluated for use and, if appropriate, provided to the enrollee.

Subd. 2. **Implementation.** The commissioner shall implement the payment prohibitions in paragraph (a) for fee-for-service medical assistance providers by January 1, 2012, and shall require managed care and county-based purchasing plans to implement the payment prohibitions in paragraph (a) for providers employed or under contract for services provided to medical assistance and MinnesotaCare enrollees beginning January 1, 2012.

Subd. 3. **Reduction in capitation rates.** The commissioner shall reduce medical assistance and MinnesotaCare capitation rates to managed care and county-based

purchasing plans beginning January 1, 2012, to reflect cost-savings to plans resulting from implementation of the payment prohibitions required by this subdivision.

Sec. 62. Minnesota Statutes 2010, section 256B.37, subdivision 5, is amended to read:

Subd. 5. **Private benefits to be used first.** Private accident and health care coverage, including Medicare for medical services and coverage provided through the United States Department of Veterans Affairs, is primary coverage and must be exhausted before medical assistance or alternative care services are paid for medical services including home health care, personal care assistance services, hospice, supplies and equipment, or services covered under a Centers for Medicare and Medicaid Services waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan or coverage provided through the United States Department of Veterans Affairs, the private health care benefits available to the person must be used first and to the fullest extent.

Sec. 63. Minnesota Statutes 2010, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing or administering the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county, including proposals for demonstration projects established under section 256B.0755. County boards must be given reasonable opportunity to ~~make recommendations regarding~~ assist in the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make ~~recommendations~~ determinations regarding the approval of local networks and their operations to ensure adequate local availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board ~~may recommend~~ shall decide a maximum number of participating health plans including county-based purchasing plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county

administrative complexity; and considering the need to promote the viability of locally developed health plans, managed care plans, or demonstration projects established under section 256B.0755. The county board or a single entity representing a group of county boards and the commissioner shall mutually select one or more qualified health plans or county-based purchasing plans for participation at the time of initial implementation of the prepaid medical assistance program or a demonstration project established under section 256B.0755 in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals and health care delivery and access goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan managed care or delivery system demonstration project functions and within the scope of the medical assistance benefit set. ~~If the county board and the commissioner mutually agree to such requirements, the department~~ The commissioner shall include such requirements in all ~~health plan~~ contracts governing the prepaid medical assistance program in that county at initial implementation of the program or demonstration project in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract ~~provisions related to local public health goals~~.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a ~~preliminary and final~~ proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans or demonstration projects under section 256B.0755 in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner

shall resolve all disputes ~~after taking into account~~ by approving the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

(i) This section also applies to other Minnesota health care programs administered by the commissioner, including but not limited to the MinnesotaCare program.

Sec. 64. Minnesota Statutes 2010, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

(g) For an eligible individual under the age of 65, in the absence of a specific managed care plan choice by the individual, the commissioner shall assign the individual to the county-based purchasing plan, if any, in the county of the individual's residence. For an eligible individual over the age of 65, the commissioner shall make the default assignment on the county-based purchasing plan entering into a contract with the commissioner to serve this population and receiving federal approval as a special needs plan.

Sec. 65. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no

sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold in this paragraph does not apply to county-based purchasing plans.

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization rates or subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason for the hospitalization for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization rate was achieved.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for state health care program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for state health care program enrollees for calendar year 2010. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved. The commissioner

shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

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

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

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

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

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

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

~~(n)~~ (o) The return of the withhold under paragraphs (d), (f), and (h) to (k) is not subject to the requirements of paragraph (c).

Sec. 66. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

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

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

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

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

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

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

(c) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund. The balance of the transfers under paragraph (a) shall be transferred to the medical education and research fund no earlier than July 1 of the following fiscal year.

(d) Beginning in fiscal year 2012, the commissioner shall reduce the amount transferred to the medical education research fund under paragraph (a), by $4,500,000

each fiscal year. This reduction must be applied to the amount available for general distribution under section 62J.692, subdivision 7, clause (5).

Sec. 67. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) A demonstration provider must accept into its medical assistance and MinnesotaCare provider networks any health care or social service provider that agrees to accept payment, quality assurance, and other contract terms that the demonstration provider applies to other similarly situated providers in its provider network.

EFFECTIVE DATE. This section is effective January 1, 2012, and applies to provider contracts that take effect on or after that date.

Sec. 68. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Provider payment rates.** (a) Each managed care and county-based plan shall, by October 1, 2011, array all providers within each provider type, employed by or

under contract with the plan, by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for the most recent reporting year for which data is available, risk-adjusted for enrollee demographics and health status.

(b) Beginning January 1, 2012, and each contract year thereafter, each managed care and county-based purchasing plan shall implement a progressive payment withhold methodology for each provider type, under which the withhold for a provider increases proportionally as the provider's risk-adjusted total annual cost increases, relative to other providers of the same type. For purposes of this paragraph, the risk-adjusted total annual cost of care is the dollar amount calculated under paragraph (a).

(c) At the end of each contract year, each plan shall array all providers within each provider type by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for that contract year, risk-adjusted for enrollee demographics and health status. For each provider whose risk-adjusted total annual cost of care is at or below a benchmark percentile established by the plan, the plan shall return the full amount of any withhold. For each provider whose risk-adjusted total annual cost of care is above the benchmark percentile, the plan shall return only the portion of the withhold sufficient to bring the provider's payment rate to the average for providers within the provider type whose risk-adjusted total annual cost of care is at the benchmark percentile. Each plan shall establish the benchmark percentile at a level that allows the plan to adjust expenditures for provider payments to reflect the reduction in capitation rates under paragraph (f).

(d) Each managed care and county-based purchasing plan must establish an appeals process to allow providers to appeal determinations of risk-adjusted total annual cost of care. Each plan's appeals process must be approved by the commissioner.

(e) The commissioner shall require each plan to submit to the commissioner, in the form and manner specified by the commissioner, all provider payment data and information on the withhold methodology that the commissioner determines is necessary to verify compliance with this subdivision.

(f) The commissioner, for the contract year beginning January 1, 2012, shall reduce plan capitation rates by 12 percent from the rates that would otherwise apply, absent application of this subdivision. The reduced rate shall be the historical base rate for negotiating capitation rates for future contract years. The commissioner may recommend additional reductions in capitation rates for future contract years to the legislature, if the commissioner determines this is necessary to ensure that health care providers under contract with managed care and county-based purchasing plans practice in an efficient manner.

(g) The commissioner of human services, in consultation with the commissioner of health, shall develop and provide to managed care and county-based purchasing plans, by September 1, 2011, standard criteria and definitions necessary for consistent calculation of the total annual risk-adjusted cost of care across plans. The commissioner may use encounter data collected under section 62U.04 to implement this subdivision, and may provide encounter data or analyses to plans. Section 62U.04, subdivision 4, paragraph (b), shall not apply to the commissioners of health and human services for purposes of this subdivision.

(h) For purposes of this subdivision, "provider" means a vendor of medical care as defined in section 256B.02, subdivision 7, for which sufficient encounter data on utilization and costs is available to implement this subdivision.

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

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

Subd. 31. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans as a condition of contract to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight, with special emphasis on areas within a one-mile radius of hospitals within their provider networks. These strategies may focus on smoking prevention and cessation, ensuring that pregnant women get adequate nutrition, and addressing demographic, social, and environmental risk factors. The strategies must coordinate health care with social services and the local public health system, and offer patient education through appropriate means. The commissioner shall require plans to submit proposed initiatives for approval to the commissioner by January 1, 2012, and the commissioner shall require plans to implement approved initiatives by July 1, 2012. The commissioner shall evaluate the strategies adopted to reduce low birth weight and shall require plans to submit outcome and other data necessary for the evaluation.

Sec. 70. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 32. **Health education.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to provide health education, wellness training, and information about the availability and benefits of preventive services to all medical assistance and MinnesotaCare enrollees, beginning January 1,

2012. Plan initiatives developed or implemented to comply with this requirement must be approved by the commissioner.

Sec. 71. Minnesota Statutes 2010, section 256B.692, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 72. Minnesota Statutes 2010, section 256B.692, subdivision 5, is amended to read:

Subd. 5. **County proposals.** (a) On or before September 1, 1997, a county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department on or before

July 1, 1997. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

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

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

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

Sec. 73. Minnesota Statutes 2010, section 256B.692, subdivision 7, is amended to read:

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the ~~recommendation~~ decision of a three-person mediation panel. The commissioner shall resolve all disputes ~~after taking into account~~ by following the ~~recommendations~~ decision of the mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Sec. 74. Minnesota Statutes 2010, section 256B.692, is amended by adding a subdivision to read:

Subd. 11. **Patient choice of qualified provider.** Effective January 1, 2012, a county board operating a county-based purchasing plan must ensure that each enrollee has the option of choosing a primary care provider or a health care home from all qualified providers who agree to accept the terms, conditions, and payment rates offered by the plan to similarly situated providers. Notwithstanding this requirement, reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must be in compliance with federal law.

Sec. 75. Minnesota Statutes 2010, section 256B.694, is amended to read:

256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

(a) Notwithstanding section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) At the request of a county or group of counties, the commissioner shall ~~consider, and may~~ approve~~,~~ contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll,~~ enrolled in Minnesota health care programs in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in section

256B.69, subdivision 23, are satisfied. Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

Sec. 76. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

(5) a dental clinic ~~associated with an oral health or dental education program~~ owned and operated by the University of Minnesota or ~~an institution within~~ the Minnesota State Colleges and Universities system.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 77. **[256B.7671] PATIENT-CENTERED DECISION-MAKING.**

(a) For purposes of this section, "patient-centered decision-making process" means a process that involves directed interaction with the patient to assist the patient in arriving at an informed objective health care decision regarding the surgical procedure that is both informed and consistent with the patient's preference and values. The interaction may be conducted by a health care provider or through the electronic use of decision aids. If decision aids are used in the process, the aids must meet the criteria established by the International Patients Decision Aids Standards Collaboration or the Cochrane Decision Aid Registry.

(b) Effective January 1, 2012, the commissioner of human services shall require active participation in a patient-centered decision-making process before authorization is approved or payment reimbursement is provided for any of the following:

(1) a surgical procedure for abnormal uterine bleeding, benign prostate enlargement, chronic back pain, early stage of breast and prostate cancers, gastroesophageal reflux disease, hemorrhoids, spinal stenosis, temporomandibular joint dysfunction, ulcerative colitis, urinary incontinence, uterine fibroids, or varicose veins; and

(2) bypass surgery for coronary disease, angioplasty for stable coronary artery disease, or total hip replacement.

(c) A list of the procedures in paragraph (b) shall be published in the State Register by October 1, 2011. The list shall be reviewed no less than every two years by the commissioner, in consultation with the commissioner of health. The commissioner shall hold a public forum and receive public comment prior to any changes to the list in paragraph (b). Any changes made shall be published in the State Register.

(d) Prior to receiving authorization or reimbursement for the procedures identified under this section, a health care provider must certify that the patient has participated in a patient-centered decision-making process. The format for this certification and the process for coordination between providers shall be developed by the Health Services Policy Committee under section 256B.0625, subdivision 3c.

(e) This section does not apply if any of the procedures identified in this section are performed under an emergency situation.

Sec. 78. **[256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment and implementation.** The commissioner of human services, in consultation with the commissioner of health, shall contract with a Minnesota-based academic and research institution specializing in providing complementary and alternative medicine education and clinical services to establish and implement a five-year demonstration project in conjunction with federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269, to improve the quality and cost-effectiveness of care provided under medical assistance to enrollees with neck and back problems. The demonstration project must maximize the use of complementary and alternative medicine-oriented primary care providers, including but not limited to physicians and chiropractors. The demonstration project must be designed to significantly improve physical and mental health for enrollees who present with neck and back problems while decreasing medical treatment costs. The commissioner, in consultation with the commissioner of health, shall deliver services through the demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

Subd. 2. **RFP and project criteria.** The commissioner, in consultation with the commissioner of health, shall develop and issue a request for proposal (RFP) for the demonstration project. The RFP must require the academic and research institution selected to demonstrate a proven track record over at least five years of conducting high-quality, federally funded clinical research. The institution and the federally qualified health centers and federally qualified health center look-alikes shall also:

(1) provide patient education, provider education, and enrollment training components on health and lifestyle issues in order to promote enrollee responsibility for health care decisions, enhance productivity, prepare enrollees to reenter the workforce, and reduce future health care expenditures;

(2) use high-quality and cost-effective integrated disease management that includes the best practices of traditional and complementary and alternative medicine;

(3) incorporate holistic medical care, appropriate nutrition, exercise, medications, and conflict resolution techniques;

(4) include a provider education component that makes use of professional organizations representing chiropractors, nurses, and other primary care providers and provides appropriate educational materials and activities in order to improve the

integration of traditional medical care with licensed chiropractic services and other alternative health care services and achieve program enrollment objectives; and

(5) provide to the commissioner the information and data necessary for the commissioner to prepare the annual reports required under subdivision 6.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the commissioner from current enrollees in the prepaid medical assistance program who have, or are determined to be at significant risk of developing, neck and back problems. Participation in the demonstration project shall be voluntary. The commissioner shall seek to enroll, over the term of the demonstration project, ten percent of current and future medical assistance enrollees who have, or are determined to be at significant risk of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic and research institution selected, federally qualified health centers, and federally qualified health center look-alikes to fund all net costs of the demonstration project.

Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner of health, beginning December 15, 2011, and each December 15 thereafter through December 15, 2015, shall report annually to the legislature on the functional and mental improvements of the populations served by the demonstration project, patient satisfaction, and the cost-effectiveness of the program. The reports must also include data on hospital admissions, days in hospital, rates of outpatient surgery and other services, and drug utilization. The report, due December 15, 2015, must include recommendations on whether the demonstration project should be continued and expanded.

Sec. 79. **[256B.841] WAIVER APPLICATION AND PROCESS.**

Subdivision 1. **Intent.** It is the intent of the legislature that medical assistance be:

(1) a sustainable, cost-effective, person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; and

(2) a results-oriented system of coordinated care that focuses on independence and choice, promotes accountability and transparency, encourages and rewards healthy outcomes and responsible choices, and promotes efficiency.

Subd. 2. **Waiver application.** (a) By September 1, 2011, the commissioner of human services shall apply for a waiver and any necessary state plan amendments from the secretary of the United States Department of Health and Human Services, including,

but not limited to, a waiver of the appropriate sections of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., or other provisions of federal law that provide program flexibility and under which Minnesota will operate all facets of the state's medical assistance program.

(b) The commissioner of human services shall provide the legislative committees with jurisdiction over health and human services finance and policy with the waiver application and financial and other related materials, at least ten days prior to submitting the application and materials to the federal Centers for Medicare and Medicaid Services.

(c) If the state's waiver application is approved, the commissioner of human services shall:

(1) notify the chairs of the legislative committees with jurisdiction over health and human services finance and policy and allow the legislative committees with jurisdiction over health and human services finance and policy to review the terms of the waiver; and

(2) not implement the waiver until ten legislative days have passed following notification of the chairs.

Subd. 3. **Rulemaking; legislative proposals.** Upon acceptance of the terms of the waiver, the commissioner of human services shall:

(1) adopt rules to implement the waiver; and

(2) propose any legislative changes necessary to implement the terms of the waiver.

Subd. 4. **Joint commission on waiver implementation.** (a) After acceptance of the terms of the waiver, the governor shall establish a joint commission on waiver implementation. The commission shall consist of eight members; four of whom shall be members of the senate, not more than three from the same political party, to be appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration, and four of whom shall be members of the house of representatives, not more than three from the same political party, to be appointed by the speaker of the house.

(b) The commission shall:

(1) oversee implementation of the waiver;

(2) confer as necessary with state agency commissioners;

(3) make recommendations on services covered under the medical assistance program;

(4) monitor and make recommendations on quality and access to care under the global waiver; and

(5) make recommendations for the efficient and cost-effective administration of the medical assistance program under the terms of the waiver.

Sec. 80. **[256B.842] PRINCIPLES AND GOALS FOR MEDICAL ASSISTANCE REFORM.**

Subdivision 1. **Goals for reform.** In developing the waiver application and implementing the waiver, the commissioner of human services shall ensure that the reformed medical assistance program is a person-centered, financially sustainable, and cost-effective program.

Subd. 2. **Reformed medical assistance criteria.** The reformed medical assistance program established through the waiver must:

(1) empower consumers to make informed and cost-effective choices about their health and offer consumers rewards for healthy decisions;

(2) ensure adequate access to needed services;

(3) enable consumers to receive individualized health care that is outcome-oriented and focused on prevention, disease management, recovery, and maintaining independence;

(4) promote competition between health care providers to ensure best value purchasing, leverage resources, and to create opportunities for improving service quality and performance;

(5) redesign purchasing and payment methods and encourage and reward high-quality and cost-effective care by incorporating and expanding upon current payment reform and quality of care initiatives, including but not limited to those initiatives authorized under chapter 62U; and

(6) continually improve technology to take advantage of recent innovations and advances that help decision makers, consumers, and providers make informed and cost-effective decisions regarding health care.

Subd. 3. **Annual report.** The commissioner of human services shall annually submit a report to the governor and the legislature, beginning December 1, 2012, and each December 1 thereafter, describing the status of the administration and implementation of the waiver.

Sec. 81. **[256B.843] WAIVER APPLICATION REQUIREMENTS.**

Subdivision 1. **Requirements for waiver request.** The commissioner shall seek federal approval to:

(1) enter into a five-year agreement with the United States Department of Health and Human Services and Centers for Medicaid and Medicare Services (CMS) under section 1115a to waive provisions of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., requiring:

(i) statewideness to allow for the provision of different services in different areas or regions of the state;

(ii) comparability of services to allow for the provision of different services to members of the same or different coverage groups;

(iii) no prohibitions restricting the amount, duration, and scope of services included in the medical assistance state plan;

(iv) no prohibitions limiting freedom of choice of providers; and

(v) retroactive payment for medical assistance, at the state's discretion;

(2) waive the applicable provisions of title XIX of the federal Social Security Act, United States Code, title 42, section 1396 et seq., in order to:

(i) expand cost sharing requirements above the five percent of income threshold for beneficiaries in certain populations;

(ii) establish health savings or power accounts that encourage and reward beneficiaries who reach certain prevention and wellness targets; and

(iii) implement a tiered set of parameters to use as the basis for determining long-term service care and setting needs;

(3) modify income and resource rules in a manner consistent with the goals of the reformed program;

(4) provide enrollees with a choice of appropriate private sector health coverage options, with full federal financial participation;

(5) treat payments made toward the cost of care as a monthly premium for beneficiaries receiving home and community-based services when applicable;

(6) provide health coverage and services to individuals over the age of 65 that are limited in scope and are available only in the home and community-based setting;

(7) consolidate all home and community-based services currently provided under title XIX of the federal Social Security Act, United States Code, title 42, section 1915(c), into a single program of home and community-based services that include options for consumer direction and shared living;

(8) expand disease management, care coordination, and wellness programs for all medical assistance recipients; and

(9) empower and encourage able-bodied medical assistance recipients to work, whenever possible.

Subd. 2. **Agency coordination.** The commissioner shall establish an intraagency assessment and coordination unit to ensure that decision making and program planning for recipients who may need long-term care, residential placement, and community support services are coordinated. The assessment and coordination unit shall determine level of

care, develop service plans and a service budget, make referrals to appropriate settings, provide education and choice counseling to consumers and providers, track utilization, and monitor outcomes.

