SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 2093

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
02/27/2012	3958	Introduction and first reading Referred to Health and Human Services
03/29/2012	5313a	Comm report: To pass as amended and re-refer to Finance
03/30/2012	5469a	Comm report: To pass as amended
	5484	Second reading
04/04/2012	5751	General Orders: Stricken and re-referred to Finance
04/05/2012	5769a	Comm report: To pass as amended
	5784	Second reading
	5842	General Orders: Stricken and laid on table HF substituted HF2294

A bill for an act

relating to state government; making adjustments to health and human services appropriations; making changes to provisions related to health care, the Department of Health, children and family services, continuing care; providing for data sharing; requiring eligibility determinations; providing grants; requiring studies and reports; appropriating money; amending Minnesota Statutes 2010, sections 43A.316, subdivision 5; 62A.047; 62A.21, subdivision 2a; 62D.02, subdivision 3; 62D.05, subdivision 6; 62D.101, subdivision 2a; 62D.12, subdivision 1; 62J.26, subdivisions 3, 5, by adding a subdivision; 62J.496, subdivision 2; 62Q.80; 62U.04, subdivisions 1, 2, 4, 5; 72A.201, subdivision 8; 144.5509; 144A.073, by adding a subdivision; 144A.351; 145.906; 245A.03, by adding a subdivision; 245A.11, subdivisions 2a, 7, 7a; 245B.07, subdivision 1; 245C.04, subdivision 6; 245C.05, subdivision 7; 256.01, by adding subdivisions; 256.975, subdivision 7; 256B.056, subdivision 1a; 256B.0625, subdivision 9, by adding a subdivision; 256B.0644; 256B.0754, subdivision 2; 256B.0911, by adding a subdivision; 256B.092, subdivision 1b; 256B.431, subdivision 17e, by adding a subdivision; 256B.434, subdivision 10; 256B.441, by adding a subdivision; 256B.48, by adding a subdivision; 256B.69, by adding a subdivision; 256D.06, subdivision 1b; 256D.44, subdivision 5; 626.556, by adding a subdivision; Minnesota Statutes 2011 Supplement, sections 62U.04, subdivisions 3, 9; 119B.13, subdivision 7; 144.1222, subdivision 5; 245A.03, subdivision 7; 256.987, subdivision 1; 256B.056, subdivision 3; 256B.06, subdivision 4; 256B.0625, subdivision 17; 256B.0631, subdivisions 1, 2; 256B.0659, subdivision 11; 256B.0911, subdivision 3c; 256B.097, subdivision 3; 256B.49, subdivisions 15, 23; 256B.69, subdivisions 5a, 9c; 256B.76, subdivisions 1, 2, 4; 256B.766; 256L.12, subdivision 9; Laws 2011, First Special Session chapter 9, article 7, section 52; article 10, sections 3, subdivisions 1, 3, 4; 4, subdivision 2; 8, subdivision 8; proposing coding for new law in Minnesota Statutes, chapters 148; 256B; repealing Minnesota Statutes 2010, sections 62D.04, subdivision 5; 62M.09, subdivision 9; 62Q.64; 144A.073, subdivision 9; 256B.48, subdivision 6; Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13; Laws 2011, First Special Session chapter 9, article 7, section 54; Minnesota Rules, part 4685.2000.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2010, section 72A.201, subdivision 8, is amended to read:

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

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

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

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

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

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

(i) the basis for the denial;

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

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

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

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

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

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

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must be filed at the same time its annual statement is submitted

under section 60A.13. ~~The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.~~

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

Sec. 2. Minnesota Statutes 2011 Supplement, 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) 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:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) 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

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, 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) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). 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).

(f) 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.

(g) 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).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E 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 are covered by the global payment made to the provider~~.~~; and

(iv) dialysis services provided in a hospital or freestanding dialysis facility.

(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 transplants, 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)~~ (ix) rehabilitation services;

~~(xi)~~ (x) physical, occupational, or speech therapy;

~~(xii)~~ (xi) transportation services;

~~(xiii)~~ (xii) case management;

~~(xiv)~~ (xiii) prosthetics, orthotics, durable medical equipment, or medical supplies;

~~(xv)~~ (xiv) dental services;

~~(xvi)~~ (xv) hospice care;

~~(xvii)~~ (xvi) audiology services and hearing aids;

~~(xviii)~~ (xvii) podiatry services;

~~(xix)~~ (xviii) chiropractic services;

~~(xx)~~ (xix) immunizations;

~~(xxi)~~ (xx) vision services and eyeglasses;

~~(xxii)~~ (xxi) waiver services;

~~(xxiii)~~ (xxii) individualized education programs; or

~~(xxiv)~~ (xxiii) chemical dependency treatment.

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, 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) 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.

EFFECTIVE DATE. This section is effective May 1, 2012.

Sec. 3. Minnesota Statutes 2010, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

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

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

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

(12) removable prostheses, ~~each dental arch limited to one every six years~~ including repairs and the replacement of each dental arch limited to one every six years;

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

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

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

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

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

(2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

(4) prophylaxis, in accordance with an appropriate individualized treatment plan formulated by a licensed dentist, but no more than four times per year.

EFFECTIVE DATE. The amendment to paragraph (b) is effective January 1, 2013.

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

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision

9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

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

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

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

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

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

Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an

ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(5) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

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

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

(c) Notwithstanding paragraph (b), a prepaid health plan may waive the family deductible described under paragraph (a), clause (5), within the existing capitation rates on an ongoing basis.

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

Sec. 6. 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. For purposes of this section, a health maintenance organization, as defined in chapter 62D, is not a vendor of medical care.

(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.~~

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

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into

account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees

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

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

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

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

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that

the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

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

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

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

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(j) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than

July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 9c, is amended to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation

with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.

(d) The legislative auditor shall contract for the audit required under this paragraph. The commissioner shall require, in the request for bids and the resulting contracts for coverage to be provided under this section, that each managed care and county-based purchasing plan submit to and fully cooperate with an annual independent third-party financial audit of the information required under paragraph (b). For purposes of this paragraph, "independent third party" means an audit firm that is independent in accordance with Government Auditing Standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. In no case shall the audit firm conducting the audit provide services to a managed care or county-based purchasing plan at the same time as the audit is being conducted or have provided services to a managed care or county-based purchasing plan during the prior three years.

(e) The audit of the information required under paragraph (b) shall be conducted by an independent third-party firm in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office.

(f) A managed care or county-based purchasing plan that provides services under this section shall provide to the commissioner biweekly encounter and claims data at a detailed level and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of data provided. The commissioner shall have written protocols for the quality assurance program that are publicly available. The commissioner shall contract with an independent third-party auditing firm to evaluate the quality assurance protocols, the capacity of those protocols to assure complete and accurate data, and the commissioner's implementation of the protocols.

(g) Contracts awarded under this section to a managed care or county-based purchasing plan must provide that the commissioner and the contracted auditor shall have unlimited access to any and all data required to complete the audit and that this access shall be enforceable in a court of competent jurisdiction through the process of injunctive or other appropriate relief.

(h) Any actuary or actuarial firm must meet the independence requirements under the professional code for fellows in the Society of Actuaries when providing actuarial services to the commissioner in connection with this subdivision and providing services to

any managed care or county-based purchasing plan participating in this subdivision during the term of the actuary's work for the commissioner under this subdivision.

(i) The actuary or actuarial firm referenced in paragraph (h) shall certify and attest to the rates paid to managed care plans and county-based purchasing plans under this section, and the certification and attestation must be auditable.

(j) The independent third-party audit shall include a determination of compliance with the federal Medicaid rate certification process.

(k) The legislative auditor's contract with the independent third-party auditing firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy if available for that purpose. The independent third-party auditing firm shall have the same powers as the legislative auditor under section 3.978, subdivision 2.

(l) Upon completion of the audit, and its receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health finance committees of the legislature.

(m) The commissioner shall annually assess managed care and county-based purchasing plans for agency costs related to implementing paragraphs (d) to (l), which have been approved as reasonable by the commissioner of management and budget. The assessment for each plan shall be in proportion to that plan's share of total medical assistance and MinnesotaCare enrollment under this section, section 256B.692, and section 256L.12.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to contracts, and the contracting process, for contracts that are effective January 1, 2013, and thereafter.

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

Subd. 9d. **Savings from report elimination.** Managed care and county-based purchasing plans shall use the savings resulting from the elimination or modification of specified reporting requirements to pay the assessment required by subdivision 9c, paragraph (m).

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

Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered

by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) ~~Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.~~ A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off-site at a private dental office if the following requirements are met:

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2011 Supplement, section 256L.12, subdivision 9, is amended to read:

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria

for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

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

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

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

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

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

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

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

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for

calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

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

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

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

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

Sec. 12. **COST-SHARING REQUIREMENTS STUDY.**

The commissioner of human services, in consultation with managed care plans, county-based purchasing plans, and other stakeholders, shall develop recommendations to implement a revised cost-sharing structure for state public health care programs that ensures application of meaningful cost-sharing requirements within the limits of title

42, Code of Federal Regulations, section 447.54, for enrollees in these programs. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2013, with draft legislation to implement these recommendations effective January 1, 2014.

Sec. 13. **STUDY OF MANAGED CARE.**

The commissioner of human services must contract with an independent vendor with demonstrated expertise in evaluating Medicaid managed care programs to evaluate the value of managed care for state public health care programs provided under Minnesota Statutes, sections 256B.69, 256B.692, and 256L.12. The evaluation must be completed and reported to the legislature by January 15, 2013. Determination of the value of managed care must include consideration of the following, as compared to a fee-for-service program:

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

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

(3) the access to health services for recipients;

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

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

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

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

Sec. 14. **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 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. In comparing for-profit health maintenance organizations operating in other

states with not-for-profit health maintenance organizations operating in Minnesota, the entity must consider differences in regulatory oversight, benefit requirements, network standards, human resource costs, and assessments, fees, and taxes that may impact the cost and quality comparisons. The commissioner shall require the entity under contract to report study findings to the commissioner and the legislature by January 15, 2013.

Sec. 15. **REPORTING REQUIREMENTS.**

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

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

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

Sec. 16. **REPORT ELIMINATION SAVINGS.**

Managed care plans and county-based purchasing plans shall use the savings resulting from the elimination or modification of reporting requirements under Minnesota Statutes, sections 62D.124; 62M.09, subdivision 9; 62Q.64; 72A.201, subdivision 8; 256B.0625, subdivision 3g; and Minnesota Rules, parts 4685.2000; and 4685.2100, to pay the assessment required in Minnesota Statutes, section 256B.69, subdivision 9c, paragraph (m).