Sec. 82. Minnesota Statutes 2010, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) Beginning ~~April 1, 2010~~ January 1, 2012, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated~~, except for outpatient prescription drug coverage, which shall continue to be administered under this section and funded under section 256D.031, subdivision 9, beginning June 1, 2010~~.

(b) Outpatient prescription drug coverage under general assistance medical care is limited to prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Outpatient prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13h.

~~(c) Outpatient prescription drug coverage does not include drugs administered in a clinic or other outpatient setting.~~

~~(d) For the period beginning April 1, 2010, to May 31, 2010, general assistance medical care covers the services listed in subdivision 4.~~

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

Sec. 83. Minnesota Statutes 2010, section 256D.031, subdivision 6, is amended to read:

Subd. 6. **Coordinated care delivery systems.** (a) Effective ~~June 1, 2010~~ January 1, 2012, the commissioner shall contract with hospitals or groups of hospitals, or county-based purchasing plans, that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals or plans shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 ~~with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic~~

~~or other outpatient setting~~; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs ~~administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9~~. A hospital or plan establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals, or a county-based purchasing plan established under section 256B.692, may contract with the commissioner to develop and implement a coordinated care delivery system ~~as follows:~~ if the hospital or group of hospitals or plan agrees to satisfy the requirements of this subdivision.

~~(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than $1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and~~

~~(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.~~

Participation by hospitals or plans shall become effective quarterly on ~~June 1, September 1, December 1, or March 1~~ January 1, April 1, July 1, or October 1. Hospital or plan participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system but services are only available through a coordinated care delivery system. Upon enrollment into a coordinated care

delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. ~~A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After February 28, 2011, services are available only through a coordinated care delivery system.~~

(d) The hospital or plan may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. When contracting with providers and clinics, the hospital or plan shall give preference to providers and clinics certified as health care homes under section 256B.0751. The hospital or plan must contract with federally qualified health centers or federally qualified health center look-alikes, as defined in section 145.9269, subdivision 1, that agree to accept the terms, conditions, and payment rates offered by the hospital or plan to similarly situated providers. If a provider or clinic or health center contracts with a hospital or plan to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital or plan and paid by the hospital or plan from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties, coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital or plan may require a recipient to designate a primary care provider or a primary care clinic. The hospital or plan may limit the delivery of services to a network of providers who have contracted with the hospital or plan to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital or plan may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital or plan must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital or plan must provide, on a quarterly basis on a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) ~~Effective June 1, 2010,~~ The provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

(k) Notwithstanding any other provision in this section to the contrary, ~~for participation beginning September 1, 2010,~~ the commissioner ~~shall offer the same contract terms related to~~ shall negotiate an enrollment threshold formula and financial liability protections ~~to~~ with a hospital or group of hospitals or plan qualified under this subdivision to develop and implement a coordinated care delivery system ~~as those contained in the coordinated care delivery system contracts effective June 1, 2010~~.

~~(l) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.~~

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

Sec. 84. Minnesota Statutes 2010, section 256D.031, subdivision 7, is amended to read:

Subd. 7. **Payments; rate setting for the ~~hospital~~ coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception

of outpatient prescription drug coverage, provided ~~on or after June 1, 2010,~~ through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals or plans participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after ~~June 1, 2010~~ March 1, 2012. The payment shall be allocated among all hospitals or plans qualified to participate on the allocation date ~~as follows:~~ based upon the enrollment thresholds negotiated with the commissioner.

~~(1) each hospital or group of hospitals shall be allocated an initial amount based on the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for general assistance medical care services to all participating hospitals;~~

~~(2) the initial allocations to Hennepin County Medical Center; Regions Hospital; Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview, shall be increased to 110 percent of the value determined in clause (1);~~

~~(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata amount in order to keep the allocations within the limit of available appropriations; and~~

~~(4) the amounts determined under clauses (1) to (3) shall be allocated to participating hospitals.~~

The commissioner may prospectively reallocate payments to participating hospitals or plans on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. ~~The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011~~.

~~(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.~~

~~(c)~~ (b) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals or plans described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the hospital or plan. The hospital or plan shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital or plan and the nonhospital provider.

~~(d)~~ (c) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

~~(e)~~ (d) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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

Sec. 85. Minnesota Statutes 2010, section 256D.031, subdivision 10, is amended to read:

Subd. 10. **Assistance for veterans.** Hospitals and plans participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

Sec. 86. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the ~~12-month~~ six-month period of eligibility.

Sec. 87. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using

appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for children in families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for children in families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

EFFECTIVE DATE. This section is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 88. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b)

are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Sec. 89. Minnesota Statutes 2010, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, ~~or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant,~~ is subject to an annual limit of $10,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

EFFECTIVE DATE. This section is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The commissioner shall notify

the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 90. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **~~Co-payments and coinsurance~~ Cost-sharing.** (a) Except as provided in paragraphs (b) ~~and~~, (c), and (h), the MinnesotaCare benefit plan shall include the following ~~co-payments and coinsurance~~ cost-sharing requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; ~~and~~

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

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

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

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

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

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

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

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

(h) Effective January 1, 2012, the following co-payments for nonpreventive visits shall apply to enrollees who are adults without children eligible under section 256L.04, subdivision 7:

(1) $3 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same type;

(2) $6 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) $10 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county-based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph using a methodology that has been approved by the commissioner.

EFFECTIVE DATE. The amendments to paragraph (e) are effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 91. **[256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning January 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with gross family income equal to or greater than 133 percent of the federal poverty guidelines, with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3. Beginning January 1, 2012, or upon federal approval, whichever is later, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 1, with gross family income equal to or greater than 133 percent of the federal poverty guidelines, with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3, offered by a health plan company as defined in section 62Q.01, subdivision 4.

(b) Enrollees eligible under paragraph (a) shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under paragraph (a). Covered services, cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under paragraph (a) shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution.** An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3.

Subd. 3. **Determination of defined contribution amount.** (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in paragraph (b) for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 133 percent of the federal poverty guidelines with a defined contribution of 150 percent of the base contribution;

(2) persons with household incomes equal to 175 percent of the federal poverty guidelines with a defined contribution of 100 percent of the base contribution;

(3) persons with household incomes equal to or greater than 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(4) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline specified in clauses (1) to (3) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) to (3).

Age	Monthly Per-Person Base Contribution
Under 21	$122.79
21-29	122.79
30-31	129.19
32-33	132.38
34-35	134.31
36-37	136.06
38-39	141.02
40-41	151.25
42-43	159.89
44-45	175.08
46-47	191.71

48-49	213.13
50-51	239.51
52-53	266.69
54-55	293.88
56-57	323.77
58-59	341.20
60+	357.19

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who are denied coverage under an individual health plan by a health plan company and who purchase coverage through the Minnesota Comprehensive Health Association.

(c) Notwithstanding paragraphs (a) and (b), the monthly defined contribution shall not exceed 90 percent of the monthly premium for the health plan purchased by the enrollee. If the enrollee purchases coverage under a health plan that does not include mental health services and chemical dependency treatment services, the monthly defined contribution amount determined under this subdivision shall be reduced by five percent.

Subd. 4. **Administration by commissioner.** The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning January 1, 2012, MinnesotaCare enrollees who are denied coverage under an individual health plan by a health plan company are eligible for coverage through a health plan offered by the MCHA and may enroll in MCHA according to section 62E.14. Any difference between the revenue and covered losses to the MCHA related to implementation of this section shall be paid to the MCHA from the health care access fund.

Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers and approvals necessary to implement coverage under this section for MinnesotaCare enrollees eligible under section 256L.04, subdivision 1, with gross family incomes equal to or greater than 133 percent of the federal poverty guidelines, while continuing to receive federal matching funds.

Sec. 92. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) ~~Families with~~ Children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size and adults in families with children with family income equal to or less than 200 percent of the federal poverty guidelines for the applicable family size, shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2010, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.

~~(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.~~

(f) [Reserved.]

EFFECTIVE DATE. This section is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013, except that the amendment striking paragraph (e) is effective retroactively from October 1, 2008, does not expire, and federal approval is no longer necessary. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 93. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons, through December 31, 2011, includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.

(b) Effective ~~July 1, 2009~~ January 1, 2012, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are greater than 75 percent of the federal poverty guidelines and equal to or less than ~~250~~ 200 percent of the federal poverty guidelines. Effective July 1, 2013, the maximum income limit under this paragraph is increased to 250 percent of the federal poverty guidelines.

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

Sec. 94. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

(b) In determining eligibility for MinnesotaCare, the commissioner shall require applicants and enrollees seeking renewal of eligibility to verify both earned and unearned income. The commissioner shall also require applicants and enrollees to submit the names of their employers and a contact name with a phone number for each employer for purposes of verifying whether the applicant or enrollee, and any dependents, are eligible for employer-subsidized coverage. Data collected is nonpublic data as defined in section 13.02, subdivision 9.

Sec. 95. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, ~~2007~~ 2011, an enrollee's eligibility must be renewed every ~~12~~ six months. ~~The 12-month period begins in the month after the month the application is approved.~~

(b) The first six-month period of eligibility begins the month the application is received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward

the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

Sec. 96. Minnesota Statutes 2010, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program ~~whose gross family income is equal to or more than 225 percent of the federal poverty guidelines~~; and (2) single adults and households without children enrolled in the MinnesotaCare program ~~whose gross family income is equal to or more than 165 percent of the federal poverty guidelines~~. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

EFFECTIVE DATE. This section is effective January 1, 2012, and expires June 30, 2013.

Sec. 97. Minnesota Statutes 2010, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare with incomes less than 133 percent of the federal poverty guidelines who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

Sec. 98. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. ~~Beginning January 1, 2008,~~

(c) Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009,~~ the limits described in section 256L.04, subdivision 7, are no longer eligible for the program and shall be disenrolled by the commissioner.

(d) For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for MinnesotaCare if gross household income exceeds ~~$57,500 for the 12-month~~ $25,000 for the six-month period of eligibility.

EFFECTIVE DATE. This section is effective January 1, 2012, and expires June 30, 2013, except the amendments to the new paragraphs (e) and (f) are effective July 1, 2011, and do not expire.

Sec. 99. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275 percent of the federal poverty guidelines~~ the limits described in section 256L.04, subdivision 1, are no longer eligible for the program and shall be disenrolled by the commissioner.

(c) Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner.

(d) For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

~~(b)~~ (e) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The

premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

EFFECTIVE DATE. The amendment in paragraph (b) is effective January 1, 2012, or upon federal approval whichever is later, and expires June 30, 2013. The commissioner shall notify the revisor of statutes when federal approval is obtained and publish a notice in the State Register.

Sec. 100. Minnesota Statutes 2010, section 256L.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address other than a place of public accommodation, unless the place of public accommodation is the person's primary or only residence, through the use of evidence of residence described in section 256D.02, subdivision 12a, paragraph (b), clause ~~(2)~~ (1);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person is a resident for any purpose. If temporarily absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Sec. 101. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after ~~January 1, 2007,~~ July 1, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by ~~50~~ 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 102. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

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

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

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.

(e) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason for the hospitalization for state health care program enrollees by a measurable rate of five percent from the plan's hospitalization rate for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization rate was achieved.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for state health care program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for state health care program enrollees for calendar year 2010. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilizations less than the

targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.

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

Sec. 103. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

The commissioner shall include information about the payment options on each premium notice. At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

Sec. 104. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

Subd. 5. **Basic Health Care Grants**

(a) **MinnesotaCare Grants**

Health Care Access	-0-	(770,000)

Incentive Program and Outreach Grants.
Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter

147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000 from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

(b) **MA Basic Health Care Grants - Families and Children** -0- (17,280,000)

Third-Party Liability. (a) During fiscal year 2009, the commissioner shall employ a contractor paid on a percentage basis to improve third-party collections. Improvement initiatives may include, but not be limited to, efforts to improve postpayment collection from nonresponsive claims and efforts to uncover third-party payers the commissioner has been unable to identify.

(b) In fiscal year 2009, the first $1,098,000 of recoveries, after contract payments and federal repayments, is appropriated to

the commissioner for technology-related expenses.

Administrative Costs. (a) For contracts effective on or after January 1, 2009, the commissioner shall limit aggregate administrative costs paid to managed care plans under Minnesota Statutes, section 256B.69, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, to an overall average of ~~6.6~~ 6.1 percent of total contract payments under Minnesota Statutes, sections 256B.69 and 256B.692, for each calendar year. For purposes of this paragraph, administrative costs do not include premium taxes paid under Minnesota Statutes, section 297I.05, subdivision 5, and provider surcharges paid under Minnesota Statutes, section 256.9657, subdivision 3.

(b) Notwithstanding any law to the contrary, the commissioner may reduce or eliminate administrative requirements to meet the administrative target under paragraph (a).

(c) Notwithstanding any contrary provision of this article, this rider shall not expire.

Hospital Payment Delay. Notwithstanding Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 6, payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for medical assistance enrollees are delayed as follows: (1) for fiscal year 2008, June payments must be included in the first payments in fiscal year 2009; and (2) for fiscal year 2009,

June payments must be included in the first payment of fiscal year 2010. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires on June 30, 2010.

(c) **MA Basic Health Care Grants - Elderly and Disabled** (14,028,000) (9,368,000)

Minnesota Disability Health Options Rate Setting Methodology. The commissioner shall develop and implement a methodology for risk adjusting payments for community alternatives for disabled individuals (CADI) and traumatic brain injury (TBI) home and community-based waiver services delivered under the Minnesota disability health options program (MnDHO) effective January 1, 2009. The commissioner shall take into account the weighting system used to determine county waiver allocations in developing the new payment methodology. Growth in the number of enrollees receiving CADI or TBI waiver payments through MnDHO is limited to an increase of 200 enrollees in each calendar year from January 2009 through December 2011. If those limits are reached, additional members may be enrolled in MnDHO for basic care services only as defined under Minnesota Statutes, section 256B.69, subdivision 28, and the commissioner may establish a waiting list for future access of MnDHO members to those waiver services.

MA Basic Elderly and Disabled Adjustments. For the fiscal year ending June

30, 2009, the commissioner may adjust the rates for each service affected by rate changes under this section in such a manner across the fiscal year to achieve the necessary cost savings and minimize disruption to service providers, notwithstanding the requirements of Laws 2007, chapter 147, article 7, section 71.

(d) **General Assistance Medical Care Grants**	-0-	(6,971,000)
(e) **Other Health Care Grants**	-0-	(17,000)

MinnesotaCare Outreach Grants Special Revenue Account. The balance in the MinnesotaCare outreach grants special revenue account on July 1, 2009, estimated to be $900,000, must be transferred to the general fund.

Grants Reduction. Effective July 1, 2008, base level funding for nonforecast, general fund health care grants issued under this paragraph shall be reduced by 1.8 percent at the allotment level.

Sec. 105. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6, is amended to read:

Subd. 6. **Health Care Grants**

(a) **MinnesotaCare Grants**	998,000	(13,376,000)

This appropriation is from the health care access fund.

Health Care Access Fund Transfer to General Fund. The commissioner of management and budget shall transfer the following amounts in the following years from the health care access fund to the general fund: ~~$998,000~~ $0 in fiscal year

2010; ~~$176,704,000~~ $59,901,000 in fiscal year 2011; $141,041,000 in fiscal year 2012; and $286,150,000 in fiscal year 2013. If at any time the governor issues an executive order not to participate in early medical assistance expansion, no funds shall be transferred from the health care access fund to the general fund until early medical assistance expansion takes effect. This paragraph is effective the day following final enactment.

MinnesotaCare Ratable Reduction. Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by 15 percent. Effective for services provided from July 1, 2010, to June 30, 2011, this reduction shall apply to all services. Effective for services provided from July 1, 2011, to December 31, 2013, this reduction shall apply to all services except inpatient hospital services. Notwithstanding any contrary provision of this article, this paragraph shall expire on December 31, 2013.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	295,512,000

Critical Access Dental. Of the general fund appropriation, $731,000 in fiscal year 2011 is to the commissioner for critical access dental provider reimbursement payments under Minnesota Statutes, section

256B.76 subdivision 4. This is a onetime appropriation.

Nonadministrative Rate Reduction. For services rendered on or after July 1, 2010, to December 31, 2013, the commissioner shall reduce contract rates paid to managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, by three percent of the contract rate attributable to nonadministrative services in effect on June 30, 2010. Notwithstanding any contrary provision in this article, this rider expires on December 31, 2013.

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	(30,265,000)
		~~(75,389,000)~~
(d) **General Assistance Medical Care Grants**	-0-	<u>(59,583,000)</u>

<u>The reduction to general assistance medical care grants is contingent upon the effective date in Laws 2010, First Special Session chapter 1, article 16, section 48. The reduction shall be reestimated based upon the actual effective date of the law. The commissioner of management and budget shall make adjustments in fiscal year 2011 to general assistance medical care appropriations to conform to the total expected expenditure reductions specified in this section.</u>

(e) **Other Health Care Grants**	-0-	(7,000,000)

Cobra Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article

5, section 78, do not cancel and are available to the commissioner for fiscal year 2011 COBRA grant expenditures. Up to $111,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner for costs related to administration of the COBRA grants.

Sec. 106. **COMMISSIONER'S ACTIONS; REPEAL OF EARLY MEDICAL ASSISTANCE EXPANSION.**

Effective January 1, 2012, the commissioner of human services shall suspend implementation and administration of Minnesota Statutes 2010, sections 256B.055, subdivision 15; 256B.056, subdivision 3, paragraph (b); and 256B.056, subdivision 4, paragraph (d). The commissioner shall refer persons enrolled under these provisions, and applicants for coverage under these provisions, to the general assistance medical care program established under Minnesota Statutes, section 256D.031.

Sec. 107. **GENERAL ASSISTANCE MEDICAL CARE PROGRAM; PROVISIONS REVIVED.**

Notwithstanding their contingent repeal in Laws 2010, First Special Session chapter 1, article 16, section 47, the following statutes are revived and have the force of law effective January 1, 2012:

(1) Minnesota Statutes 2010, section 256D.03, subdivisions 3, 3a, 6, 7, and 8;

(2) Minnesota Statutes 2010, section 256D.031, subdivisions 1, 2, 3, 4, 6, 7, and 10; and

(3) Laws 2010, chapter 200, article 1, section 18.

Sec. 108. **PLAN TO COORDINATE CARE FOR CHILDREN WITH HIGH-COST MENTAL HEALTH CONDITIONS.**

The commissioner of human services shall develop and submit to the legislature by December 15, 2011, a plan to provide care coordination to medical assistance and MinnesotaCare enrollees who are children with high-cost mental health conditions. For purposes of this section, a child has a "high-cost mental health condition" if mental health and medical expenses over the past year totalled $100,000 or more. For purposes of this

section, "care coordination" means collaboration between an advanced practice nurse and primary care physicians and specialists to manage care; development of mental health management plans for recurrent mental health issues; oversight and coordination of all aspects of care in partnership with families; organization of medical, treatment, and therapy information into a summary of critical information; coordination and appropriate sequencing of evaluations and multiple appointments; information and assistance with accessing resources; and telephone triage for behavior or other problems.