Sec. 17. **REPEALER.**

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

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

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

Subd. 4. **Mandatory HMO participation as provider in public programs.** Minnesota Statutes 2010, section 62D.04, subdivision 5, is repealed effective January 1, 2013.

ARTICLE 2

DEPARTMENT OF HEALTH

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

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

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

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

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

(2) a health maintenance organization offering supplemental benefits must maintain an additional surplus in the first year supplemental benefits are offered equal to the lesser of $500,000 or 33 percent of the supplemental benefit expenses. At the end of the second year supplemental benefits are offered, the health maintenance organization must maintain an additional surplus equal to the lesser of $1,000,000 or 33 percent of the supplemental benefit expenses. At the end of the third year benefits are offered and every year after that, the health maintenance organization must maintain an additional surplus equal to the greater of $1,000,000 or 33 percent of the supplemental benefit expenses. When in the judgment of the commissioner the health maintenance organization's surplus is inadequate, the commissioner may require the health maintenance organization to maintain additional surplus;

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

(4) in marketing supplemental benefits, the health maintenance organization shall fully disclose and describe to enrollees and potential enrollees the nature and extent of the supplemental coverage, and any claims filing and other administrative responsibilities in regard to supplemental benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) providing payment to participating providers;

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

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

(6) initiating disease management services, as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) preventive services, including:

(i) health education and wellness services;

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

(iii) immunizations; and

(iv) early disease detection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Development of tools to improve costs and quality outcomes.** The commissioner of health shall develop a plan to create transparent prices, encourage greater provider innovation and collaboration across points on the health continuum in cost-effective, high-quality care delivery, reduce the administrative burden on

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

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

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

(1) provider attribution of costs and quality;

(2) appropriate adjustment for outlier or catastrophic cases;

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

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

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

(6) appropriate adjustment for variation in payment rates;

(7) the appropriate provider level for analysis;

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

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

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

Subd. 3. **Provider peer grouping; system development; advisory committee.** (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) The commissioner shall establish an advisory committee comprised of representatives of health care providers, health plan companies, consumers, state agencies, employers, academic researchers, and organizations that work to improve health care quality in Minnesota. The advisory committee shall meet no fewer than three times per year. The commissioner shall consult with the advisory committee in developing and administering the peer grouping system, including but not limited to the following activities:

(1) establishing peer groups;

(2) selecting quality measures;

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

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

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

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

Subd. 3a. **Provider peer grouping; dissemination of data to providers.** ~~(b) By no later than October 15, 2010,~~ (a) 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 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. 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 in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner the accuracy and representativeness of any analyses or reports and submit comments to the commissioner or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have ~~30~~ 60 days to review the data for accuracy and initiate an appeal as specified in ~~paragraph (d)~~ subdivision 3b.

~~(c) By no later than January 1, 2011,~~ (b) 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 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. 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 in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d),

and adopted by the commissioner the accuracy and representativeness of any analyses or reports and submit comments to the commissioner or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have ~~30~~ 60 days to review the data for accuracy and initiate an appeal as specified in ~~paragraph (d)~~ subdivision 3b.

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

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

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

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

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

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

Subd. 3c. **Provider peer grouping; publication of information for the public.** ~~(c) 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.~~ (a) The commissioner may publicly release summary data related to the peer grouping system as long as the data do not contain information or descriptions from which the identity of individual hospitals, clinics, or other providers may be discerned.

~~(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.~~ (b) The

commissioner may publicly release analyses or results related to the peer grouping system that identify hospitals, clinics, or other providers only if the following criteria are met:

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

(2) the commissioner has provided an opportunity for providers to verify and review data for which the provider is the subject consistent with the recommendations developed pursuant to paragraph (d) and adopted by the commissioner;

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

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

~~(g)~~ (c) After publishing the first public report, the commissioner shall, no less frequently 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, as well as 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, including case mix adjustments.

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

Subd. 3d. **Provider peer grouping; standards for dissemination and publication.** (a) Prior to disseminating data to providers under ~~paragraph (b) or (c)~~ subdivision 3a or publishing information under ~~paragraph (c) or (f)~~ subdivision 3c, the commissioner, in consultation with the advisory committee, shall ensure the scientific and statistical validity and reliability of the results according to the standards described in paragraph ~~(h)~~ (b). If additional time is needed to establish the scientific validity, statistical significance, and reliability of the results, the commissioner may delay the dissemination of data to providers under ~~paragraph (b) or (c)~~ subdivision 3a, or the publication of information under ~~paragraph (c) or (f)~~ subdivision 3c. ~~If the delay is more than 60 days, the commissioner shall report in writing to the 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)~~ subdivision 3a at least ~~90~~ 120 days before publishing results under ~~paragraph (c) or (f)~~ subdivision 3c.

~~(h)~~ (b) The commissioner's assurance of valid, timely, 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~~ thresholds for both quality and costs 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 the advisory committee and 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. 8. Minnesota Statutes 2010, section 62U.04, subdivision 4, is amended to read:

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

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

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

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

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) ~~for the purpose of carrying out its responsibilities in this section, and must maintain the data that it receives according to the provisions of this~~

~~section.~~ to carry out its responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

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

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

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

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

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision ~~for the purpose of carrying out its responsibilities under this section~~ to carry out its responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

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

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

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

(1) the commissioner of management and budget ~~shall~~ may use the information and methods developed under ~~subdivision 3~~ subdivisions 3 to 3d 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~~ may 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~~ may use the information and methods developed under ~~subdivision 3~~ subdivisions 3 to 3d 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~~ may offer at least one health plan that uses the information developed under ~~subdivision 3~~ subdivisions 3 to 3d 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. 11. Minnesota Statutes 2011 Supplement, section 144.1222, subdivision 5, is amended to read:

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2010, section 144.5509, is amended to read:

144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.

(a) A radiation therapy facility may be constructed only by an entity owned, operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either alone or in cooperation with another entity. This paragraph expires August 1, 2014.

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

(c) After August 1, 2014, a radiation therapy facility may be constructed only if the following requirements are met:

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

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

(d) Any referring physician must provide each patient who is in need of radiation therapy services with a list of all radiation therapy facilities located within the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright. Physicians with a financial interest in any radiation therapy facility must disclose to the patient the existence of the interest.

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2010, section 145.906, is amended to read:

145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.

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

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

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

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

Sec. 14. Minnesota Statutes 2010, section 256B.0754, subdivision 2, is amended to read:

Subd. 2. **Payment reform.** By no later than 12 months after the commissioner of health publishes the information in section ~~62U.04, subdivision 3, paragraph (c)~~ 62U.04, subdivision 3c, paragraph (b), the commissioner of human services ~~shall~~ may use the information and methods developed under section 62U.04 to establish a payment system that:

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

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

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

Sec. 15. Laws 2011, First Special Session chapter 9, article 10, section 4, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Promotion**

	Appropriations by Fund	
General	45,577,000	46,030,000
State Government Special Revenue	1,033,000	1,033,000
Health Care Access	16,719,000	1,719,000
Federal TANF	11,713,000	11,713,000

TANF Appropriations. (1) $1,156,000 of the TANF funds is appropriated each year of the biennium 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 of the biennium 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 of the biennium 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 of the biennium 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.

Statewide Health Improvement Program. ~~(a)~~ $15,000,000 in the biennium ending June 30, 2013, is appropriated from the health care access fund for the statewide health improvement program and is available until expended. Notwithstanding Minnesota Statutes, sections 144.396, and 145.928, the commissioner may use tobacco prevention grant funding and grant funding under Minnesota Statutes, section 145.928, to support the statewide health improvement program. The commissioner may focus the program geographically or on a specific goal of tobacco use reduction or on reducing obesity. ~~By February 15, 2013, the commissioner shall report to the chairs of the health and human services committee on progress toward meeting the goals of the program as outlined in Minnesota Statutes, section 145.986, and estimate the dollar value of the reduced health care costs for both public and private payers.~~

~~(b) By February 15, 2012, the commissioner shall develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health maintenance organizations collaboration plans. The implementation~~

~~plan shall include an advisory board to determine priority needs for health improvement in reducing obesity and tobacco use in Minnesota and to review and approve hospital community benefit activities reported under Minnesota Statutes, section 144.699, and health maintenance organizations collaboration plans in Minnesota Statutes, section 62Q.075. The commissioner shall consult with hospital and health maintenance organizations in creating and implementing the plan. The plan described in this paragraph shall be implemented by July 1, 2012.~~

~~(c) The commissioners of Minnesota management and budget, human services, and health shall include in each forecast beginning February of 2013 a report that identifies an estimated dollar value of the health care savings in the state health care programs that are directly attributable to the strategies funded from the statewide health improvement program. The report shall include a description of methodologies and assumptions used to calculate the estimate.~~

Funding Usage. Up to 75 percent of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program and up to 75 percent of the fiscal year 2013 appropriation may be used for calendar year 2012 allocations. The fiscal year 2014 base shall be increased by $5,193,000.

Base Level Adjustment. The general fund base is increased by $5,188,000 in fiscal year 2014 and decreased by $5,000 in 2015.

Sec. 16. **STUDY OF RADIATION THERAPY FACILITIES CAPACITY.**

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

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

Sec. 17. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the terms "commissioner of health" or similar term to "commissioner of commerce" or similar term and "department of health" or similar term to "department of commerce" or similar term wherever necessary in Minnesota Statutes, chapters 62A to 62U, and other relevant statutes as needed to signify the transfer of regulatory jurisdiction of health maintenance organizations from the commissioner of health to the commissioner of commerce.

Sec. 18. **EFFECTIVE DATE.**

Sections 5 to 10 and 14 are effective July 1, 2012, and apply to all information provided or released to the public or to health care providers, pursuant to Minnesota Statutes, section 62U.04, on or after that date. Section 7 shall be implemented by the commissioner of health within available resources.