Sec. 109. **DATA ON CLAIMS AND UTILIZATION.**

The commissioner of human services, in consultation with the Health and Human Services Reform Committee, shall develop and provide to the legislature by December 15, 2011, a methodology and any draft legislation necessary to allow for the release, upon request, of summary data as defined in Minnesota Statutes, section 13.02, subdivision 19, on claims and utilization for medical assistance, general assistance medical care, and MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical Systems Improvement, and other research institutions to conduct analyses of health care outcomes and treatment effectiveness, provided the research institutions do not release private or nonpublic data or data for which dissemination is prohibited by law.

Sec. 110. **REDUCTION OF STATE-MANDATED ADMINISTRATIVE REPORTS.**

(a) The commissioner of management and budget shall convene a report reduction working group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, obsolete, and low-priority state-mandated administrative reports required of health plans and county-based purchasing plans that serve persons enrolled in Minnesota health care programs. The commissioner of management and budget and the report reduction working group shall develop a plan to oversee the report reduction activities of the individual state agencies and coordinate the activities of multiple state agencies to consolidate reports or eliminate redundant reports required by more than one state agency on the same or a similar topic.

(b) The commissioners of health, human services, and commerce shall reduce, eliminate, or consolidate state-mandated reports according to the plan developed by the commissioner of management and budget through the report reduction working group. In addition to other report reduction actions the commissioners or the working group may undertake, the commissioners shall:

(1) collect encounter data, including provider payment data if collected, in a consolidated report provided to a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(2) collect only one provider network report annually through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(3) collect only one standard financial report through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data. Data collected must be of a nature and in a format to allow comparison of the cost-effectiveness of fee-for-service payment systems and prepaid programs administered by health plans and county-based purchasing plans;

(4) consolidate and simplify reports and documentation requirements relating to member communications and marketing materials, and establish a single review process for all programs, products, and agencies in order to ensure uniform and consistent regulation of health plan contracts;

(5) consolidate state regulation and oversight of health plans and county-based purchasing plans so that activities of multiple agencies are administered through an efficient and uniform multiagency process of oversight and audits, with consistent standards, measures, and definitions for state oversight of quality, utilization management, care management, delegation accountability, access to care, appeals and grievances, and financial management;

(6) establish uniform requirements and procedures for denial, termination, or reduction of services and member appeals and grievances, and align state requirements and procedures with federal requirements and procedures; and

(7) reform the state's performance improvement projects, requirements, and procedures to be more flexible and efficient, and to place greater focus on measuring improvement of outcomes and less on mandating detailed or prescriptive requirements for specific performance improvement projects or activities.

(d) New reporting requirements or ad hoc report requests shall be established by a state agency only:

(1) if required by a federal agency;

(2) if needed for a state regulatory audit or corrective action plan; or

(3) after the completion of a review and analysis, and the development of recommendations by the commissioner of management and budget, in consultation with the report reduction working group, regarding the necessity, importance, and administrative cost of the new report, and after completing a review to determine

whether the information sought can be obtained through another available state or federal report. The results of the review, analysis, and recommendations of the commissioner of management and budget must be provided to health plans and county-based purchasing plans for review and comment at least 60 days before a new report or requirement is established.

(e) To the extent possible, all state agencies shall use the procedures, reports, and audits of the Centers for Medicare and Medicaid Services instead of requiring an additional state-mandated report on the same or a similar topic.

(f) By January 15, 2012, the commissioner of management and budget shall provide a report on the activities and results of the report reduction project to the legislature. The report must include:

(1) a timetable for report reduction actions already taken or planned by the commissioners or the report reduction working group;

(2) the specific reports that have been or will be eliminated or consolidated;

(3) the amount of money that will be saved through reductions in administrative costs of health plans and county-based purchasing plans as a result of the report reduction project; and

(4) proposed legislation for changes to laws or rules that are needed to allow state agencies to further reduce, consolidate, or eliminate reports when the changes cannot be made administratively.

Sec. 111. **COMPETITIVE BIDDING PILOT.**

For managed care contracts effective January 1, 2012, the commissioner of human services is required to establish a competitive price bidding pilot for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The pilot must allow a minimum of two managed care organizations to serve the metropolitan area. The pilot shall expire after two full calendar years on December 31, 2013. The commissioner of human service shall conduct an evaluation of the pilot to determine the cost-effectiveness and impacts to provider access at the end of the two-year period. The commissioner must consult with other states that have experience implementing competitive bidding in their medical assistance population and incorporate best practices from those states in designing this pilot. The commissioner, prior to implementation, must also consult with stakeholders on the design and implementation of the pilot, including providers, plans, advocacy groups, and other interested parties.

Sec. 112. **REQUEST FOR PROPOSAL; PROVIDER BILLING PATTERNS.**

(a) The commissioner of human services shall issue a request for proposal, using existing resources, to identify abnormal provider billing patterns in order to prevent and identify improper medical assistance payments.

(b) The request for proposal must include the following requirements for the contractor:

(1) identification and reporting of improper claims, outlier claims, and improper payments, both prior to and subsequent to reimbursement;

(2) utilization of fraud detection methods that maximize contemporary predictive analytic tools, including but not limited to identity analytics, link analysis, and matching capabilities;

(3) utilization of data analytics that improve fraud detection through the identification of outlier reimbursement;

(4) reduction in state expenditures by reducing or eliminating payouts of improper medical assistance claims; and

(5) demonstrated success with other states and state agencies using the specified proposed solution, deployment, and implementation.

(c) The commissioner shall enter into a contract for the services in this section by October 1, 2011. The contract must incorporate a performance-based vendor financing mechanism under which the vendor shares in the risk of the project's success.

Sec. 113. **HEALTH SERVICES POLICY COMMITTEE STUDIES.**

(a) The commissioner of human services, through the health services policy committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall identify and review medical assistance services provided by health care professionals who are not trained to provide the services in a high-quality manner. The commissioner shall develop a process to limit payment for medical assistance services to providers who are not appropriately trained to provide the service, and shall present recommendations and draft legislation by January 15, 2012, to the legislature.

(b) The commissioner of human services, through the health services policy committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall study the effectiveness of new strategies for wound care treatment for medical assistance and MinnesotaCare enrollees with diabetes, including but not limited to the use of new wound care technologies, assessment tools, and reporting programs. The commissioner shall present recommendations by December 15, 2011, to the legislature on whether these new strategies for wound care treatment should be covered under medical assistance and MinnesotaCare.

Sec. 114. **SPECIALIZED MAINTENANCE THERAPY.**

The commissioner of human services shall evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with serious and persistent mental illness who are at risk of hospitalization will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by December 15, 2011.

Sec. 115. **COVERAGE FOR LOWER-INCOME MINNESOTACARE ENROLLEES.**

The commissioner of human services shall develop and present to the legislature, by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees eligible under Minnesota Statutes, section 256L.04, subdivisions 1 and 7, with incomes less than 133 percent of the federal poverty guidelines. The plan must be designed to improve continuity and quality of care, reduce unnecessary emergency room visits, and reduce average per-enrollee costs. In developing the plan, the commissioner shall consider innovative methods of service delivery, including but not limited to increasing the use and choice of private sector health plan coverage and encouraging the use of community health clinics, as defined in the federal Community Health Care Act of 1964, as health care homes.

Sec. 116. **DIRECTION TO COMMISSIONER; FEDERAL WAIVERS.**

(a) The commissioner of human services shall apply to the Centers for Medicare and Medicaid Services (CMS) for federal waivers to cover:

(1) families with children eligible under Minnesota Statutes, section 256L.04, subdivision 1; and

(2) adults eligible under Minnesota Statutes, section 256L.04, subdivision 1, under the MinnesotaCare healthy Minnesota contribution program established under Minnesota Statutes, section 256L.031, by July 1, 2011. The commissioner shall report to the legislative committees with jurisdiction over health and human services policy and finance whether or not the federal waiver application was accepted within ten working days of receipt of the decision.

(b) The commissioner of human services shall apply to the CMS for a section 1115(a) demonstration waiver, and any other necessary federal waivers and amendments, including, but not limited to, a waiver of the appropriate sections of title XIX, United

States Code, title 42, section 1396a, and a waiver of any applicable federal maintenance of effort provisions that would provide Minnesota with medical assistance program flexibility in exchange for federal budget certainty. The commissioner shall seek federal approval to enter into an agreement with CMS under which Minnesota would:

(1) accept an aggregate annual allotment for the medical assistance program, trended forward at an agreed upon rate, with protections to cover medical inflation and projected caseload growth; and

(2) receive federal waivers of Medicaid requirements related to: statewideness and comparability of services; the amount, duration, and scope of services; freedom of choice; cost-sharing; and other areas of program administration specified by the commissioner.

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

Sec. 117. **TRANSPARENCY AND QUALITY REPORTING FOR PUBLIC HEALTH CARE PROGRAMS.**

When negotiating with external vendors to provide managed care services, the commissioner of human services shall require use of an advanced request for information tool. This tool must provide the department with an evidence-based assessment that focuses on the cost control, quality, and information transparency of the health care vendor. The assessment may include evidence-based performance measures that have been shown to influence better health, better health care, and more cost-effective use of resources including, but not limited to, areas that determine each plan's capabilities and performance with respect to:

(1) consumer engagement, support, and incentives;

(2) processes and outcomes for closing gaps in care according to clinical guideline expectations;

(3) provider management, including outcome and population-based reimbursement, transparent measurement of provider performance, and support of physician practice structures that lead to better care; and

(4) measures of clinical outcomes and waste approved by the National Quality Forum.

Sec. 118. **RISK CORRIDORS.**

(a) Effective for services rendered on or after January 1, 2012, the commissioner shall establish risk corridors for state public programs that are actuarially sound for each managed care plan and each county-based purchasing plan. The risk corridors will be calculated annually based on the calendar year's net underwriting gain or loss. If the

managed care plan or county-based purchasing plan has achieved a net underwriting gain of greater than three percent of revenue, 80 percent of any excess must be repaid to the commissioner by July 31 of the year following calculation of the risk corridor year, and 20 percent must be invested by the plan directly into programs for improving quality of care or access to care for state public health care program enrollees. If the managed care plan or county-based purchasing plan has incurred a net underwriting loss greater than three percent of total revenue, 50 percent of any excess must be repaid to the plan by the commissioner by July 31 of the year following calculation of the risk corridor year. Determination of total revenues and net underwriting gain or loss must be based on the Minnesota Supplement Report #1 which is filed on April 1 of the year following calculation of the risk corridor and adjusted for the actual withhold calculation under sections 256B.69, subdivision 5a, and 256L.12, subdivision 9. The report must be filed with and publicly disclosed by the Department of Health.

(b) For purposes of this section, "state public programs" means those prepaid medical assistance and MinnesotaCare programs for which a managed care plan or county-based purchasing plan contracts with the commissioner to provide coverage under sections 256B.69, 256B.692, and 256L.12. The risk corridors shall not apply to plans for persons who are enrolled in integrated Medicare and medical assistance programs under section 256B.69, subdivisions 23 and 28.

(c) This section expires January 1, 2014.

Sec. 119. **STUDY OF ENROLLED PROVIDER NETWORKS.**

(a) The commissioner of human services shall present recommendations to the legislature by December 15, 2011, for a reformed health care delivery system under which enrolled provider networks provide basic health care services to qualified medical assistance and MinnesotaCare enrollees, supplemented by a major medical or stop-loss policy. For purposes of this section, "enrolled provider network" means a health care provider or group of health care providers that contracts with the commissioner to meet standards related to quality, affordability, and patient satisfaction for the provision of basic care services.

(b) The recommendations must address:

(1) eligibility, quality, reporting, fiscal solvency, and other criteria for enrolled provider networks;

(2) the geographic area of the state in which the reformed delivery system is to be implemented, including a schedule for any phase-in of the new delivery system;

(3) methods to coordinate care delivery through enrolled provider networks with care delivery through managed care and county-based purchasing plans, and the extent to which care delivery through enrolled provider networks should replace care delivery through managed care and county-based purchasing plans;

(4) the extent to which managed care and county-based purchasing plans should provide claims processing, administrative, quality assurance, and other services for enrolled provider networks and the commissioner;

(5) the definition of basic care services, criteria for stop-loss coverage or major-medical coverage, and the extent to which risk-sharing should be applied to enrolled provider networks;

(6) the extent to which certain health care services should continue to be delivered through fee-for-service;

(7) eligibility criteria for medical assistance and MinnesotaCare enrollees to be served by enrolled provider networks, and whether enrollee participation should be mandatory or voluntary;

(8) enrollee cost-sharing and premiums;

(9) methods to coordinate the delivery of care through enrolled provider networks with state and federal initiatives related to health care homes and care coordination, quality improvement, and payment reform; and

(10) the extent to which federal waivers and approval will be necessary for implementation.

(c) The report must include an estimate of the costs and savings to the state of delivering care through enrolled provider networks, and an implementation plan and timeline for establishing the reformed health care delivery system.

Sec. 120. **REPEALER.**

(a) Minnesota Statutes 2010, section 256.01, subdivision 2b, (**performance payments**) is repealed effective July 1, 2011.

(b) Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, (**Legislative Commission on Health Care Access**) are repealed.

(c) Laws 2009, chapter 79, article 5, section 64, (**256L.07, subdivision 2**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(d) Laws 2009, chapter 79, article 5, section 65, (**256L.07, subdivision 3**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(e) Laws 2009, chapter 79, article 5, section 68, (**256L.15, subdivision 2, exemption of low-income children from MinnesotaCare premiums and insurance barriers**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(f) Minnesota Statutes 2010, section 256L.07, subdivision 7, **exempting eligibility for children formally under medical assistance**, is repealed retroactively from October 1, 2008, and federal approval is no longer necessary.

(g) The amendment in Laws 2009, chapter 79, article 5, section 55, as amended by Laws 2009, chapter 173, article 1, section 36, (**256L.04, subdivision 1, children deemed eligible are exempt from eligibility requirements**) is repealed retroactively from January 1, 2009, and federal approval is no longer necessary.

(h) Laws 2009, chapter 79, article 5, section 56, (**256L.04, subdivision 1b, exemption from income limit for children**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(i) Laws 2009, chapter 79, article 5, section 60, (**256L.05, subdivision 1c, open enrollment and streamlined application**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(j) Laws 2009, chapter 79, article 5, section 66, (**256L.07, subdivision 8, automatic eligibility certain children**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(k) The amendment in Laws 2009, chapter 79, article 5, section 57, (**256L.04, subdivision 7a, ineligibility for adults with certain income**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(l) The amendment in Laws 2009, chapter 79, article 5, section 61, (**256L.05, subdivision 3, children eligibility following termination from foster care**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(m) The amendment in Laws 2009, chapter 79, article 5, section 62, (**256L.05, subdivision 3a, exemption from cancellation for nonrenewal for children**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(n) The amendment in Laws 2009, chapter 79, article 5, section 63, (**256L.07, subdivision 1, children whose gross family income is greater than 275 percent FPG may remain enrolled**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(o) The amendment in Laws 2009, chapter 79, article 5, section 64, (**256L.07, subdivision 2, exempts children from requirement not to have employer-subsidized coverage**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(p) The amendment in Laws 2009, chapter 79, article 5, section 65, (**256L.07, subdivision 3, requires children with family gross income over 200 percent of FPG to have had no health coverage for four months prior to application**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(q) The amendment in Laws 2009, chapter 79, article 5, section 68, (**256L.15, subdivision 2, children in families with income less than 200 percent FPG pay no premium**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(r) The amendment in Laws 2009, chapter 79, article 5, section 69, (**256L.15, subdivision 3, exempts children with family income below 200 percent FPG from sliding fee scale**) is repealed retroactively from July 1, 2009, and federal approval is no longer necessary.

(s) Laws 2009, chapter 79, article 5, section 79, (**uncoded federal approval**) is repealed the day following final enactment.

(t) Minnesota Statutes 2010, section 256B.057, subdivision 2c, (**extended medical assistance for certain children**) is repealed.

(u) The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9, (**renewal rolling month and premium grace month**) are repealed.

Sec. 121. **REPEALER; EARLY MEDICAL ASSISTANCE EXPANSION.**

Minnesota Statutes 2010, section 256B.055, subdivision 15, is repealed January 1, 2012.

ARTICLE 6

CONTINUING CARE

Section 1. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay

a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

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

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

(2) the insurer denied insurance;

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

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

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

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

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

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

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

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

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental~~

~~contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

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

Sec. 2. Minnesota Statutes 2010, section 256.01, subdivision 24, is amended to read:

Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability Linkage Line, ~~a~~ to serve as Minnesota's neutral access point for statewide ~~consumer~~ disability information~~, referral,~~ and assistance ~~system for people with disabilities and chronic illnesses that~~. The Disability Linkage Line shall:

(1) deliver information and assistance based on national and state standards;

~~(1) provides~~ (2) provide information about state and federal eligibility requirements, benefits, and service options;

(3) provide benefits and options counseling;

~~(2) makes~~ (4) make referrals to appropriate support entities;

~~(3) delivers information and assistance based on national and state standards;~~

~~(4) assists~~ (5) educate people ~~to~~ on their options so they can make well-informed ~~decisions~~ choices; ~~and~~

~~(5) supports~~ (6) help support the timely resolution of service access and benefit issues~~.~~;

(7) inform people of their long-term community services and supports;

(8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; and

(9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 3. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, ~~paragraph (j),~~ and 256B.055, subdivision 12, the commissioner shall review all medical evidence submitted by county agencies with a referral and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief appeals referee.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 4. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

Subd. 4a. **Case management ~~appeals~~ temporary stay of demission.** ~~Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules.** The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services under section 256B.092 from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

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

Sec. 5. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 6. Minnesota Statutes 2010, section 256B.056, is amended by adding a subdivision to read:

Subd. 5d. **Spenddown adjustments.** When income is projected for a six-month budget period, retroactive adjustments to income determined to be available to a person

under section 256B.0575 must be made at the end of each six-month budget period based on changes occurring during the budget period. For changes occurring outside the six-month budget period, such retroactive adjustments are limited to the six full calendar months before the month the change is reported or discovered.

Sec. 7. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician~~, may retain eligibility for up to four calendar months~~; or

(2) ~~effective January 1, 2004,~~ loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

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

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

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

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

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

~~(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.~~

~~(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.~~

~~(e)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision.~~ (e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under section 256.01, subdivision 18b.

(1) An enrollee must pay the greater of a $65 premium or the premium ~~shall be~~ calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

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

~~(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (1).~~

(3) ~~Effective November 1, 2003,~~ All enrollees who receive unearned income must pay ~~one-half of one~~ five percent of unearned income in addition to the premium amount, except as provided under section 256.01, subdivision 18b.

~~(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).~~

~~(5)~~ (4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

Sec. 8. Minnesota Statutes 2010, section 256B.0657, is amended to read:

256B.0657 SELF-DIRECTED SUPPORTS ~~OPTION~~ OPTIONS.

Subdivision 1. **Definition.** (a) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (d).

(b) "Legal representative" means a legal guardian of a child or an adult, or parent of a minor child.

(c) "Individual representative" means an individual who has been authorized, in a written statement by the person or the person's legal representative, to speak on the person's behalf and help the person understand and make informed choices in matters related to identification of needs and choice of services and supports and assist the person to implement an approved support plan and has no financial interest in the provision of any services included in the individual's plan unless related by blood, adoption, or marriage.

(d) "Self-directed supports ~~option~~ options" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistance services under section 256B.0659, or for a home and community-based services waiver program under section 256B.0915, 256B.092, or 256B.49, or alternative care under section 256B.0913;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services ~~not~~ except for services provided by those related by blood ~~or~~, adoption, marriage, or family foster care consistent with the requirements of section 256B.0651, subdivision 1, paragraph (e);

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian, individual representative, or parent to carry them out, the guardian, individual representative, or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll ~~or~~, exclude, or require other measures such as training, increased assistance, reporting, or oversight for recipients, including guardians ~~and~~, parents, and individual representatives under the following circumstances:

(1) recipients who have been restricted by the ~~Primary Care Utilization Review Committee~~ Minnesota restricted recipient program may be excluded for a specified time period;

(2) recipients who exit the self-directed supports option during the recipient's service plan year shall not access the self-directed supports option for the remainder of that service plan year; and

(3) when the department determines that the recipient cannot manage recipient responsibilities under the program.

(c) For vendors or other self-directed service providers, the commissioner may take any action authorized under surveillance and integrity review in Minnesota Rules, parts 9505.2160 to 9505.2245.

Subd. 3. **Eligibility for other services.** Selection of the self-directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit~~, including home care targeted case management~~, except that a person ~~receiving~~ choosing lead agency managed home and community-based waiver services, agency-provided personal care assistance services, a family support grant, or a consumer support grant is not eligible for funding under the self-directed supports option.

Subd. 4. **Assessment requirements.** (a) The self-directed supports option assessment must meet the following requirements:

(1) it shall be conducted ~~by the county public health nurse or a certified public health nurse under contract with the county~~ consistent with the requirements of personal care assistance services under section 256B.0659, subdivision 3a; home and community-based waiver services programs under section 256B.0915, 256B.092, or 256B.49; and the alternative care program under section 256B.0913, until section 256B.0911, subdivision 3a, has been implemented;

(2) it shall be conducted face-to-face in the recipient's home initially, and at least annually thereafter; when there is a significant change in the recipient's condition; and when there is a change in the person's need for ~~personal care assistance~~ services under the programs listed in subdivision 2, paragraph (a), clause (2). A recipient who is residing in a facility may be assessed for the self-directed support option for the purpose of returning to the community using this option; and

(3) it shall be completed using the format established by the commissioner.

(b) The results of the personal care assistance assessment and recommendations shall be communicated to the commissioner and the recipient ~~by the county public health nurse or certified public health nurse under contract with the county~~ as required under section 256B.0659, subdivision 3a. The person's annual and monthly average authorization for the self-directed budget amount shall be provided within 40 days after the personal care assessment or reassessment, or within ten days after a request not related to an assessment.

(c) The lead agency responsible for administration of home and community-based waiver services under section 256B.0915, 256B.092, or 256B.49, and alternative care under section 256B.0913, shall provide annual and monthly average authorization for the self-directed services budget amounts for all eligible persons within 40 days after an initial assessment or annual review and within ten days if requested at a time unrelated to the assessment or annual review.

Subd. 5. **Self-directed supports option plan requirements.** (a) The plan and provider for the self-directed supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistance and other services and supports identified in the recipient's self-directed supports option assessment;

(2) the plan shall be developed by the recipient, legal representative, or ~~by the guardian of an adult recipient or by a parent or guardian of a minor child,~~ managing partner, and may be assisted by a provider who meets the requirements established for using a person-centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistance services or home and community-based waiver or alternative care authorization included in the budget. A recipient may reserve funds monthly for the purchase of items that meet the standards in subdivision 6, paragraph (a), clause (2), and are reflected in the support plan. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistance services authorized amount unless a change in condition is documented.

(b) The commissioner or the commissioner's designee shall:

(1) ensure that outreach activities and information materials on self-directed options are developed and provided across the state to persons who use or are seeking community support services;

~~(1)~~ (2) establish the format and criteria for the plan ~~as well as the requirements for providers who assist with plan development~~;

~~(2)~~ (3) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

~~(3)~~ (4) notify the recipient, ~~parent, or guardian~~ legal representative, or individual representative of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

~~(4)~~ (5) provide a copy of the plan to the fiscal support entity selected by the recipient from among at least three certified entities.

(c) The commissioner shall:

(1) establish provider enrollment requirements for provision of fiscal support entity services and person-centered support plan services, including benefits counseling to support employment; and

(2) collect a fee to cover the costs of certifying providers for the services described in this subdivision.

Subd. 6. **Services covered.** (a) Services covered under the self-directed supports option include:

(1) personal care assistance services under section 256B.0659, and services under the home and community-based waivers, except those provided in licensed or registered residential settings unless the services are provided in a family foster care setting which meets the requirements of section 256B.0651, subdivision 1, paragraph (e); and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

Subd. 7. **Noncovered services.** Services or supports that are not eligible for payment under the self-directed supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) any fees incurred by the recipient, such as Minnesota health care program fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage or fiscal support entity payments;

(4) room and board and personal items that are not related to the disability, except that medically prescribed specialized diet items may be covered if they reduce the need for human assistance;

(5) home modifications that add square footage, except those modifications that configure a bathroom to accommodate a wheelchair;

(6) home modifications for a residence other than the primary residence of the recipient, or in the event of a minor with parents not living together, the primary residences of the parents;

(7) expenses for travel, lodging, or meals related to training the recipient, the ~~parent or guardian of an adult recipient, or the parent or guardian of a minor child~~ legal representative, or paid or unpaid caregivers that exceed $500 in a 12-month period;

(8) experimental treatment;

(9) any service or item to the extent the service or item is covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

Subd. 8. **Self-directed budget requirements.** (a) The budget for the provision of the self-directed service option shall be established for persons eligible for personal care assistance services under section 256B.0659 based on:

(1) assessed personal care assistance units, not to exceed the maximum number of personal care assistance units available, as determined by section 256B.0659; and

(2) the personal care assistance unit rate:

(i) with a reduction to the unit rate to pay for a program administrator as defined in subdivision 10; and

(ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for the state.

(b) The budget for persons eligible for programs listed in subdivision 2, paragraph (a), clause (2), is based on the approved budget methodologies for each program.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and

capabilities. These measures must include (i) background studies, ~~and~~ (ii) backup and emergency plans, including disaster planning, and (iii) for persons using home and community-based waiver services, monitoring by the lead agency on quality assurance measures and recipient health, safety, and welfare.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option, including information on the quality assurance efforts.

(c) Performance assessments measures, such as of a recipient's functioning, satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group.

Subd. 10. **Fiscal support entity.** (a) Each recipient or legal representative shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. ~~Recipients~~ The recipient or legal representative shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient, individual representative, or the recipient's legal representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient ~~and the home care targeted case manager~~, legal representative, and individual representative with a monthly written summary of the self-directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(5) must have current and adequate liability insurance and bonding and sufficient cash flow and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting; and

(6) must maintain records to track all self-directed supports option services expenditures, including time records of persons paid to provide supports and receipts for

any goods purchased. The records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request. Claims submitted by the fiscal support entity must correspond with services, amounts, and time periods as authorized in the recipient's self-directed supports option plan.

(c) The commissioner shall have authority to:

(1) set or negotiate rates with fiscal support entities;

(2) limit the number of fiscal support entities;

(3) identify a process to certify and recertify fiscal support entities and assure fiscal support entities are available to recipients throughout the state; and

(4) establish a uniform format and protocol to be used by eligible fiscal support entities.

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide ~~consumer-directed~~ self-directed services stakeholder group, including representatives of all types of ~~consumer-directed~~ self-directed service users, advocacy organizations, counties, and ~~consumer-directed~~ self-directed service providers. The commissioner shall seek recommendations from this stakeholder group in developing, monitoring, evaluating, and modifying:

(1) the self-directed plan format;

(2) requirements and guidelines for the person-centered plan assessment and planning process;

(3) implementation of the option and the quality assurance and risk management techniques; ~~and~~

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation; and

(5) the self-directed supports options available through the home and community-based waivers under section 256B.0916 and the personal care assistance program under section 256B.0659, including recommendations on possible ways to increase participation, improve flexibility, and provide incentives for recipients to participate in a life transition and crisis funding pool with others to save and contribute part of their authorized budgets, which can be carried over year to year and used according to priority standards under section 256B.092, subdivision 12, paragraph (a), clauses (1), (3), (4), (5), and (6).

The stakeholder group shall provide recommendations on the repeal of the personal care assistance choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet

at least three times each year to provide advice on policy, implementation, and other aspects of ~~consumer and~~ self-directed services.

Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports option is available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of ~~1,000~~ 2,000 people in the first fiscal year of implementation and an additional ~~1,000~~ 3,000 people in the second fiscal year. The commissioner shall evaluate the self-directed supports option during the first two years of implementation and make any necessary changes ~~prior to the option becoming available statewide~~.

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

Sec. 9. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 275 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance

provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; ~~and~~

(5) agency marketing and advertising materials and documentation of marketing activities and costs; and

(6) for each personal care assistant, whether or not the personal care assistant is providing care to a relative as defined in subdivision 11.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to read:

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

(a) "Long-term care consultation services" means:

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

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

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

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

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

(6) federally mandated screening to determine the need for an institutional level of care under subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support plan development with appropriate referrals, including the option for ~~consumer-directed community~~ self-directed supports;

(8) providing recommendations for nursing facility placement when there are no cost-effective community services available; ~~and~~

(9) assistance to transition people back to community settings after facility admission; and

(10) providing notice to the individual or legal representative of the annual and monthly average authorized amount for traditional agency services and self-directed services under section 256B.0657 for which the recipient is found eligible.

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

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

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

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

Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within ~~15 calendar~~ 20 calendar days after the date on which an assessment was requested or recommended. After January 1, 2011, these requirements also apply to personal care assistance services, private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including ~~consumer-directed~~ self-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care. For persons determined ineligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the

community support plan must also include the estimated annual and monthly average authorized budget amount for those services.

(f) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. 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 persons determined eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (10), the community support plan must also include:

(6) identification of individual goals;

(7) identification of short-term and long-term service outcomes. Short-term service outcomes are defined as achievable within six months;

(8) a recommended schedule for case management visits. When achievement of short-term service outcomes may affect the amount of service required, the schedule must be at least every six months and must reflect evaluation and progress toward identified short-term service outcomes; and

(9) the estimated annual and monthly budget amount for services.

In addition, for persons determined eligible for state plan home care under subdivision 1a, paragraph (a), clause (8), the person or person's representative must also receive a copy of the home care service plan developed by a certified assessor.

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

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

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

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

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

(3) information about Minnesota health care programs;

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to read:

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified

boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria ~~established~~ developed by the commissioner, and in section ~~144.0724, subdivision 11, and~~ 256B.092, using forms developed by the commissioner. Effective no sooner than on or after January 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing

facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) Seventy-five percent of 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.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g).

(c) 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 (b) and may adjust the monthly payment amount in paragraph (a). 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.

(d) 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 section 256B.0917, 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.

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

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

(g) 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.~~ Counties may set a fee schedule for initial assessments and support plan development for individuals who are not financially eligible for medical assistance or MinnesotaCare. The maximum fee must not be greater than the actual cost of the initial assessment and support plan development.

(h) The commissioner shall develop an alternative payment methodology for long-term care consultation services that includes the funding available under this subdivision, and sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of federal funding for this activity.

Sec. 15. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4a, paragraph (d), but for the provision of services under the alternative care program~~. Effective January 1, 2011, this determination must be made according to the criteria established in section 144.0724, subdivision 11~~;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) ~~only one dependency~~ up to two dependencies in bathing, dressing, grooming, ~~or~~ walking, ~~or (iii) a dependency score of less than three if eating is the only dependency~~ and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed ~~$600~~ $593 per month for all new participants enrolled in the program on or after July 1, ~~2009~~ 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 16. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client except for individuals described in paragraph (b) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in

which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by ~~the greater of~~ any legislatively adopted home and community-based services percentage rate ~~increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with:

(1) no dependencies in activities of daily living~~.~~; or

(2) ~~only one dependency~~ up to two dependencies in bathing, dressing, grooming, ~~or~~ walking, ~~or (3) a dependency score of less than three if eating is the only dependency,~~ and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911

shall be ~~the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A~~ $1,750 per month effective on ~~October~~ July 1, ~~2008~~ 2011, ~~per month~~ for all new participants enrolled in the program on or after July 1, ~~2009~~ 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) or (b).

Sec. 17. Minnesota Statutes 2010, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion budget

limit for the cost of elderly waivered services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be based on the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the ~~resident~~ elderly waiver applicant currently resides ~~multiplied~~. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365 ~~and~~, divided by 12, ~~less~~ and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion ~~rate may~~ budget limit shall be adjusted ~~by the greater of any subsequent legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates~~ annually as described in subdivision 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the ~~conversion rate limit is equal to the~~ nursing facility ~~rate~~ per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including ~~extended medical~~ specialized supplies and equipment and environmental ~~modifications and~~ accessibility adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters

established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

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

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

~~(e)~~ (f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a

building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after ~~January~~ July 1, 2011, and all other participants at their first reassessment after ~~January~~ July 1, 2011, dependency in at least ~~two~~ three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services

in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h ~~for the contract period beginning October 1, 2009~~. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

Sec. 22. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to read:

Subd. 6a. **Statewide availability of ~~consumer-directed community~~ self-directed support services.** (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver ~~for persons with developmental disabilities~~ under section 256B.092 and by April 1, 2005, for waivers under sections 256B.0915 and 256B.49, to make ~~consumer-directed community~~ self-directed support services available in every county of the state ~~by January 1, 2002~~.

(b) Until the waiver amendment for self-directed community supports under section 54 is effective, if a county declines to meet the requirements for provision of ~~consumer-directed community~~ self-directed supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer ~~consumer-directed community~~ self-directed supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with developmental disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative with funds received through the ~~consumer-directed community~~ self-directed support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and~~ services.** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~

~~(1) review of eligibility for services;~~

~~(2) screening;~~

~~(3) intake;~~

~~(4) diagnosis;~~

~~(5) the review and authorization of services based upon an individualized service plan; and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~ Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services cannot be provided to a recipient by a private agency that has any financial interest in the provisions of any other services included in the recipient's coordinated service and support plan.

(b) Case management ~~service activities provided to or arranged for a person include~~ services must be provided to each recipient of home and community-based waiver

services and available to those eligible for case management under sections 256B.0621 and 256B.0924, subdivision 4, who choose this service. Case management services for an eligible person include:

(1) development of the ~~individual~~ coordinated service and support plan;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services, including coordinating with the person's health care home or health coordinator, if coordination of long-term care or community supports and health care is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the plan including at least one face-to-face visit with each person annually by the case manager; and

(8) ~~annual reviews of service plans and services provided~~ providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the support plan within ten working days after receiving the community support plan from the certified assessor under section 256B.0911.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by ~~county agencies or under contract~~ a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in section 256B.0621, subdivision 5, paragraphs (a) and (b), clauses (1) to (5), and has no financial interest in the provision of any other services to the person choosing case management service.

(d) ~~Case managers are responsible for the administrative duties and service provisions listed in paragraphs (a) and (b).~~ Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the individualized service and habilitation plans.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

(f) Persons eligible for home and community-based waiver services may choose a case management service provider from among the public or private vendors enrolled according to paragraph (d).

(g) For persons eligible for case management under section 256B.0924, and Minnesota Rules, parts 9525.0004 to 9525.0036, the county or lead agency shall designate the case management service provider.

EFFECTIVE DATE. This section is effective January 1, 2013, except subdivision 1a, paragraph (b), clause (6), is effective July 1, 2011.

Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **~~Individual~~ Coordinated service and support plan.** ~~The individual~~ Each recipient of case management services and any legal representative shall be provided a written copy of the coordinated service and support plan ~~must~~, which:

(1) ~~include~~ is developed within ten working days after the case management service receives the community support plan from the certified assessor under section 256B.0911;

(2) includes the results of the assessment information on the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably assures the health, safety, and welfare of the recipient;

~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers;

~~(3) identify~~ (6) identifies long- and short-range goals for the person;

~~(4) identify~~ (7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, ~~and~~ available resources~~. The individual service plan shall also specify other services the person needs that are not available~~, and other services the person needs that are not available. The individual coordinated service and support plan shall also specify service outcomes and the provider's responsibility to monitor the achievement of the service outcomes;

~~(5) identify~~ (8) identifies the need for an ~~individual program~~ individual's provider plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

~~(6) identify~~ (9) identifies provider responsibilities to implement and make recommendations for modification to the ~~individual~~ coordinated service and support plan;

~~(7) include~~ (10) includes notice of the right to have assessments completed and service plans developed within specified time periods, the right to appeal action or

inaction, and the right to request ~~a conciliation conference or a hearing~~ an appeal under section 256.045;

~~(8) bc~~ (11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

~~(9) bc~~ (12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

~~Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.~~

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

Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

Subd. 1e. **Case management service monitoring, coordination, and evaluation~~, and monitoring of services~~ duties.** (a) If the ~~individual~~ coordinated service and support plan identifies the need for individual ~~program~~ provider plans for authorized services, the case ~~manager~~ management service provider shall assure that ~~individual program~~ the individual provider plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual ~~program~~ provider plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the individual service plan;

(3) are consistent with other aspects of the ~~individual~~ coordinated service and support plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services and service outcomes among the various service providers.

(b) The case ~~manager~~ management service provider shall monitor the provision of services:

(1) to assure that the individual service plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the individual service plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual ~~program~~ provider plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual~~ coordinated service and support plan.

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

Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of ~~individual~~ a coordinated service and support plan.** Unless otherwise required by federal law, the county agency is not required to complete ~~an individual~~ a coordinated service and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

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

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

Subd. 3. **Authorization and termination of services.** ~~County agency case managers~~ Lead agencies, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to ~~individual~~ coordinated service and support plans. Services provided to persons with developmental disabilities may only be authorized and terminated ~~by case managers~~ according to (1) rules of the commissioner and (2) the ~~individual~~ coordinated service and support plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized

by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

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

Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. ~~**Screening team**~~ **Additional certified assessor duties.** The ~~screening team~~ certified assessor shall:

(1) review diagnostic data;

(2) review health, social, and developmental assessment data using a ~~uniform screening~~ comprehensive assessment tool specified by the commissioner;

(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;

(4) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

(5) assess whether a person is in need of long-term residential care;

(6) make recommendations regarding ~~placement~~ services and payment for: (i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence; (ii) training and habilitation service, vocational rehabilitation, and employment training activities; (iii) community residential ~~placement~~ services; ~~(iv) regional treatment center placement;~~ or ~~(v)~~ (iv) a home and community-based service alternative to community residential placement or regional treatment center placement;

(7) evaluate the availability, location, and quality of the services listed in clause (6), including the impact of ~~placement alternatives~~ services and supports options on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

(8) identify the cost implications of recommendations in clause (6) and provide written notice of the annual and monthly average authorized amount to be spent for services for the recipient;

(9) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities; and

(10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.