ARTICLE 3

CHILDREN AND FAMILY SERVICES

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

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than ten full-day absent days per child, excluding

holidays, in a fiscal year. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ten absent day limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children in families may exceed the ten absent days limit if at least one parent is: (1) under the age of 21; (2) does not have a high school or general equivalency diploma; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) If the commissioner of human services determines that an applicant or recipient has illegally or improperly enrolled in any public assistance program, the commissioner

shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 1, is amended to read:

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

Sec. 6. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

Subd. 1b. **Earned income savings account.** In addition to the $50 disregard required under subdivision 1, the county agency shall disregard an additional earned income up to a maximum of ~~$150~~ $500 per month for: (1) persons residing in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons living in supervised apartments with services funded under Minnesota Rules, parts 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan; and (3) persons residing in group residential housing, as that term is defined in section 256I.03, subdivision 3, for whom the county agency has approved a discharge plan which includes work. The additional amount disregarded must be placed in a separate savings account by the eligible individual, to be used upon discharge from the residential facility into the community. For individuals residing in a chemical dependency program licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from the savings account require the signature of the individual and for those individuals with an authorized representative payee, the signature of the payee. A maximum of ~~$1,000~~ $2,000, including interest, of the money in the savings account must be excluded from the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in that account in excess of ~~$1,000~~ $2,000 must be applied to the resident's cost of care. If excluded money is removed from the savings account by the eligible individual at any time before the individual is discharged from the facility into the community, the money is income to the individual in the month of receipt and a resource in subsequent months. If an eligible individual moves from a community facility to an inpatient hospital setting, the separate savings account is an excluded asset for up to 18 months. During that time, amounts that accumulate in excess of the ~~$1,000~~ $2,000 savings limit must be applied to the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the 18-month period, the entire account must be applied to the patient's cost of care.

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

Sec. 7. Minnesota Statutes 2010, section 626.556, is amended by adding a subdivision to read:

Subd. 10n. **Required referral to early intervention services.** A child under age three who is involved in a substantiated case of maltreatment shall be referred for screening under the Individuals with Disabilities Education Act, part C. Parents must be informed that the evaluation and acceptance of services are voluntary. The commissioner of human services shall monitor referral rates by county and annually report the

information to the legislature beginning March 15, 2014. Refusal to have a child screened is not a basis for a child in need of protection or services petition under chapter 260C.

Sec. 8. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 1, is amended to read:

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

Appropriations by Fund	2012	2013
General	5,657,737,000	5,584,471,000
State Government Special Revenue	3,565,000	3,565,000
Health Care Access	330,435,000	353,283,000
Federal TANF	265,378,000	268,101,000
Lottery Prize	1,665,000	1,665,000
Special Revenue	500,000	1,000,000

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

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is

appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

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

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

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

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

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

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

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

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

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

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

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

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

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

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

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

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

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

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

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following

amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2012, ~~$23,692,000~~ $23,761,000;

(2) fiscal year 2013, ~~$44,969,000~~ $48,738,000;

(3) fiscal year 2014, ~~$32,579,000~~ $32,665,000; and

(4) fiscal year 2015, ~~$32,476,000~~ $32,590,000.

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

TANF Transfer to Federal Child Care and Development Fund. (a) The following TANF fund amounts are appropriated to the commissioner for purposes of MFIP/Transition Year Child Care Assistance under Minnesota Statutes, section 119B.05:

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

(2) fiscal year 2013, $28,020,000;

(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 October 1, 2011.

Sec. 9. **DIRECTIONS TO THE COMMISSIONER.**

The commissioner of human services, in consultation with the commissioner of public safety, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance regarding

the implementation of Minnesota Statutes, section 256.01, subdivisions 18d, 18e, and 18f, the number of persons affected, and fiscal impact by program by April 1, 2013.

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

ARTICLE 4

CONTINUING CARE

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

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

(1) federally qualified health centers;

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

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

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

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

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

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

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

(1) critical access hospitals;

(2) federally qualified health centers;

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

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

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

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

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

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

(2) a quote from a vendor;

(3) a description of the health care entities and other groups participating in the project;

(4) evidence of financial stability and a demonstrated ability to repay the loan; and

(5) a description of how the system to be financed interoperates or plans in the future to interoperate with other health care entities and provider groups located in the same geographical area;

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

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

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

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

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

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

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

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

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services by county and region including:

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

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

(iii) comparative measures of long-term care services availability and ~~progress~~ changes over time; and

(4) recommendations regarding goals for the future of long-term care services, policy and fiscal changes, and resource needs.

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

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

(b) The requirements for certification are:

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

(i) mental health diagnoses;

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

(iii) recovery from mental illness;

(iv) treatment options including evidence-based practices;

(v) medications and their side effects;

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

(vii) community resources;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to

operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

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

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

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

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

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

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

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

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

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

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

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

(e) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division~~, and~~. The department shall ~~immediately~~ decrease the licensed capacity for the

home, if the voluntary changes described in paragraph (g) are not sufficient to meet the savings required by 2011 reductions in licensed bed capacity and maintain statewide long-term care residential services capacity within budgetary limits. The commissioner shall delicense up to 128 beds by June 30, 2013, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

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

(1) until August 1, 2013, the beds of a license holder whose primary diagnosis is mental illness and the license holder is:

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

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

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

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

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

(g) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (e) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 of each year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

Sec. 6. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

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

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

each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

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

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

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

(i) individualized plan of care;

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 7a. **Alternate overnight supervision technology; adult foster care license.** (a) The commissioner may grant an applicant or license holder an adult foster care license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses monitoring technology to alert the license holder when an incident occurs that may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

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

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

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

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

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

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

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

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

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

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

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

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

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

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

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

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

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

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

(iv) each foster care recipient's individualized plan of care, individual service plan under section 256B.092, subdivision 1b, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that foster care recipient.