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

Sec. 29. **[256B.0961] STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.**

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including traumatic brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

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

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of the commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012 to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first two years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Departments of Human Services and Health, and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Departments of Human Services and Health in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota; and

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under

paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Departments of Human Services, and Health, and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual

statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

EFFECTIVE DATE. (a) Subdivisions 1 to 6 are effective July 1, 2011.

(b) The jurisdictions of the regional quality councils in subdivision 4 must be defined, with implementation dates, by July 1, 2012. During the biennium beginning July 1, 2011, the Quality Assurance Commission shall continue to implement the alternative licensing system under this section.

Sec. 30. Minnesota Statutes 2010, section 256B.19, is amended by adding a subdivision to read:

Subd. 2d. **Obligation of local agency to process medical assistance applications within established timelines.** (a) Except as provided in paragraph (b), when an individual submits an application for medical assistance and the applicant's eligibility is based on disability or on being age 65 or older, the county must determine the applicant's eligibility and mail a notice of its decision to the applicant within:

(1) 60 days from the date of the application for an individual whose eligibility is based on disability; or

(2) 45 days from the date of the application for an individual whose eligibility is based on being age 65 or older.

(b) The county must determine eligibility and mail a notice of its decision within the time frames stated in paragraph (a), except in the following circumstances:

(1) the county cannot make a determination because, despite reasonable efforts by the county to communicate what is required, the applicant or an examining physician delays or fails to take a required action; or

(2) there is an administrative or other emergency beyond the county's control. For purposes of this clause, a staffing shortage does not constitute an emergency beyond the county's control.

For the events in either clause (1) or (2), the county must document in the applicant's case record the reason for delaying beyond the established time frames.

(c) The county must not use the time frames established in paragraph (a) as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the established time frames.

(d) Effective July 1, 2011, unless one of the exceptions listed under paragraph (b) applies, if a county fails to comply with paragraph (a) and the applicant ultimately is determined to be eligible for medical assistance, the county is responsible for the entire cost of medical assistance services provided to the applicant by a nursing facility and not paid for by federal funds, from and including the first date of eligibility through the date on which the county mails written notice of its decision on the application. The applicable facility will bill and receive payment directly from the commissioner in customary fashion, and the commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

(e) This subdivision supersedes subdivision 1, clause (2), if both apply to an applicant.

Sec. 31. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to read:

Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

(b) For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the commissioner shall limit payment for leave days in a nursing facility to 60 percent of that nursing facility's total payment rate for the involved resident.

(c) For services rendered on or after July 1, 2011, for facilities reimbursed under this chapter, the commissioner shall limit payment for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415.

Sec. 32. Minnesota Statutes 2010, section 256B.431, is amended by adding a subdivision to read:

Subd. 44. **Property rate increase for a facility in Bloomington effective November 1, 2010.** Notwithstanding any other law to the contrary, money available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of $19.33.

Sec. 33. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, ~~October 1, 2011, and October 1, 2012.~~ this paragraph shall apply only to the property-related payment rate~~,~~ ~~except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided~~. For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this

purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility

by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 34. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per

bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(g) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(h) Beginning July 16, 2011, the commissioner shall no longer approve planned closure rate adjustments under this subdivision.

Sec. 35. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 60. **Rate increase for low-rate facilities.** (a) Effective October 1, 2011, the commissioner shall adjust the operating payment rates of a nursing facility whose operating payment rate on September 30, 2011, is greater than the 95th percentile of all nursing facilities operating payment rates. The commissioner shall:

(1) array all operating payment rates in effect on September 30, 2011, at a case-mix weight equal to 1.00 (DDF) from lowest to highest;

(2) remove from the array any nursing facility determined by the commissioner to be providing specialized care, determined in accordance with criteria in subdivision 51a, paragraph (b), and any facilities receiving a rate increase under paragraph (c), clause (1);

(3) determine the 95th percentile of the array in clause (1);

(4) compute a reduction amount not to exceed three percent, if a facility's amount in clause (1) is greater than the amount computed in clause (3) by subtracting a facility's DDF rate in clause (1) from the amount computed in clause (3);

(5) compute the portion of each facility's DDF operating payment rate that is the direct care per diem based on the rates in effect on September 30, 2011; and

(6) determine the change for all other case-mix levels, by multiplying the amount in clause (4) by the percentage in clause (5) and by the corresponding case-mix weight for each care level. Add to this product the non-direct care per diem portion of the amount in clause (4).

(b) The total amount to be saved by the rate reductions will be computed. The commissioner shall:

(1) for each facility receiving a rate change in paragraph (a), multiply each case-mix level's rate change in paragraph (a), clause (6), by the corresponding case-mix resident days from the most recent cost report that has been desk audited; and

(2) sum all the products computed in clause (1).

(c) The amount of total payment reductions computed in paragraph (b) shall be distributed to the facilities with the lowest DDF operating payment rates determined in paragraph (a), clause (1). The commissioner shall:

(1) for nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, give an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route;

(2) start with the facility or facilities with the lowest DDF operating payment rate and compute the amount of a rate adjustment needed to make the DDF rate equal to the DDF of the facility directly below it in the array;

(3) compute the rate increases for the other case-mix levels using the amount computed in clause (2), and the process stated in paragraph (a), clauses (5) and (6);

(4) compute the total amount the lowest facilities will receive using the process described in paragraph (b);

(5) compute the running total to be spent at all facilities receiving an increase under this paragraph by summing each facility's amount computed in clause (4); and

(6) repeat the process in clauses (2) to (5) as long as the amount in clause (5) does not exceed the amount in paragraph (b), clause (2). In no case shall the DDF operating payment rate increase determined in clauses (2) to (6) exceed two percent.

Sec. 36. Minnesota Statutes 2010, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances:

(1) the nursing facility may:

~~(1)~~ (i) charge private paying residents a higher rate for a private room~~.~~; and

~~(2)~~ (ii) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner~~.~~;

(2) effective July 1, 2011, through September 30, 2012, nursing facilities may charge private paying residents rates up to two percent higher than the allowable payment rate determined by the commissioner for the RUGS group currently assigned to the resident;

(3) effective October 1, 2012, through September 30, 2013, nursing facilities may charge private paying residents rates up to four percent higher than the allowable payment rate determined by the commissioner for the RUGS group currently assigned to the resident;

(4) effective October 1, 2013, through September 30, 2014, nursing facilities may charge private paying residents rates up to six percent higher than the allowable payment rate determined by the commissioner for the RUGS group currently assigned to the resident;

(5) effective October 1, 2014, nursing facilities may charge private paying residents up to eight percent higher than the allowable payment rate determined by the commissioner for the RUGS group currently assigned to the resident; and

(6) the higher private pay charges allowed in this paragraph shall be limited to actual costs per resident day, as determined by the commissioner, based on data provided in the statistical and cost report in section 256B.441.

Nothing in this section precludes a nursing facility from charging a rate allowable under the facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action.

Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

(b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan. For residents on medical assistance, medical assistance payment according to the state plan must be accepted as payment in full for continued stay, except where otherwise provided for under statute;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota Board of Pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

(d) Providing differential treatment on the basis of status with regard to public assistance.

(e) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance ~~or refusal to purchase special services~~.

Discrimination in admissions ~~discrimination~~, services offered, or room assignment shall include, but is not limited to:

(1) basing admissions decisions upon ~~assurance by the applicant to the nursing facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek~~ information or assurances regarding current or future eligibility for public assistance for payment of nursing facility care ~~costs~~; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility is utilizing that information for any purpose prohibited by this paragraph.

(f) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney's fees or their equivalent.

(g) Refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

(h) For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the

commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 37. Minnesota Statutes 2010, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under ~~sections 144.0724, subdivision 11, and~~ section 256B.0911~~,~~ or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** ~~(a)~~ Each recipient of a home and community-based waiver under this section shall be provided case management services according to section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the federally approved waiver application. ~~The case management service activities provided will include:~~

~~(1) assessing the needs of the individual within 20 working days of a recipient's request;~~

~~(2) developing the written individual service plan within ten working days after the assessment is completed;~~

~~(3) informing the recipient or the recipient's legal guardian or conservator of service options;~~

~~(4) assisting the recipient in the identification of potential service providers;~~

~~(5) assisting the recipient to access services;~~

~~(6) coordinating, evaluating, and monitoring of the services identified in the service plan;~~

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

~~(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.~~

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

Sec. 39. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section ~~144.0724, subdivision 11~~ 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify individuals whose level of functioning is reasonably expected to improve and reassess these individuals every six months. Individuals who meet these criteria must have a comprehensive transitional

service plan developed under subdivision 15, paragraphs (b) and (c). Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

EFFECTIVE DATE. This section is effective January 1, 2012, except for paragraph (f), which is effective July 1, 2013.

Sec. 40. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. ~~**Individualized**~~ **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which:~~ that complies with the requirements of section 256B.092, subdivisions 1b and 1e.

~~(1) is developed and signed by the recipient within ten working days of the completion of the assessment;~~

~~(2) meets the assessed needs of the recipient;~~

~~(3) reasonably ensures the health and safety of the recipient;~~

~~(4) promotes independence;~~

~~(5) allows for services to be provided in the most integrated settings; and~~

~~(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.~~

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the individual to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist

in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the individual to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the individual's current level of functioning. Individuals who move from a transitional to a maintenance service plan must be reassessed to determine if the individual would benefit from a transitional service plan on at least an annual basis. This assessment should consider any changes to technological or natural community supports.

~~(b)~~ (e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

EFFECTIVE DATE. This section is effective January 1, 2012, except for paragraphs (b), (c), and (d), which are effective July 1, 2013.

Sec. 41. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/MR rate increase.** Effective July 1, 2011, the commissioner shall increase the daily rate to $138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 42. Minnesota Statutes 2010, section 256B.5012, is amended by adding a subdivision to read:

Subd. 10. **ICF/MR rate adjustment.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to ... percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 43. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(b) any period an applicant spends on a placement basis in a training and habilitation program, including a rehabilitation facility or work or employment program as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to section 256B.0659;~~ semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 44. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 12, is amended to read:

EFFECTIVE DATE. ~~The~~ This section is effective ~~July 1, 2011~~ on or after January 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21.

Sec. 45. Laws 2009, chapter 79, article 8, section 51, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 17, section 14, is amended to read:

EFFECTIVE DATE. This section is effective ~~July 1, 2011~~ January 1, 2014.

Sec. 46. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

Subd. 8. **Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Aging and Adult Services Grants	13,499,000	15,805,000
Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.		
Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.		
Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in		

fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

(b) Alternative Care Grants	50,234,000	48,576,000

Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home

and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver Allocations. Prior to the availability of the alternative license defined in Minnesota

Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

~~**Alternatives to Personal Care Assistance Services.** Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.~~

(e) Mental Health Grants

	Appropriations by Fund	
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

Payments for Substance Abuse Treatment. For placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

(1) rates charged for these services on January 1, 2009; or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Rates for fiscal years 2010 and 2011 must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, the statewide aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the projected aggregate payment under the rates in effect for fiscal year 2011 excluding the rate reduction for rates that were below the average on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund

administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality

assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 47. **DIRECTIONS TO COMMISSIONER.**

Subdivision 1. **Co-payments for home and community-based services.** Upon federal approval, the commissioner of human services shall develop and implement a co-payment schedule for individuals receiving home and community-based services under Minnesota Statutes, chapter 256B.

Subd. 2. **Federal waiver amendment.** The commissioner shall seek an amendment to the 1915c home and community-based waivers under Minnesota Statutes, sections 256B.092 and 256B.49, to allow properly licensed residential programs under Minnesota Statutes, section 245A.02, subdivision 14, to provide residential services to up to eight individuals with physical or developmental disabilities, chronic illnesses, or traumatic brain injuries. A facility licensed for five to eight people must be an existing residential building, such as a duplex, that is owned by the same company and meets all other licensing requirements.

Subd. 3. **Recommendations for personal care assistance service changes.** The commissioner shall consult with stakeholder groups, including counties, advocates, persons receiving personal care assistance services, and personal care assistance providers, and make recommendations to the legislature by February 1, 2014, on changes that could be made to the program to improve oversight, program efficiency, and cost-effectiveness.

Subd. 4. **Nursing facility pay-for-performance reimbursement system.** The commissioner of human services shall report to the legislative committees with jurisdiction over nursing facility policy and finance with recommendations for developing and implementing a pay-for-performance reimbursement system with a quality add-on by January 15, 2012.

Subd. 5. **ICF/MR transition plan.** The commissioner of human services shall work with stakeholders to develop and implement a plan by June 30, 2013, to transition individuals currently residing in intermediate care facilities for persons with developmental disabilities into the least restrictive community settings possible. The plan must include a requirement for a cooperative planning process between the counties and providers for the downsizing or closure of intermediate care facilities for persons with developmental disabilities, with funding from the bed closures converting to home and community-based waiver funding to fund services for those leaving the intermediate care facilities for persons with developmental disabilities based on a plan approved by the commissioner. In order to facilitate this process, the commissioner shall provide information to facilities and

counties about the number of people in facilities who have requested to move to home and community-based services. Individuals residing in intermediate care facilities for persons with developmental disabilities who choose to remain there or whose health or safety would be put at risk in a less restrictive setting may continue to reside in intermediate care facilities for persons with developmental disabilities.

Subd. 6. **Representative payee.** The commissioner of human services shall make recommendations to the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2012, on ways to better manage funds for persons who rely on a representative payee.

Sec. 48. **STATE PLAN AMENDMENT TO IMPLEMENT SELF-DIRECTED PERSONAL SUPPORTS.**

By July 15, 2011, the commissioner shall submit a state plan amendment to implement Minnesota Statutes, section 256B.0657, as soon as possible upon federal approval.

Sec. 49. **AMENDMENT FOR SELF-DIRECTED COMMUNITY SUPPORTS.**

By September 1, 2011, the commissioner shall submit an amendment to the home and community-based waiver programs consistent with implementing the self-directed option under Minnesota Statutes, section 256B.0657, through statewide enrolled providers contracted to provide outreach information, training, and fiscal support entity services to all eligible recipients choosing this option and with shared care in some types of services. The waiver amendment shall be consistent with changes in case management services under Minnesota Statutes, section 256B.092.

Sec. 50. **ESTABLISHMENT OF RATES FOR SHARED HOME AND COMMUNITY-BASED WAIVER SERVICES.**

By January 1, 2012, the commissioner shall establish rates to begin paying for in-home services and personal supports under all of the home and community-based waiver services programs consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

Sec. 51. **ESTABLISHMENT OF RATE FOR CASE MANAGEMENT SERVICES.**

By July 1, 2012, the commissioner shall establish the rate to be paid for case management services under Minnesota Statutes, sections 256B.0621, subdivision 2, clause

(4), 256B.092, and 256B.49, consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

Sec. 52. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.**

By February 1, 2012, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation to be effective July 1, 2012, for the following:

(1) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management services, including targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625, subdivision 20; and 256B.0924; mental health case management services for children and adults, all types of home and community-based waiver case management, and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

(2) recommendations on county of financial responsibility requirements and quality assurance measures for case management;

(3) identification of county administrative functions that may remain entwined in case management service delivery models; and

(4) implementation of a methodology to fully fund county case management administrative functions.

Sec. 53. **MY LIFE, MY CHOICES TASK FORCE.**

Subdivision 1. **Establishment.** The My Life, My Choices Task Force is established to create a system of supports and services for people with disabilities governed by the following principles:

(1) freedom to act as a consumer of services in the marketplace;

(2) freedom to choose to take as much risk as any other citizen;

(3) more choices in levels of service that may vary throughout life;

(4) opportunity to work with a trusted partner and fiscal support entity to manage a personal budget and to be accountable for reporting spending and personal outcomes;

(5) opportunity to live with minimal constraints instead of minimal freedoms; and

(6) ability to consolidate funding streams into an individualized budget.

Subd. 2. **Membership.** The My Life, My Choices Task Force shall consist of the lieutenant governor; the commissioner of human services, or designee; a representative of the Minnesota Chamber of Commerce; and the following to be appointed by the governor:

one administrative law judge, one labor representative, two family members of people with disabilities, and one individual with disabilities. In addition, the following shall be appointed jointly by the speaker of the house and the senate Subcommittee on Committees of the Committee on Rules and Administration, a representative of a disability advocacy organization; a representative of a disability legal services advocacy organization; representatives of two nonprofit organizations, one of which serves all 87 counties; and a representative of a philanthropic organization. Appointed nongovernmental members of the task force shall serve as staff for the task force and take on the responsibilities of coordinating meetings, reporting on committee recommendations, and providing other staff support as needed to meet the responsibilities of the task force as described in subdivision 3. Legislative appointment of nongovernmental members of the task force shall be conditioned upon agreement from the appointees to provide staff assistance to execute the work of the task force. The chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance shall serve as ex officio members.

Subd. 3. **Duties.** The task force shall make recommendations, including proposed legislation, and report to the legislative committees with jurisdiction over health and human services policy and finance by November 15, 2011, on creating a system of supports and services for people with disabilities by July 1, 2012, as governed by the principles under subdivision 1. In making recommendations and proposed legislation, the council shall work in conjunction with the Consumer-Directed Community Supports Task Force and shall include self-directed planning, individual budgeting, choice of trusted partner, self-directed purchasing of services and supports, reporting of outcomes, ability to share in any savings, and any additional rules or laws that may need to be waived. Recommendations from the task force shall be fully implemented by July 1, 2013.

Subd. 4. **Expense reimbursement.** The members of the task force shall not be reimbursed for expenses related to the duties of the task force. The task force shall be independently staffed and coordinated by nongovernmental appointees who serve on the task force, and no state funding shall be appropriated for expenses related to the task force under this section.

Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

ARTICLE 7

REDESIGNING SERVICE DELIVERY

Section 1. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision to read:

Subd. 4b. **Electronic verification.** County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for the child care assistance under this chapter. The information is sufficient to determine eligibility.

Sec. 2. Minnesota Statutes 2010, section 256.01, subdivision 14b, is amended to read:

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

(b) For the purposes of this section, "American Indian child" means a person under 18 years of age who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

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

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

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

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

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

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

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

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

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

(2) family preservation;

(3) facilitative, supportive, and reunification services;

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 14c. **American Indian child welfare, social, and human services project; White Earth Band of Ojibwe.** (a) The commissioner of human services shall enter into a contractual agreement as authorized under subdivision 2, paragraph (a), clause (7), with the White Earth Band of Ojibwe Indians for the tribe to provide all human services and public assistance programs that are under the supervision of the commissioner to tribal members who reside on the reservation. Grants may be issued to the White Earth Band of Ojibwe Indians to support the project. The commissioner may waive existing rules to support this project. The commissioner shall seek any federal approvals necessary to carry out the project as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for purposes of the project.

(b) The commissioner shall redirect all funds provided to Mahnomen County for these services, including administrative expenses, to the White Earth Band of Ojibwe Indians.

(c) The commissioner, in consultation with the tribe, is authorized to determine: (1) which programs not currently provided by the White Earth Band of Ojibwe Indians will be transferred to the tribe; and (2) the process by which the new programs will be transferred. In the case of a dispute, a two-thirds vote of the tribal council to transfer a program to the tribe must overrule the decision of the commissioner.

(d) When the commissioner approves transfer of programs and the tribe assumes responsibility under this section, Mahnomen County is relieved of responsibility for providing program services to tribal members who live on the reservation while the tribal project is in effect and funded. The commissioner shall seek and use any funds available, including federal funds, foundation funds, existing grant funds, and other state funds as available.

(e) The tribe shall comply with all reporting and record keeping requirements under state and federal laws and rules.

Sec. 4. **[256.0145] COMPUTER SYSTEM SIMPLIFICATION.**

Subdivision 1. **Reprogram MAXIS.** The commissioner of human services, as part of the enterprise architecture project, shall reprogram the MAXIS computer system to automatically apply child support payments entered into the PRISM computer system to a MAXIS case file.

Subd. 2. **Program the social service information system.** The commissioner of human services shall require all prepaid health plans to accept a billing format identical to the MMIS billing format for payment to county agencies for mental health targeted case management claims, elderly waiver claims, and other claim categories as added to the benefit set. The commissioner shall make any necessary changes to the SSIS system to bill prepaid health plans for those claims.

Sec. 5. **[256.0147] COUNTY ELECTRONIC VERIFICATION TO DETERMINE ELIGIBILITY.**

County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for child support enforcement, general assistance, Minnesota supplemental aid, and programs, services, and supports under chapter 256J. The information is sufficient to determine eligibility. State and county caseworkers shall not be cited in error, as part of

any audit and quality review, for an incorrect eligibility determination based on current but inaccurate information received through a state-approved electronic data source. If there is a potential error, the reviewer must forward a corrective action notice to the caseworker for proper and immediate correction. If the state or county caseworker has data available through client reporting, or other means, that are more accurate than state-approved electronic data, the caseworker should use the more accurate information in making the eligibility determination.

Sec. 6. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

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

(1) enrolled in integrated Medicare and Medicaid programs under subdivisions 23 and 28;

(2) enrolled in managed care long-term care programs under subdivision 6b;

(3) dually eligible for Medicare and medical assistance; or

(4) in the waiting period for Medicare.

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

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

Sec. 7. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(f) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Sec. 8. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment

by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of ~~nursing homes, regional treatment centers, and~~ licensed residential facilities ~~with negotiated rates~~ shall not have overpayments recovered from their personal needs allowance.

Sec. 9. Minnesota Statutes 2010, section 256J.38, subdivision 1, is amended to read:

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

(1) reconstruct each affected budget month and corresponding payment month;

(2) use the policies and procedures that were in effect for the payment month; and

(3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

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

Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local social services agency shall establish and administer the food stamp program according to rules of the commissioner of human services, the supervision of the commissioner as specified in section 256.01, and all federal laws and regulations. The commissioner of human services shall monitor food stamp program delivery on an ongoing basis to ensure that each county complies with federal laws and regulations. Program requirements to be monitored include, but are not limited to, number of applications, number of approvals,

number of cases pending, length of time required to process each application and deliver benefits, number of applicants eligible for expedited issuance, length of time required to process and deliver expedited issuance, number of terminations and reasons for terminations, client profiles by age, household composition and income level and sources, and the use of phone certification and home visits. The commissioner shall determine the county-by-county and statewide participation rate.

(b) On July 1 of each year, the commissioner of human services shall determine a statewide and county-by-county food stamp program participation rate. The commissioner may designate a different agency to administer the food stamp program in a county if the agency administering the program fails to increase the food stamp program participation rate among families or eligible individuals, or comply with all federal laws and regulations governing the food stamp program. The commissioner shall review agency performance annually to determine compliance with this paragraph.

(c) A person who commits any of the following acts has violated section 256.98 or 609.821, or both, and is subject to both the criminal and civil penalties provided under those sections:

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willful statement or misrepresentation, or intentional concealment of a material fact, food stamps or vouchers issued according to sections 145.891 to 145.897 to which the person is not entitled or in an amount greater than that to which that person is entitled or which specify nutritional supplements to which that person is not entitled; or

(2) presents or causes to be presented, coupons or vouchers issued according to sections 145.891 to 145.897 for payment or redemption knowing them to have been received, transferred or used in a manner contrary to existing state or federal law; or

(3) willfully uses, possesses, or transfers food stamp coupons, authorization to purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner contrary to existing state or federal law, rules, or regulations; or

(4) buys or sells food stamp coupons, authorization to purchase cards, other assistance transaction devices, vouchers issued according to sections 145.891 to 145.897, or any food obtained through the redemption of vouchers issued according to sections 145.891 to 145.897 for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps, authorization to purchase cards, or other assistance transaction devices found in the possession of any person who is neither a recipient of the food stamp program nor otherwise authorized to possess and use such materials. Confiscated property shall be disposed of as the commissioner may direct and consistent with state and federal food

stamp law. The confiscated property must be retained for a period of not less than 30 days to allow any affected person to appeal the confiscation under section 256.045.

(e) ~~Food stamp overpayment claims which are due in whole or in part to client error shall be established by the county agency for a period of six years from the date of any resultant overpayment~~ Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(f) With regard to the federal tax revenue offset program only, recovery incentives authorized by the federal food and consumer service shall be retained at the rate of 50 percent by the state agency and 50 percent by the certifying county agency.

(g) A peace officer, welfare fraud investigator, federal law enforcement official, or the commissioner of health may confiscate vouchers found in the possession of any person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise authorized to possess and use such vouchers. Confiscated property shall be disposed of as the commissioner of health may direct and consistent with state and federal law. The confiscated property must be retained for a period of not less than 30 days.

(h) The commissioner of human services may seek a waiver from the United States Department of Agriculture to allow the state to specify foods that may and may not be purchased in Minnesota with benefits funded by the federal Food Stamp Program. The commissioner shall consult with the members of the house of representatives and senate policy committees having jurisdiction over food support issues in developing the waiver. The commissioner, in consultation with the commissioners of health and education, shall develop a broad public health policy related to improved nutrition and health status. The commissioner must seek legislative approval prior to implementing the waiver.

Sec. 11. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

Subd. 4. **Essential human services or essential services.** "Essential human services" or "essential services" means assistance and services to recipients or potential recipients of public welfare and other services delivered by counties or tribes that are mandated in federal and state law that are to be available in all counties of the state.

Sec. 12. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

Subd. 5. **Service delivery authority.** "Service delivery authority" means a single county, or ~~group~~ consortium of counties operating by execution of a joint powers agreement under section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of the county board of commissioners to participate in the redesign

under this chapter or has been assigned by the commissioner pursuant to section 402A.18. A service delivery authority includes an Indian tribe or group of tribes that have voluntarily chosen by resolution of tribal government to participate in redesign under this chapter.

Sec. 13. Minnesota Statutes 2010, section 402A.15, is amended to read:

402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME REFORMS.

Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome Reforms shall develop a uniform process to establish and review performance and outcome standards for all essential human services based on the current level of resources available, and ~~to~~ shall develop appropriate reporting measures and a uniform accountability process for responding to a county's or ~~human~~ service delivery authority's failure to make adequate progress on achieving performance measures. The accountability process shall focus on the performance measures rather than inflexible implementation requirements.

(b) The steering committee shall:

(1) by November 1, 2009, establish an agreed-upon list of essential services;

(2) by February 15, 2010, develop and recommend to the legislature a uniform, graduated process, in addition to the remedies identified in section 402A.18, for responding to a county's failure to make adequate progress on achieving performance measures; and

(3) by December 15, 2012, for each essential service, make recommendations to the legislature regarding ~~(1)~~ (i) performance measures and goals based on those measures for each essential service, ~~(2)~~ and (ii) a system for reporting on the performance measures and goals~~, and (3) appropriate resources, including funding, needed to achieve those performance measures and goals. The resource recommendations shall take into consideration program demand and the unique differences of local areas in geography and the populations served. Priority shall be given to services with the greatest variation in availability and greatest administrative demands~~. By January 15 of each year starting January 15, 2011, the steering committee shall report its recommendations to the governor and legislative committees with jurisdiction over health and human services. As part of its report, the steering committee shall, as appropriate, recommend statutory provisions, rules and requirements, and reports that should be repealed or eliminated.

(c) As far as possible, the performance measures, reporting system, and funding shall be consistent across program areas. The development of performance measures shall consider the manner in which data will be collected and performance will be reported. The steering committee shall consider state and local administrative costs related to collecting data and reporting outcomes when developing performance measures. ~~The~~

~~steering committee shall correlate the performance measures and goals to available levels of resources, including state and local funding.~~ The steering committee shall also identify and incorporate federal performance measures in its recommendations for those program areas where federal funding is contingent on meeting federal performance standards. The steering committee shall take into consideration that the goal of implementing changes to program monitoring and reporting the progress toward achieving outcomes is to significantly minimize the cost of administrative requirements and to allow funds freed by reduced administrative expenditures to be used to provide additional services, allow flexibility in service design and management, and focus energies on achieving program and client outcomes.

(d) In making its recommendations, the steering committee shall consider input from the council established in section 402A.20. ~~The steering committee shall review the measurable goals established in a memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied as statewide performance outcomes.~~

(e) The steering committee shall form work groups that include persons who provide or receive essential services and representatives of organizations who advocate on behalf of those persons.

(f) By December 15, 2009, the steering committee shall establish a three-year schedule for completion of its work. The schedule shall be published on the Department of Human Services Web site and reported to the legislative committees with jurisdiction over health and human services. In addition, the commissioner shall post quarterly updates on the progress of the steering committee on the Department of Human Services Web site.

Subd. 2. **Composition.** (a) The steering committee shall include:

(1) the commissioner of human services, or designee, and two additional representatives of the department;

(2) two county commissioners, representative of rural and urban counties, selected by the Association of Minnesota Counties;

(3) two county directors of human services, representative of rural and urban counties, selected by the Minnesota Association of County Social Service Administrators; and

(4) three clients or client advocates representing different populations receiving services from the Department of Human Services, who are appointed by the commissioner.

(b) The commissioner, or designee, and a county commissioner shall serve as cochairs of the committee. The committee shall be convened within 60 days of May 15, 2009.

(c) State agency staff shall serve as informational resources and staff to the steering committee. Statewide county associations may assemble county program data as required.

~~(d) To promote information sharing and coordination between the steering committee and council, one of the county representatives from paragraph (a), clause (2), and one of the county representatives from paragraph (a), clause (3), must also serve as a representative on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).~~

Sec. 14. Minnesota Statutes 2010, section 402A.18, is amended to read:

402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET PERFORMANCE OUTCOMES.

Subdivision 1. **Underperforming county; specific service.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for a specific essential service, the commissioner may impose the following remedies and adjust state and federal program allocations accordingly:

(1) voluntary incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of the specific essential service with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of the specific essential service to the commissioner.

Subd. 2. **Underperforming county; more than one-half of ~~service~~ services.** If the commissioner determines that a county or service delivery authority is deficient in achieving minimum performance outcomes for more than one-half of the defined essential ~~service~~ services, the commissioner may impose the following remedies:

(1) voluntary incorporation of the administration and operation of ~~the specific~~ essential ~~service~~ services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of ~~the specific~~ essential ~~service~~ services with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for program administration and operation of ~~the specific~~ essential ~~service~~ services to the commissioner.

Subd. 2a. **Financial responsibility of underperforming county.** A county subject to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of the essential service or essential services the amount of nonfederal and nonstate funding needed to remedy performance outcome deficiencies.

Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may impose the remedies authorized under this section, the following conditions must be met:

(1) the county or service delivery authority determined by the commissioner to be deficient in achieving minimum performance outcomes has the opportunity, in coordination with the council, to develop a program outcome improvement plan. The program outcome improvement plan must be developed no later than six months from the date of the deficiency determination; and

(2) the council has conducted an assessment of the program outcome improvement plan to determine if the county or service delivery authority has made satisfactory progress toward performance outcomes and has made a recommendation about remedies to the commissioner. The ~~review~~ assessment and recommendation must be made to the commissioner within 12 months from the date of the deficiency determination.

Sec. 15. Minnesota Statutes 2010, section 402A.20, is amended to read:

402A.20 COUNCIL.

Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service Delivery Redesign Council is established. Appointed council members must be appointed by their respective agencies, associations, or governmental units by November 1, 2009. The council shall be cochaired by the commissioner of human services, or designee, and a county representative from paragraph (b), clause (4) or (5), appointed by the Association of Minnesota Counties. Recommendations of the council must be approved by a majority of the voting council members. The provisions of section 15.059 do not apply to this council, and this council does not expire.

(b) The council must consist of the following members:

(1) two legislators appointed by the speaker of the house, one from the minority and one from the majority;

(2) two legislators appointed by the Senate Rules Committee, one from the majority and one from the minority;

(3) the commissioner of human services, or designee, and three employees from the department;

(4) two county commissioners appointed by the Association of Minnesota Counties;

(5) two county representatives appointed by the Minnesota Association of County Social Service Administrators;

(6) one representative appointed by AFSCME as a nonvoting member; and

(7) one representative appointed by the Teamsters as a nonvoting member.

(c) Administrative support to the council may be provided by the Association of Minnesota Counties and affiliates.

(d) Member agencies and associations are responsible for initial and subsequent appointments to the council.

Subd. 2. **Council duties.** The council shall:

(1) provide review of the service delivery redesign process, including proposed memoranda of understanding to establish a service delivery authority to conduct and administer experimental projects to test new methods and procedures of delivering services;

~~(2) certify, in accordance with section 402A.30, subdivision 4, the formation of a service delivery authority, including the memorandum of understanding in section 402A.30, subdivision 2, paragraph (b);~~

~~(3) ensure the consistency of the memorandum of understanding entered into under section 402A.30, subdivision 2, paragraph (b), with the performance standards recommended by the steering committee and enacted by the legislature;~~

~~(4)~~ (2) ensure the consistency of the memorandum of understanding, to the extent appropriate, ~~or~~ with other memorandum of understanding entered into by other service delivery authorities;

(3) review and make recommendations on applications from a service delivery authority for waivers of statutory or rule program requirements that are needed for flexibility to determine the most cost-effective means of achieving specified measurable goals in a redesign of human services delivery;

~~(5)~~ (4) establish a process to take public input on the ~~service delivery framework specified in the memorandum of understanding in section 402A.30, subdivision 2,~~

~~paragraph (b)~~ scope of essential services over which a service delivery authority has jurisdiction;

~~(6)~~ (5) form work groups as necessary to carry out the duties of the council under the redesign;

~~(7)~~ (6) serve as a forum for resolving conflicts among participating counties and tribes or between participating counties or tribes and the commissioner of human services, provided nothing in this section is intended to create a formal binding legal process;

~~(8)~~ (7) engage in the program improvement process established in section 402A.18, subdivision 3; and

~~(9)~~ (8) identify and recommend incentives for counties and tribes to participate in ~~human services~~ service delivery authorities.

Subd. 3. **Program evaluation.** By December 15, 2014, the council shall request consideration by the legislative auditor for a reevaluation under section 3.971, subdivision 7, of those aspects of the program evaluation of human services administration reported in January 2007 affected by this chapter.

Sec. 16. **[402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

Subdivision 1. **Requirements for establishing a service delivery authority.** (a) A county, tribe, or consortium of counties is eligible to establish a service delivery authority if:

(1) the county, tribe, or consortium of counties is:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more;

(iii) a consortium of four or more counties in reasonable geographic proximity without regard to population; or

(iv) one or more tribes with a total combined population of 25,000 or more.

The council may recommend that the commissioner of human services exempt a single county, tribe, or consortium of counties from the minimum population standard if the county, tribe, or consortium of counties can demonstrate that it can otherwise meet the requirements of this chapter.

(b) A service delivery authority shall:

(1) comply with current state and federal law, including any existing federal or state performance measures and performance measures under section 402A.15 when they are enacted into law, except where waivers are approved by the commissioner. Nothing in this subdivision requires the establishment of performance measures under section

402A.15 prior to a service delivery authority participating in the service delivery redesign under this chapter;

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of those services included in a proposal for a redesigned service or services and identify a single administrative agent for purposes of contact and communication with the department;

(4) identify the waivers from statutory or rule program requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals that the participating service delivery authority is expected to achieve;

(5) set forth a reasonable level of targeted reductions in overhead and administrative costs for each service delivery authority participating in the service delivery redesign; and

(6) set forth the terms under which a county, tribe, or consortium of counties may withdraw from participation.

(c) Once a county, tribe, or consortium of counties establishes a service delivery authority, no county, tribe, or consortium of counties that is a member of the service delivery authority may participate as a member of any other service delivery authority. The service delivery authority may allow an additional county, a tribe, or a consortium of counties to join the service delivery authority subject to the approval of the council and the commissioner.

(d) Nothing in this chapter precludes local governments from using sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Nothing in this chapter limits the authority of a county board or tribal council to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Subd. 2. **Relief from statutory requirements.** (a) Unless otherwise identified in the memorandum of understanding, any county, tribe, or consortium of counties forming a service delivery authority is exempt from the provisions of sections 245.465; 245.4835; 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph (b); and 256M.30.

(b) This subdivision does not preclude any county, tribe, or consortium of counties forming a service delivery authority from requesting additional waivers from statutory and rule requirements to ensure greater local control and flexibility.

Subd. 3. **Duties.** The service delivery authority shall:

(1) within the scope of essential services set forth in the memorandum of understanding establishing the authority, carry out the responsibilities required of local agencies under chapter 393 and human services boards under chapter 402;

(2) manage the public resources devoted to human services and other public services delivered or purchased by the counties or tribes that are subsidized or regulated by the Department of Human Services under chapters 245 to 261;

(3) employ staff to assist in carrying out its duties;

(4) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human services functions in the event of any business interruption according to local, state, and federal emergency planning requirements;

(5) receive and expend funds received for the redesign process under the memorandum of understanding;

(6) plan and deliver services directly or through contract with other governmental, tribal, or nongovernmental providers;

(7) rent, purchase, sell, and otherwise dispose of real and personal property as necessary to carry out the redesign; and

(8) carry out any other service designated as a responsibility of a county.

Subd. 4. **Process for establishing a service delivery authority.** (a) The county, tribe, or consortium of counties meeting the requirements of section 402A.30 and proposing to establish a service delivery authority shall present to the council:

(1) in conjunction with the commissioner, a proposed memorandum of understanding meeting the requirements of subdivision 1, paragraph (b), and outlining:

(i) the details of the proposal;

(ii) the state, tribal, and local resources, which may include, but are not limited to, funding, administrative and technology support, and other requirements necessary for the service delivery authority; and

(iii) the relief available to the service delivery authority if the resource commitments identified in item (ii) are not met; and

(2) a board resolution from the board of commissioners of each participating county stating the county's intent to participate, or in the case of a tribe, a resolution from tribal government, stating the tribe's intent to participate.

(b) After the council has considered and recommended approval of a proposed memorandum of understanding, the commissioner may finalize and execute the memorandum of understanding.

Subd. 5. **Commissioner authority to seek waivers.** The commissioner may use the authority under section 256.01, subdivision 2, paragraph (l), to grant waivers identified as

part of a proposed service delivery authority under subdivision 1, paragraph (b), clause (4), except that waivers granted under this section must be approved by the council under section 402A.20 rather than the Legislative Advisory Committee.

Sec. 17. **ALIGNMENT OF VERIFICATION AND REDETERMINATION POLICIES.**

The commissioner of human services shall develop recommendations to align eligibility verification procedures for all health care, economic assistance, food support, child support enforcement, and child care programs. The commissioner shall report back to the chairs of the legislative committees with jurisdiction over these issues by January 15, 2012, with recommendations and draft legislation to implement the alignment of eligibility verifications.