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

electronic monitoring technology is used in the home, the informed consent form must also explain the following:

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

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

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

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

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

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

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

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

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

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

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

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

(l) To be eligible for a license under paragraph (a), the adult foster care license holder must not have had a conditional license issued under section 245A.06 or any licensing

sanction under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

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

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

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

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

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

Sec. 9. Minnesota Statutes 2010, section 245B.07, subdivision 1, is amended to read:

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

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

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

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

to provide an individual service plan after a written request from the license holder, the license holder shall not be sanctioned or penalized financially for not having a current individual service plan in the consumer's data file;

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

(5) progress review reports;

(6) incidents involving the consumer;

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

(8) discharge summary, when applicable;

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

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

(11) information about self-abuse.

Sec. 10. Minnesota Statutes 2010, section 245C.04, subdivision 6, is amended to read:

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

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

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

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

(2) the individual who is the subject of the background study provides direct contact services under the provider's licensed program for at least 40 hours per year so

the individual will be recognized by a probation officer or corrections agent to prompt a report to the commissioner regarding criminal convictions as required under section 245C.05, subdivision 7.

Sec. 11. Minnesota Statutes 2010, section 245C.05, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2010, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices

about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) develop referral protocols and processes that will assist certified health care homes and hospitals to identify at-risk older adults and determine when to refer these individuals to the Senior LinkAge Line for long-term care options counseling under this section. The commissioner is directed to work with the commissioner of health to develop protocols that would comply with the health care home designation criteria and protocols available at the time of hospital discharge.

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

Sec. 13. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to read:

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

Sec. 14. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is amended to read:

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

the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

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

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

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

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

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, reaches age 65 and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7, when the person reaches age 65. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) notwithstanding the requirements of clause (6), persons whose 65th birthday occurs in 2012 or 2013 are required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

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

Sec. 15. Minnesota Statutes 2011 Supplement, 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 September 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.

(f) Outside of a metropolitan county as defined in section 473.121, subdivision 4, reimbursement rates under this subdivision may be adjusted monthly by the commissioner when the statewide average price of regular grade gasoline is over $3 per gallon, as calculated by Oil Price Information Service. The rate adjustment shall be a one-percent increase or decrease for each corresponding $0.10 increase or decrease in the statewide average price of regular grade gasoline.

Sec. 16. Minnesota Statutes 2011 Supplement, 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; and

(10) home and community-based waiver services for persons with developmental disabilities under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; personal care assistance services under section 256B.0659; and day training and habilitation services for adults with developmental disabilities under sections 252.40 to 252.46.

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

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

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

(b) Registered housing with services establishments shall inform all prospective residents or the prospective resident's designated or legal representative of the ~~availability of long-term care consultation and the need to receive and verify the consultation prior to signing a lease or contract~~ requirement for long-term care options counseling and the opportunity to decline long-term care options counseling. Prospective residents declining long-term care options counseling are required to sign a waiver form designated by the commissioner and supplied by the provider. The housing with services establishment shall maintain copies of signed waiver forms or verification that the consultation was conducted for audit for a period of three years. Long-term care consultation for registered housing with services is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision 1a, paragraph (d), and the Area Agencies on Aging, and is a point of entry to a combination

of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

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

(i) the resident verbally requests; or

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

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

~~(2)~~ (3) the consultation must include a review of the prospective resident's reasons for considering housing with services, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or housing with services settings that may meet the prospective resident's needs;

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

~~(4)~~ (5) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

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

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

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

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

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

Sec. 18. Minnesota Statutes 2010, section 256B.0911, is amended by adding a subdivision to read:

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

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

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

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

Sec. 19. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Individual service plan.** (a) The individual service plan must:

(1) include the results of the assessment information on the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(2) identify the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(3) identify long- and short-range goals for the person;

(4) identify specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The individual service plan shall also specify other services the person needs that are not available;

(5) identify the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(6) identify provider responsibilities to implement and make recommendations for modification to the individual service plan;

(7) include notice of the right to request a conciliation conference or a hearing under section 256.045;

(8) be agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

(9) be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

(b) Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 20. Minnesota Statutes 2011 Supplement, section 256B.097, subdivision 3, is amended to read:

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first two years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota; ~~and~~

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2013, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2013.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Sec. 21. Minnesota Statutes 2010, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Sec. 22. Minnesota Statutes 2010, section 256B.431, is amended by adding a subdivision to read:

Subd. 45. **Rate adjustments for some moratorium exception projects.** Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 23. Minnesota Statutes 2010, section 256B.434, subdivision 10, is amended to read:

Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the

basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

~~(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.~~

~~(d)~~ (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

~~(e)~~ (d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

~~(f)~~ (e) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.

Sec. 24. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with operating payment rates being the sum of 60 percent of the operating payment rate determined in accordance with subdivision 54 and 40 percent of the operating payment rate that would have been allowed had the facility not been designated;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivisions 3f, paragraph (a), and 17e, shall be 40 percent of the amount that would otherwise apply; and

(5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

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

Sec. 25. Minnesota Statutes 2010, section 256B.48, is amended by adding a subdivision to read:

Subd. 6a. **Referrals to Medicare providers required.** Notwithstanding subdivision 1, nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner shall audit nursing facilities that do not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

Sec. 26. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to

achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed

to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or traumatic brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing~~, unless~~ and the licensed capacity shall be reduced accordingly, unless the savings required by the 2011 licensed bed closure reductions for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (g), or as provided under ~~section 245A.03, subdivision 7~~, paragraph (a), clauses (3) and (4)~~, and the licensed capacity shall be reduced accordingly~~. If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by ~~June 30, 2012~~ July 1, 2013.