Sec. 18. **ALTERNATIVE STRATEGIES FOR CERTAIN REDETERMINATIONS.**

The commissioner of human services shall develop and implement by January 15, 2012, a simplified process to redetermine eligibility for recipient populations in the medical assistance, Minnesota supplemental aid, food support, and group residential housing programs who are eligible based upon disability, age, or chronic medical conditions, and who are expected to experience minimal change in income or assets from month to month. The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 19. **REQUEST FOR PROPOSALS; COMBINED ONLINE APPLICATION.**

(a) The commissioner of human services shall issue a request for proposals for a contract to implement a phased-in integrated online eligibility and application portal for health care programs, if federal matching funds are available. The health care portal must be developed in phases with the capacity to integrate food support, cash assistance, and child care programs as funds are available. The request for proposals must require that the system recommended and implemented by the contractor:

(1) streamline eligibility determination and case processing in the state to support statewide eligibility processing;

(2) enable interested persons to determine eligibility for each program, and to apply for programs online in a manner that the applicant will be asked only those questions that relate to the programs the person is applying for;

(3) leverage technology that has been operational in production in other similar state environments; and

(4) include Web-based application and worker application processing support and opportunity for expansion.

(b) If responses to the request for proposals meet the requirements set forth, the commissioner shall enter into a contract for the services specified in paragraph (a) by January 31, 2012. The contract may incorporate a performance-based vendor financing option whereby the vendor shares the risk of the project's success. If the commissioner determines there is no adequate response to the request for proposals, the commissioner shall report this to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services prior to January 31, 2012.

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

Sec. 20. **REPEALER.**

(a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.

(b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2010, section 245.50, is amended to read:

245.50 INTERSTATE CONTRACTS, MENTAL HEALTH, CHEMICAL HEALTH, DETOXIFICATION SERVICES.

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

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency" means a public or private hospital, mental health center, chemical health treatment facility, detoxification facility, or other person or organization which provides mental health ~~or~~, chemical health, or detoxification services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment or detoxification under this section.

(e) "Sending state" means the state in which the sending agency is located.

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment or detoxification services to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board or the commissioner of human services may contract with an agency or facility in a bordering state for mental health ~~or,~~ chemical health, or detoxification services for residents of Minnesota, and a Minnesota mental health ~~or,~~ chemical health, or detoxification agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

(2) are on probation or parole;

(3) are the subject of a presentence investigation; or

(4) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

Subd. 4. **Contracts.** Contracts entered into under this section must, at a minimum:

(1) describe the services to be provided;

(2) establish responsibility for the costs of services;

(3) establish responsibility for the costs of transporting individuals receiving services under this section;

(4) specify the duration of the contract;

(5) specify the means of terminating the contract;

(6) specify the terms and conditions for refusal to admit or retain an individual; and

(7) identify the goals to be accomplished by the placement of an individual under this section.

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to

a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness ~~or~~, chemical dependency, or detoxification. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or an advance practice registered nurse certified in mental health, who is licensed in the bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7. Such examiner may initiate an emergency hold under section 253B.05 on a Minnesota resident who is in a hospital that is under contract with a

Minnesota governmental entity under this section provided the resident, in the opinion of the examiner, meets the criteria in section 253B.05.

(g) This section shall apply to detoxification services that are unrelated to treatment whether the services are provided on a voluntary or involuntary basis.

Sec. 2. Minnesota Statutes 2010, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county. A county's payment must be made from the county's own sources of revenue and payments must equal ~~ten~~ 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day, that the civilly committed sex offender spends at the facility. If payments received by the state under this chapter exceed ~~90~~ 75 percent of the cost of care, the county is responsible for paying the state the remaining amount. The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. This section is effective for all individuals who are civilly committed to the Minnesota sex offender program on or after August 1, 2011.

Sec. 3. Minnesota Statutes 2010, section 252.025, subdivision 7, is amended to read:

Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety. This program is statewide and must provide specialized residential services in Cambridge and an array of community-based services with sufficient levels of care and a sufficient number of specialists to ensure that individuals referred to the program receive the appropriate care. The individuals working in the community-based services under this section are state employees supervised by the commissioner of human services. No midcontract layoffs shall occur as a result of restructuring under this section, but layoffs may occur as a normal consequence of a low census or closure of the facility due to decreased census.

Sec. 4. Minnesota Statutes 2010, section 253B.212, is amended to read:

253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS; WHITE EARTH BAND OF OJIBWE.

Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake Band of Chippewa Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the Red Lake Band of Chippewa Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service may not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

Subd. 1a. **Cost of care; commitment by tribal court order; White Earth Band of Ojibwe Indians.** The commissioner of human services may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the White Earth Band of Ojibwe Indians who have been committed by tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The tribe may also contract directly with the commissioner for treatment of those members of the White Earth Band who have been committed by tribal court order to the White Earth Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and the White Earth Band shall not transfer any person for admission to a regional center unless the commitment procedure utilized by the tribal court provided due process protections similar to those afforded by sections 253B.05 to 253B.10.

Subd. 2. **Effect given to tribal commitment order.** When, under an agreement entered into pursuant to ~~subdivision 1~~ subdivisions 1 or 1a, the Indian Health Service applies to a regional center for admission of a person committed to the jurisdiction of the health service by the tribal court as a person who is mentally ill, developmentally disabled, or chemically dependent, the commissioner may treat the patient with the consent of the Indian Health Service.

A person admitted to a regional center pursuant to this section has all the rights accorded by section 253B.03. In addition, treatment reports, prepared in accordance with the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health Service within 60 days of commencement of the patient's stay at the facility. A subsequent

treatment report shall be filed with the Indian Health Service within six months of the patient's admission to the facility or prior to discharge, whichever comes first. Provisional discharge or transfer of the patient may be authorized by the head of the treatment facility only with the consent of the Indian Health Service. Discharge from the facility to the Indian Health Service may be authorized by the head of the treatment facility after notice to and consultation with the Indian Health Service.

Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service subject to the limitations on residential chemical dependency treatment in section 254B.04, subdivision 1. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 6. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~16.14~~ 22.95 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~16.14~~ 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of

payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

EFFECTIVE DATE. This section is effective for claims processed beginning July 1, 2011.

Sec. 7. Minnesota Statutes 2010, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical dependency fund services subject to the following limitations: (1) no more than three residential chemical dependency treatment episodes for the same person in a four-year period of time unless the person meets the criteria established by the commissioner of human services; and (2) no more than four residential chemical dependency treatment episodes in a lifetime unless the person meets the criteria established by the commissioner of human services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(b) A person not entitled to services under paragraph (a), but with family income that is less than 215 percent of the federal poverty guidelines for the applicable family size, shall be eligible to receive chemical dependency fund services within the limit of funds appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(c) Persons whose income is between 215 percent and 412 percent of the federal poverty guidelines for the applicable family size shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

EFFECTIVE DATE. This section is effective for all chemical dependency residential treatment beginning on or after July 1, 2011.

Sec. 8. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, and recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

Sec. 9. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal financial participation collections to a special revenue account. The commissioner shall allocate ~~83.86~~ 77.05 percent of patient payments and third-party payments to the special revenue account and ~~16.14~~ 22.95 percent to the county financially responsible for the patient.

EFFECTIVE DATE. This section is effective for claims processed beginning July 1, 2011.

Sec. 10. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to read:

Subd. 41. **Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county or an American Indian tribe through a residential facility,

for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

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

Sec. 11. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

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

Sec. 12. **COMMUNITY MENTAL HEALTH SERVICES; USE OF BEHAVIORAL HEALTH HOSPITALS.**

The commissioner shall issue a written report to the chairs and ranking minority members of the house and senate committees with jurisdiction of health and human

services by December 31, 2011, on how the community behavioral health hospital facilities will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The commissioner must consult with the regional planning work groups for adult mental health and must include the recommendations of the work groups in the legislative report. The report must address future use of community behavioral health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65 percent licensed bed occupancy rate, and using the facilities for another purpose that will meet the mental health needs of residents of the region. The regional planning work groups shall work with the commissioner to prioritize the needs of their regions. These priorities, by region, must be included in the commissioner's report to the legislature.

Sec. 13. **INTEGRATED DUAL DIAGNOSIS TREATMENT.**

(a) The commissioner shall require individuals who perform chemical dependency assessments or mental health assessments to use approved screening tools in order to identify whether an individual who is the subject of the assessment has a co-occurring mental health or chemical dependency disorder. Screening for co-occurring disorders must begin no later than December 31, 2011.

(b) No later than October 1, 2011, the commissioner shall develop and implement a certification process for integrated dual diagnosis treatment providers.

(c) No later than December 31, 2011, the commissioner shall develop and implement a referral system so that individuals who, at screening, are identified with co-occurring disorders are referred to certified integrated dual diagnosis treatment providers.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 14. **STATE-OPERATED SERVICES FACILITIES.**

(a) The commissioner shall close the Willmar Community Behavioral Health Hospital no later than October 1, 2011.

(b) The commissioner shall present a plan to the legislative committees with jurisdiction over health and human services finance no later than January 1, 2012, on how the department will:

(1) accommodate the mental health needs of clients impacted by the closure or redesign of any state-operated services facilities; and

(2) accommodate the state employees adversely affected by the closure or redesign of any state-operated services facilities.

Sec. 15. **REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.**

(a) No layoffs shall occur as a result of restructuring services at the Anoka-Metro Regional Treatment Center.

(b) The commissioner shall issue a report to the legislative committees with jurisdiction over health and human services finance no later than December 31, 2011, which provides the number of employees in management positions at the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital at St. Peter and the ratio of management to direct-care staff for each facility.

Sec. 16. **COMMISSIONER'S CRITERIA FOR RESIDENTIAL TREATMENT.**

The commissioner shall develop specific criteria to approve treatment for individuals who require residential chemical dependency treatment in excess of the maximum allowed in section 254B.04, subdivision 1, due to co-occurring disorders, including disorders related to cognition, traumatic brain injury, or documented disability. Criteria shall be developed for use no later than October 1, 2011.

Sec. 17. **REPEALER.**

Laws 2009, chapter 79, article 3, section 18, as amended by Laws 2010, First Special Session chapter 1, article 19, section 19, is repealed.

ARTICLE 9

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.

	2012	**2013**	**Total**
General	$ 5,646,994,000	$ 5,159,920,000	$ 10,806,914,000
State Government Special Revenue	63,198,000	63,154,000	126,352,000
Health Care Access	400,917,000	409,880,000	810,797,000
Federal TANF	274,091,000	282,814,000	556,905,000
Lottery Prize Fund	1,665,000	1,665,000	3,330,000
Total	**$ 6,386,865,000**	**$ 5,917,433,000**	**$ 12,304,298,000**

Sec. 2. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the

general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal year 2013. "The biennium" is fiscal years 2012 and 2013.

	APPROPRIATIONS Available for the Year Ending June 30	
	2012	**2013**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 6,215,925,000**	**$ 5,756,045,000**

Appropriations by Fund

	2012	2013
General	5,564,174,000	5,081,996,000
State Government Special Revenue	565,000	565,000
Health Care Access	387,143,000	400,718,000
Federal TANF	262,378,000	271,101,000
Lottery Prize Fund	1,665,000	1,665,000

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of Minnesota Management and Budget, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does

not cancel but is available for ongoing development and operations.

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

TANF Maintenance of Effort.

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

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

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

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

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

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under

Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j);

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

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

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

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

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

(e) Notwithstanding any contrary provision in this article, paragraph (a), clauses (1) to

(7), and paragraphs (b) to (d), expire June 30, 2015.

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

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

(1) fiscal year 2012, $12,037,000;

(2) fiscal year 2013, $29,942,000;

(3) fiscal year 2014, $23,235,000; and

(4) fiscal year 2015, $23,198,000.

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

TANF Transfer to Federal Child Care and Development Fund. (a) The following TANF fund amounts are appropriated to the commissioner for purposes of MFIP/Transition Year Child Care Assistance under Minnesota Statutes, section 119B.05:

(1) fiscal year 2012, $11,020,000;

(2) fiscal year 2013, $35,020,000;

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

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

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

to federal child care and development fund regulations.

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

(b) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2015.

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

Supplemental Security Interim Assistance Reimbursement Funds. $2,800,000 of uncommitted revenue available to the commissioner of human services for SSI advocacy and outreach services must be transferred to and deposited into the general fund by June 30, 2012.

Subd. 2. **Central Office Operations**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Operations**

	Appropriations by Fund	
General	81,458,000	80,335,000
Health Care Access	11,742,000	11,508,000
State Government Special Revenue	440,000	440,000
Federal TANF	222,000	222,000

DHS Receipt Center Accounting. The commissioner is authorized to transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Base Adjustment. The general fund base for fiscal year 2014 shall be increased by $79,000. This adjustment is onetime.

(b) **Children and Families**

	Appropriations by Fund	
General	9,615,000	9,417,000
Federal TANF	2,160,000	2,160,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2012 and 2013 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(c) **Health Care**

	Appropriations by Fund	
General	16,284,000	16,030,000
Health Care Access	22,574,000	26,555,000

Minnesota Senior Health Options

Reimbursement. Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

Utilization Review. Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to the commissioner for these purposes. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

Base Adjustment. The general fund base shall be decreased by $2,000 in fiscal year 2014 and $114,000 in 2015.

The health care access fund base is decreased by $16,000 in fiscal year 2014 and $142,000 in 2015.

(d) **Continuing Care**

	Appropriations by Fund	
General	18,110,000	18,011,000
State Government Special Revenue	125,000	125,000

Base Adjustment. The general fund base is decreased by $259,000 in each of fiscal years 2014 and 2015.

(e) **Chemical and Mental Health**

	Appropriations by Fund	
General	4,194,000	4,194,000
Lottery Prize	157,000	157,000

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	84,256,000	91,212,000
Federal TANF	84,425,000	75,417,000

(b) **MFIP Child Care Assistance Grants** 55,726,000 26,652,000

(c) **General Assistance Grants** 43,629,000 42,440,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in fiscal year 2012 and $7,889,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid Grants** 38,091,000 39,092,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $1,100,000 in fiscal year 2012 and $1,100,000 in fiscal year 2013. Funds to counties shall be

allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(e) **Group Residential Housing Grants**	121,092,000	129,250,000
(f) **MinnesotaCare Grants**	351,927,000	361,755,000

This appropriation is from the health care access fund.

(g) **GAMC Grants**	120,000,000	280,000,000

Coordinated Care Delivery System. This appropriation is to fund coordinated care delivery systems under Minnesota Statutes, section 256D.031, subdivision 6.

Payments for Cost Settlements. The commissioner is authorized to use amounts repaid to the general assistance medical care program under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, to pay cost settlements for claims for services provided prior to June 1, 2010. Notwithstanding any contrary provision in this article, this provision does not expire.

Base Adjustment. The general fund base is reduced by $120,000,000 in fiscal year 2014 and by $280,000,000 in fiscal year 2015.

(h) **Medical Assistance Grants**	4,253,018,000	3,602,473,000

Managed Care Incentive Payments. The commissioner shall not make managed care incentive payments for expanding preventive services during fiscal years beginning July 1, 2011 and July 1, 2012.

Reduction of Rates for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, lead agencies

must reduce rates in effect on January 1, 2011, by ten percent for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI, DD, and TBI waivers and customized living settings for CADI and TBI. Lead agencies must adjust contracts within 60 days of the effective date.

Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI, DD, and TBI waivers and customized living settings for CADI and TBI.

Home and Community-Based Waiver Appropriations Limits. Total state and federal funding for the biennium beginning on July 1, 2011, for the Medicaid home and community-based waivers for persons with disabilities including DD waiver under Minnesota Statutes, section 256B.092; and the CADI and TBI waivers under Minnesota Statutes, section 256B.49, are limited to the following amounts: the DD waiver is limited to $2,038,330,000; the CADI waiver is limited to $963,854,000;and the TBI waiver is limited to $206,408,000. Of these amounts, the commissioner shall set aside five percent of each waiver amount

to manage emergency situations around the state. The commissioner must ensure that at least the same number of people are served on the home and community-based waiver programs as were served on March 30, 2010. Notwithstanding any law or rule to the contrary, in order to meet the funding limits in this provision, the commissioner may reduce or adjust benefits and services, reduce or adjust case-mix capitation rates, limit or freeze waiver enrollment, establish needed thresholds for service eligibility, adjust eligibility criteria to the extent allowable under federal regulations, establish prior authorization criteria, and adjust county home and community-based waiver allocations as needed. Priorities for the use of waiver slots must be for individuals anticipated to be discharged from an institutional setting or who are at imminent risk of an institutional placement. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the restructuring, closure, or downsizing of a residential facility or nursing facility to serve directly affected individuals on the home and community-based waivers. The commissioner and counties are prohibited from reducing provider rates under this provision unless the reduction is due to a change in the type or amount of services to be delivered. The commissioner shall maintain the waiting list and access to the waiver.

Management of Fee-for-Service Spending. Total state and federal funding for the biennium beginning on July 1, 2011, for

fee-for-service medical assistance basic care for the elderly and persons with disabilities is limited to $2,536,949,000. Total state and federal funding for the biennium beginning July 1, 2011, for fee-for-service medical assistance basic care for adults without children is limited to $526,251,000.

(1) Total state and federal funding for fee-for-service medical assistance basic care for the elderly and persons with disabilities is limited to $950,183,000 for fiscal year 2012 and $1,115,961,000 for fiscal year 2013.

(2) The commissioner shall contract with a vendor to manage spending within these limits, beginning January 1, 2012. The vendor selected may:

(i) manage and coordinate the care provided by high-cost providers;

(ii) implement payment reform initiatives to encourage efficient and cost-effective service provision;

(iii) identify and deny payment for unnecessary services; and

(iv) implement other initiatives proven to improve the efficiency of fee-for-service care delivery.

The contract with the vendor must be on a contingency basis, under which the vendor retains six percent of any savings obtained from management of fee-for-service spending.

(3) The commissioner, by October 1, 2012, shall evaluate the extent to which initiatives implemented by the vendor will be successful

in managing spending within the specified limits. If the commissioner determines that the vendor will not be successful in managing spending within the specified limits, the commissioner shall reduce medical assistance provider payments by an amount sufficient to comply with the spending limits. In implementing rate reductions, the commissioner shall exempt payments to nursing facilities and providers of home and community-based waiver services.

Contingent Rate Reductions. If the commissioner determines that implementation of the global waiver under Minnesota Statutes, sections 256B.841, 256B.842, and 256B.843, will not achieve a state general fund savings of $300,000,000 for the biennium beginning July 1, 2011, the commissioner shall calculate an estimate of the shortfall in savings, and, for the fiscal year beginning July 1, 2012, shall reduce medical assistance provider payment rates, including but not limited to rates to individual health care providers and provider agencies, hospitals, nursing facilities, other residential settings, and capitation rates provided to managed care and county-based purchasing plans, by the amount necessary to recoup the shortfall in savings over that fiscal year.

(i) **Alternative Care Grants**	44,630,000	44,689,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(j) **Chemical Dependency Entitlement Grants** 104,113,000 127,281,000

Subd. 4. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,525,000	90,611,000

MFIP Consolidated Fund Grants. The TANF fund base is reduced by $14,000,000 each year beginning in fiscal year 2012.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar year quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

Healthy Communities. $150,000 in fiscal year 2012 and $150,000 in fiscal year 2013 are appropriated from the general fund to the commissioner of human services for contracting with the Search Institute to

promote healthy community initiatives. The commissioner may expend up to five percent of the appropriation to provide for the program evaluation.