Sec. 27. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 23, is amended to read:

Subd. 23. **Community-living settings.** "Community-living settings" means a single-family home or apartment where the service recipient or their family owns or rents, ~~as demonstrated by a lease agreement,~~ and maintains control over the individual unit as

demonstrated by the lease agreement, or has a plan for transition of a lease from a service provider to the individual. Within two years of signing the initial lease, the service provider shall transfer the lease to the individual. In the event the landlord denies the transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the individual. Community-living settings are subject to the following:

(1) individuals are not required to receive services;

(2) individuals are not required to have a disability or specific diagnosis to live in the community-living setting, unless state or federal funding requires it;

(3) individuals may hire service providers of their choice;

(4) individuals may choose whether to share their household and with whom;

(5) the home or apartment must include living, sleeping, bathing, and cooking areas;

(6) individuals must have lockable access and egress;

(7) individuals must be free to receive visitors and leave the settings at times and for durations of their own choosing;

(8) leases must not reserve the right to assign units or change unit assignments; and

(9) access to the greater community must be easily facilitated based on the individual's needs and preferences.

Sec. 28. **[256B.492] ADULT FOSTER CARE VOLUNTARY CLOSURE.**

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services shall ask providers of adult foster care services to present proposals for the conversion of services provided for persons with developmental disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, to services to other community settings in conjunction with the cessation of operations and closure of identified facilities.

Subd. 2. **Inventory of foster care capacity.** The commissioner of human services shall submit to the legislature by February 15, 2013, a report that includes:

(1) an inventory of the assessed needs of all individuals with disabilities receiving foster care services under section 256B.092;

(2) an inventory of total licensed foster care capacity for adults and children available in Minnesota as of January 1, 2013; and

(3) a comparison of the needs of individuals receiving services in foster care settings and nonfoster care settings.

The report will also contain recommendations on developing a profile of individuals requiring foster care services and the projected level of foster care capacity needed to serve that population.

Subd. 3. **Voluntary closure process need determination.** If the report required in subdivision 2 determines the existing supply of foster care capacity is higher than needed to meet the needs of individuals requiring that level of care, the commissioner shall, within the limits of available appropriations, announce and implement a program for closure of adult foster care homes.

Subd. 4. **Application process.** (a) The commissioner shall establish a process of application, review, and approval for licensees to submit proposals for the closure of facilities.

(b) A licensee shall notify the following parties in writing when an application for a planned closure adjustment is submitted:

(1) the county social services agency; and

(2) current and prospective residents and their families.

(c) After providing written notice, and prior to admission, the licensee must fully inform prospective residents and their families of the intent to close operations and of the relocation plan.

Subd. 5. **Review and approval process.** (a) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the home or homes to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents and the affected county social service agency, commencement of closure, and completion of closure;

(3) the proposed relocation plan jointly developed by the county of financial responsibility and the providers for current residents of any facility designated for closure; and

(4) documentation in a format approved by the commissioner that all the adult foster care homes receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(c) In reviewing and approving closure proposals, the commissioner shall give first priority to proposals that:

(1) result in the closing of a facility;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative placements will be developed based on individual resident needs and applicable federal and state rules.

The commissioner shall also consider any information provided by residents, their family, or the county social services agency on the impact of the planned closure on the services they receive.

(d) The commissioner shall select proposals that best meet the criteria established in this subdivision within the appropriation made available for planned closure of adult foster care facilities. The commissioner shall notify licensees of the selections made and approved by the commissioner.

(e) For each proposal approved by the commissioner, a contract must be established between the commissioner, the county of financial responsibility, and the participating licensee.

Subd. 6. **Adjustment to rates.** (a) For purposes of this section, the commissioner shall establish an enhanced payment rate under section 256B.0913 to facilitate an orderly transition for persons with developmental disabilities from adult foster care to other community-based settings.

(b) The maximum length the commissioner may establish an enhanced rate is six months.

(c) The commissioner shall allocate funds, up to a total of $450 in state and federal funds per adult foster care home bed that is closing, to be used for relocation costs incurred by counties under this process

(d) The commissioner shall analyze the fiscal impact of the closure of each facility on medical assistance expenditures. Any savings is allocated to the medical assistance program.

Sec. 29. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

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

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

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health

residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

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

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

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. In a multifamily building ~~of four or more units, the maximum number of apartments that may be used by recipients of this program shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012.~~ of more than four units, the maximum number of units that may be used by recipients of this program shall be the greater of four units of 25 percent of the units in the building. In multifamily buildings of four or fewer units, all of the units may be used by recipients of this program. When housing is controlled by the service provider, the individual may choose their own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.

Sec. 30. Laws 2011, First Special Session chapter 9, article 7, section 52, is amended to read:

Sec. 52. **IMPLEMENT NURSING HOME LEVEL OF CARE CRITERIA.**

The commissioner shall seek any necessary federal approval in order to implement the changes to the level of care criteria in Minnesota Statutes, section 144.0724, subdivision 11, on or after July 1, 2012, for adults and children.