Circles of Support. $200,000 in fiscal year 2012 and $200,000 in fiscal year 2013 are appropriated from the general fund to the commissioner of human services for the purpose of providing grants to community action agencies for circles of support initiatives.

Northern Connections. $100,000 is appropriated in fiscal year 2012 and $100,000 is appropriated in fiscal year 2013 from the general fund to the commissioner of human services for a grant to expand Northern Connections workforce program that provides one-stop supportive services to individuals as they transition into the workforce to up to two interested counties in rural Minnesota.

(b) **Basic Sliding Fee Child Care Assistance Grants** 38,131,000 41,035,000

Base Adjustment. The general fund base is decreased by $1,131,000 in fiscal year 2014 and $1,126,000 in fiscal year 2015.

Child Care and Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,000,000 in fiscal year 2012 from the federal child care and development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child

care and development funds are expended according to the federal child care and development fund regulations.

(c) **Child Care Development Grants**	1,487,000	1,487,000
(d) **Child Support Enforcement Grants**	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under section 1115a of the Social Security Act is appropriated to the commissioner for this activity.

(e) **Children's Services Grants**

	Appropriations by Fund	
General	46,788,000	46,788,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance Payments. $1,661,000 each year is for continuation of current payments for adoption assistance and relative custody assistance.

Adoption Assistance and Relative Custody Assistance Transfer. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2012 and fiscal year 2013 for adoption incentive grants are appropriated to the commissioner for these purposes.

(f) **Children and Community Services Grants**	64,301,000	64,301,000
(g) **Children and Economic Support Grants**	16,755,000	16,265,000

Long-term homeless services. $700,000 is appropriated from the federal TANF fund for the biennium beginning July 1, 2011, to the commissioner of human services for long-term homeless services for low-income homeless families under Minnesota Statutes, section 256K.26. This is a onetime appropriation and is not added to the base.

Base Adjustment. The general fund base is increased by $491,000 in fiscal year 2014 only.

(h) **Health Care Grants**

	Appropriations by Fund	
General	195,000	-0-
Health Care Access	900,000	900,000

Surplus Appropriation Canceled. Of the appropriation in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (e), for the COBRA premium state subsidy program, $11,750,000 must be canceled in fiscal year 2011. This provision is effective the day following final enactment.

Grant Cancellation. Effective for the biennium beginning July 1, 2011, the following appropriations are canceled: (1) a general fund appropriation of $205,000 for

the U Special Kids program; (2) a general fund appropriation of $90,000 for medical assistance outreach grants; and (3) a health care access fund appropriation of $40,000 for MinnesotaCare outreach grants.

State Subsidy Program for Community Mental Health Centers. $100,000 is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2011, to provide onetime grants to establish new community mental health centers that are eligible for payment under Minnesota Statutes, section 256B.0625, subdivision 5. In awarding grants, the commissioner shall give preference to areas of the state that lack access to mental health services or are underserved.

(i) **Aging and Adult Services Grants**	18,734,000	18,910,000

Aging Grants Reduction. Effective July 1, 2011, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $3,600,000 for each year of the biennium. These reductions are onetime and do not affect base funding for the 2014-2015 biennium. Grants made during the 2012-2013 biennium under Minnesota Statutes, section 256B.9754, must not be used for new construction or building renovation.

Essential Community Support Grant Delay. Essential community supports grants under Minnesota Statutes, section 256B.0917, subdivision 14, is reduced by $6,410,000 in fiscal year 2012 and

$7,279,000 in fiscal year 2013. Base level funding for fiscal year 2014 is reduced by $5,919,000. These reductions are onetime and do not affect base level funding for fiscal year 2015.

(j) **Deaf and Hard-of-Hearing Grants**	1,936,000	1,767,000
(k) **Disabilities Grants**	22,025,000	23,863,000

Money Follows the Person Rebalancing Demonstration Project. Notwithstanding the provisions of Minnesota Statutes, section 256.011, subdivision 3, estimated general fund savings resulting from the operation of the Money Follows the Person federal grant fund must be retained within the medical assistance general fund appropriation for the payment of federally required rebalancing expenditures. If a rebalancing expenditure is not eligible for medical assistance, the corresponding portion of estimated savings must be transferred to and paid from a special revenue account established for this purpose. Money in the account does not cancel and is appropriated to the commissioner for the purposes of the demonstration project.

Region 10. Any unspent allocation for Region 10 Quality Assurance from the biennium beginning on July 1, 2009, may be carried over into the biennium beginning on July 1, 2011.

Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs. The commissioner shall make available a total of $250,000 per year in local planning grants, beginning July 1, 2011, to assist

lead agencies and provider organizations in developing alternatives to congregate living within the available level of resources for the home and community-based services waivers for persons with disabilities.

(l) **Adult Mental Health Grants**

	Appropriations by Fund	
General	77,539,000	77,539,000
Lottery Prize Fund	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The lottery prize fund base for this program shall be increased by $78,000 in each of fiscal years 2014 and 2015.

(m) **Children's Mental Health Grants**	16,682,000	16,682,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) **Chemical Dependency Nonentitlement Grants**	1,336,000	1,336,000

Subd. 5. **State-Operated Services**

Transfer Authority Related to State-Operated Services. Money appropriated for state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

(a) **State-Operated Services Mental Health**	115,286,000	115,135,000

State-Operated Services. To achieve these savings, the commissioner shall close the Willmar Community Behavioral Health Hospital no later than October 1, 2011, and shall close the inpatient child and adolescent behavioral health service program in Willmar, the subacute mental health facility in Wadena, and the community behavioral health hospitals in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, and Rochester no later than October 1, 2012.

Base Adjustment. The general fund base is reduced by $8,443,000 in fiscal year 2014 and $11,543,000 in fiscal year 2015.

(b) **Minnesota Security Hospital**	69,582,000	69,582,000
Subd. 6. **Sex Offender Program**	70,416,000	67,570,000

Transfer Authority Related to Minnesota Sex Offender Program. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Minnesota Sex Offender Program Reduction. The fiscal year 2011 general fund appropriation for Minnesota sex offender services under Laws 2009, chapter 79, article 13, section 3, subdivision 10, paragraph (b), is reduced by $3,000,000.

Subd. 7. **Technical Activities**	78,206,000	102,551,000

This appropriation is from the federal TANF fund.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 147,939,000 $ 136,632,000**

Appropriations by Fund

	2012	2013
General	77,634,000	72,738,000
State Government Special Revenue	45,268,000	45,325,000
Health Care Access	13,774,000	9,162,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Community and Family Health Promotion**

Appropriations by Fund

General	50,430,000	45,690,000
State Government Special Revenue	1,033,000	1,033,000
Health Care Access	2,918,000	2,459,000
Federal TANF	11,713,000	11,713,000

TANF Appropriations. (1) $1,156,000 of the TANF funds is appropriated each year to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF funds is appropriated each year to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF funds is appropriated each year to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,978,000 of the TANF funds is appropriated each year to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
General	10,434,000	10,230,000
State Government Special Revenue	14,026,000	14,083,000
Health Care Access	10,856,000	6,703,000

MERC Fund Transfers. The commissioner of management and budget shall transfer $9,800,000 from the MERC fund to the general fund by October 1, 2011.

Comprehensive Advanced Life Support. Of the general fund appropriation, $31,000

each year is added to the base of the comprehensive advanced life support (CALS) program under Minnesota Statutes, section 144.6062.

Unused Federal Match Funds. Of the funds appropriated in Laws 2009, chapter 79, article 13, section 4, subdivision 3, for state matching funds for the federal Health Information Technology for Economic and Clinical Health Act, $2,800,000 is transferred to the health care access fund by October 1, 2011.

Advisory Committee on Patient and Community Engagement. $50,000 is appropriated to the commissioner of health to provide a grant to a private sector organization designated as the advisory committee on patient and community engagement to be used by the organization for:

(1) per diems and expenses for persons who serve on the designated organization's board; and

(2) expenses for conducting focus groups, community engagement events, surveys, and other activities undertaken by the designated organization to obtain information, input, and preferences from diverse communities for purposes of community engagement in health system issues.

Health Careers Opportunities Grants. $447,000 each year is appropriated to the commissioner of health from the health care access fund for the health careers

opportunities grant program under Minnesota Statutes, section 144.1499.

Health Professions Opportunities Scholarship Program. $63,000 each year is appropriated to the commissioner of health from the health care access fund for the health professions opportunities scholarship program under Minnesota Statutes, section 144.1503. $138,000 in fiscal year 2012 and $276,000 each year thereafter is appropriated to the commissioner of health from the general fund for the health professions opportunities scholarship program under Minnesota Statutes, section 144.1503.

Base Level Adjustment. The state government special revenue fund base shall be reduced by $141,000 in fiscal years 2014 and 2015. The health care access base shall be increased by $600,000 in fiscal year 2014.

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	9,370,000	9,370,000
State Government Special Revenue	30,209,000	30,209,000

Subd. 5. **Administrative Support Services** 7,400,000 7,448,000

Sec. 5. **COUNCIL ON DISABILITY** **$ 524,000 $ 524,000**

Sec. 6. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 1,655,000 $ 1,655,000**

Funds appropriated for fiscal year 2011 are available until expended.

Sec. 7. **OMBUDSPERSON FOR FAMILIES** **$ 265,000 $ 265,000**

Sec. 8. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 17,365,000**	**$ 17,264,000**
This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.		
Subd. 2. **Board of Chiropractic Examiners**	469,000	469,000
Subd. 3. **Board of Dentistry**	1,959,000	1,914,000
Health Professional Services Program. $834,000 in fiscal year 2012 and $804,000 in fiscal year 2013 from the state government special revenue fund are for the health professional services program.		
Subd. 4. **Board of Dietetic and Nutrition Practice**	110,000	110,000
Subd. 5. **Board of Marriage and Family Therapy**	192,000	167,000
Rulemaking. Of this appropriation, $25,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.		
Subd. 6. **Board of Medical Practice**	3,866,000	3,866,000
Subd. 7. **Board of Nursing**	3,545,000	3,545,000
Subd. 8. **Board of Nursing Home Administrators**	2,153,000	2,145,000
Rulemaking. Of this appropriation, $44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.		
Electronic Licensing System Adaptors. Of this appropriation, $761,000 in fiscal year 2013 from the state government special revenue fund is to the administrative services unit to cover the costs to connect to the e-licensing system. Minnesota Statutes, section 16E.22. Base level funding for this		

activity in fiscal year 2014 shall be $100,000. Base level funding for this activity in fiscal year 2015 shall be $50,000.

Development and Implementation of a Disciplinary, Regulatory, Licensing and Information Management System. Of this appropriation, $800,000 in fiscal year 2012 and $300,000 in fiscal year 2013 are for the development of a shared system. Base level funding for this activity in fiscal year 2014 shall be $50,000.

Administrative Services Unit - Operating Costs. Of this appropriation, $526,000 in fiscal year 2012 and $526,000 in fiscal year 2013 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year 2012, $225,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2012 and $150,000 in fiscal year 2013 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2012 and $200,000 in fiscal year 2013 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Subd. 9. **Board of Optometry**	106,000	106,000
Subd. 10. **Board of Pharmacy**	1,977,000	1,980,000

Prescription Electronic Reporting. Of this appropriation, $356,000 in fiscal year 2012 and $356,000 in fiscal year 2013 from the state government special revenue fund are to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126. Base level funding for this activity in fiscal year 2014 shall be $356,000.

Subd. 11. **Board of Physical Therapy**	389,000	345,000

Rulemaking. Of this appropriation, $44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Subd. 12. **Board of Podiatry**	75,000	75,000
Subd. 13. **Board of Psychology**	846,000	846,000
Subd. 14. **Board of Social Work**	1,036,000	1,053,000
Subd. 15. **Board of Veterinary Medicine**	228,000	229,000
Subd. 16. **Board of Behavioral Health and Therapy**	414,000	414,000

Sec. 9. **EMERGENCY MEDICAL SERVICES BOARD** **$ 2,742,000 $ 2,742,000**

Of the appropriation, $700,000 in fiscal year 2012 and $700,000 in fiscal year 2013 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 33. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; and

(2) reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision 6, is amended to read:

Subd. 6. **Continuing Care Grants**

(a) **Aging and Adult Services Grants**	(3,600,000)	(3,600,000)

Community Service/Service Development Grants Reduction. Effective retroactively

from July 1, 2009, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $5,807,000 for each year of the biennium. Grants made during the biennium under Minnesota Statutes, section 256.9754, shall not be used for new construction or building renovation.

Aging Grants Delay. Aging grants must be reduced by $917,000 in fiscal year 2011 and increased by $917,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

(b) **Medical Assistance Long-Term Care Facilities Grants**	(3,827,000)	(2,745,000)

ICF/MR Variable Rates Suspension. Effective retroactively from July 1, 2009, to June 30, 2010, no new variable rates shall be authorized for intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, section 256B.5013, subdivision 1.

ICF/MR Occupancy Rate Adjustment Suspension. Effective retroactively from July 1, 2009, to June 30, 2011, approval of new applications for occupancy rate adjustments for unoccupied short-term beds under Minnesota Statutes, section 256B.5013, subdivision 7, is suspended.

(c) **Medical Assistance Long-Term Care Waivers and Home Care Grants**	(2,318,000)	(5,807,000)

Developmental Disability Waiver Acuity Factor. Effective retroactively from January 1, 2010, the January 1, 2010, one percent

growth factor in the developmental disability waiver allocations under Minnesota Statutes, section 256B.092, subdivisions 4 and 5, that is attributable to changes in acuity, is suspended to June 30, ~~2011~~ 2012. Notwithstanding any law to the contrary, this provision does not expire.

(d) **Adult Mental Health Grants**	(5,000,000)	-0-
(e) **Chemical Dependency Entitlement Grants**	(3,622,000)	(3,622,000)
(f) **Chemical Dependency Nonentitlement Grants**	(393,000)	(393,000)
(g) **Other Continuing Care Grants**	-0-	~~(2,500,000)~~ (1,414,000)

Other Continuing Care Grants Delay. Other continuing care grants must be reduced by $1,414,000 in fiscal year 2011 and increased by $1,414,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

(h) **Deaf and Hard-of-Hearing Grants**	-0-	(169,000)

Deaf and Hard-of-Hearing Grants Delay. Effective retroactively from July 1, 2010, deaf and hard-of-hearing grants must be reduced by $169,000 in fiscal year 2011 and increased by $169,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

Sec. 12. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, and after notification of the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee, may transfer unencumbered

appropriation balances for the biennium ending June 30, 2013, within fiscal years among the MFIP; general assistance; general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; medical assistance; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid; and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs of the senate health and human services budget and policy committee and the house of representatives health and human services finance committee quarterly about transfers made under this provision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2011, unless a different effective date is specified.

ARTICLE 10

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT APPROPRIATIONS.**

The sums shown are added to, or if shown in parentheses, are subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2; Laws 2010, First Special Session chapter 1, articles 15, 23, and 25; and Laws 2010, Second Special Session chapter 1, article 3, to the commissioner of human services and for the purposes specified in this article. The appropriations are from the general fund or another named fund and are available for the fiscal year indicated for

each purpose. The figure "2011" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2011.

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (235,463,000)**

Appropriations by Fund

	2011
General	(381,869,000)
Health Care Access	169,514,000
Federal TANF	(23,108,000)

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Revenue and Pass-through** **732,000**

This appropriation is from the federal TANF fund.

Subd. 3. **Children and Economic Assistance Grants**

Appropriations by Fund

General	(7,098,000)
Federal TANF	(23,840,000)

(a) **MFIP/DWP Grants**

Appropriations by Fund

General	18,715,000
Federal TANF	(23,840,000)

(b) **MFIP Child Care Assistance Grants** (24,394,000)

(c) **General Assistance Grants** (664,000)

(d) **Minnesota Supplemental Aid Grants** 793,000

(e) **Group Residential Housing Grants** (1,548,000)

Subd. 4. **Basic Health Care Grants**

Appropriations by Fund

General	(335,050,000)
Health Care Access	169,514,000

(a) **MinnesotaCare Grants** 169,514,000

This appropriation is from the health care access fund.

(b) **Medical Assistance Basic Health Care - Families and Children** (49,368,000)

(c) **Medical Assistance Basic Health Care - Elderly and Disabled** (43,258,000)

(d) **Medical Assistance Basic Health Care - Adults without Children** (242,424,000)

Subd. 5. **Continuing Care Grants** (39,721,000)

(a) **Medical Assistance Long-Term Care Facilities** (14,627,000)

(b) **Medical Assistance Long-Term Care Waivers** (44,718,000)

(c) **Chemical Dependency Entitlement Grants** 19,624,000

Sec. 3. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6, is amended to read:

Subd. 6. **Health Care Grants**

(a) **MinnesotaCare Grants** 998,000 (13,376,000)

This appropriation is from the health care access fund.

Health Care Access Fund Transfer to General Fund. The commissioner of management and budget shall transfer the following amounts in the following years from the health care access fund to the general fund: ~~$998,000~~ $0 in fiscal year 2010; ~~$176,704,000~~ $59,901,000 in fiscal year 2011; $141,041,000 in fiscal year 2012; and $286,150,000 in fiscal year 2013. If at any time the governor issues an executive order not to participate in early medical assistance expansion, no funds shall be transferred from the health care access fund to the general fund until early medical

assistance expansion takes effect. This paragraph is effective the day following final enactment.

MinnesotaCare Ratable Reduction. Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by 15 percent. Effective for services provided from July 1, 2010, to June 30, 2011, this reduction shall apply to all services. Effective for services provided from July 1, 2011, to December 31, 2013, this reduction shall apply to all services except inpatient hospital services. Notwithstanding any contrary provision of this article, this paragraph shall expire on December 31, 2013.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	295,512,000

Critical Access Dental. Of the general fund appropriation, $731,000 in fiscal year 2011 is to the commissioner for critical access dental provider reimbursement payments under Minnesota Statutes, section 256B.76 subdivision 4. This is a onetime appropriation.

Nonadministrative Rate Reduction. For services rendered on or after July 1, 2010, to December 31, 2013, the commissioner shall reduce contract rates paid to managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, and to

county-based purchasing plans under Minnesota Statutes, section 256B.692, by three percent of the contract rate attributable to nonadministrative services in effect on June 30, 2010. Notwithstanding any contrary provision in this article, this rider expires on December 31, 2013.

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled** -0- (30,265,000)

~~(75,389,000)~~

(d) **General Assistance Medical Care Grants** -0- (59,583,000)

The reduction to general assistance medical care grants is contingent upon the effective date in Laws 2010, First Special Session chapter 1, article 16, section 48. The reduction shall be reestimated based upon the actual effective date of the law. The commissioner of management and budget shall make adjustments in fiscal year 2011 to general assistance medical care appropriations to conform to the total expected expenditure reductions specified in this section.

(e) **Other Health Care Grants** -0- (7,000,000)

Cobra Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel and are available to the commissioner for fiscal year 2011 COBRA grant expenditures. Up to $111,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner for costs related to administration of the COBRA grants.

Sec. 4. **EFFECTIVE DATE.**

This article is effective the day following final enactment.