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

Sec. 31. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3, is amended to read:

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) **MFIP Child Care Assistance Grants**	55,456,000	30,923,000
(c) **General Assistance Grants**	49,192,000	46,938,000

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 $6,689,812 in fiscal year 2012 and $6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid Grants**	38,095,000	39,120,000
(e) **Group Residential Housing Grants**	121,080,000	129,238,000
(f) **MinnesotaCare Grants**	295,046,000	317,272,000
This appropriation is from the health care access fund.		
(g) **Medical Assistance Grants**	4,501,582,000	4,437,282,000

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 and DD waivers and customized living settings for CADI. Lead agencies shall consult with providers to review individual service plans and identify changes or modifications to reduce the utilization of services while maintaining the health and safety of the individual receiving services. Lead agencies must adjust contracts within 60 days of the effective date.

Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the

reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI.

Reduce customized living and 24-hour customized living component rates. Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental Disability Waiver. The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through

June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Limit Growth in the Community Alternatives for Disabled Individuals Waiver. The commissioner shall limit growth in the community alternatives for disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section 256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Personal Care Assistance Relative Care. The commissioner shall adjust the

capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11.

(h) **Alternative Care Grants**	46,421,000	46,035,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) **Chemical Dependency Entitlement Grants**	94,675,000	93,298,000

Sec. 32. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 4, is amended to read:

Subd. 4. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	100,525,000	94,611,000

MFIP Consolidated Fund Grants. The TANF fund base is reduced by $10,000,000 each year beginning in fiscal year 2012.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar year quarters in

the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

(b) **Basic Sliding Fee Child Care Assistance Grants**	37,144,000	38,678,000

Base Adjustment. The general fund base is decreased by $990,000 in fiscal year 2014 and $979,000 in fiscal year 2015.

Child Care and Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,000,000 in fiscal year 2012 from the federal child care and development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

(c) **Child Care Development Grants**	774,000	774,000

Base Adjustment. The general fund base is increased by $713,000 in fiscal years 2014 and 2015.

(d) **Child Support Enforcement Grants**	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal

child support grant expenditures authorized under section 1115a of the Social Security Act is appropriated to the commissioner for this activity.

(e) **Children's Services Grants**

	Appropriations by Fund	
General	47,949,000	48,507,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance Transfer. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2012 and fiscal year 2013 for adoption incentive grants are appropriated to the commissioner for these purposes.

(f) **Children and Community Services Grants** 53,301,000 53,301,000

(g) **Children and Economic Support Grants**

	Appropriations by Fund	
General	16,103,000	16,180,000
Federal TANF	700,000	0

Long-Term Homeless Services. $700,000 is appropriated from the federal TANF fund for the biennium beginning July 1, 2011, to the commissioner of human

services for long-term homeless services for low-income homeless families under Minnesota Statutes, section 256K.26. This is a onetime appropriation and is not added to the base.

Base Adjustment. The general fund base is increased by $42,000 in fiscal year 2014 and $43,000 in fiscal year 2015.

Minnesota Food Assistance Program. $333,000 in fiscal year 2012 and $408,000 in fiscal year 2013 are to increase the general fund base for the Minnesota food assistance program. Unexpended funds for fiscal year 2012 do not cancel but are available to the commissioner for this purpose in fiscal year 2013.

(h) **Health Care Grants**

Appropriations by Fund		
General	26,000	66,000
Health Care Access	190,000	190,000

Base Adjustment. The general fund base is increased by $24,000 in each of fiscal years 2014 and 2015.

(i) **Aging and Adult Services Grants** 12,154,000 11,456,000

Aging Grants Reduction. Effective July 1, 2011, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $3,600,000 for each year of the biennium. These reductions are onetime and do not affect base funding for the 2014-2015 biennium. Grants made during the 2012-2013 biennium under Minnesota Statutes, section 256B.9754, must not be used for new construction or building renovation.

Essential Community Support Grant Delay. Upon federal approval to implement the nursing facility level of care on July 1, 2013, essential community supports grants under Minnesota Statutes, section 256B.0917, subdivision 14, are reduced by $6,410,000 in fiscal year 2013. Base level funding is increased by $5,541,000 in fiscal year 2014 and $6,410,000 in fiscal year 2015.

Base Level Adjustment. The general fund base is increased by $10,035,000 in fiscal year 2014 and increased by $10,901,000 in fiscal year 2015.

(j) **Deaf and Hard-of-Hearing Grants**	1,936,000	1,767,000
(k) **Disabilities Grants**	15,945,000	18,284,000

Grants for Housing Access Services. In fiscal year 2012, the commissioner shall make available a total of $161,000 in housing access services grants to individuals who relocate from an adult foster care home to a community living setting for assistance with completion of rental applications or lease agreements; assistance with publicly financed housing options; development of household budgets; and assistance with funding affordable furnishings and related household matters.

HIV Grants. The general fund appropriation for the HIV drug and insurance grant program shall be reduced by $2,425,000 in fiscal year 2012 and increased by $2,425,000 in fiscal year 2014. These adjustments are onetime and shall not be applied to the base. Notwithstanding any contrary provision, this provision expires June 30, 2014.

Region 10. Of this appropriation, $100,000 each year is for a grant provided under Minnesota Statutes, section 256B.097.

Base Level Adjustment. The general fund base is increased by $2,944,000 in fiscal year 2014 and $653,000 in fiscal year 2015.

Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs. (1) The commissioner shall make available a total of $250,000 per year in local planning grants, beginning July 1, 2011, to assist lead agencies and provider organizations in developing alternatives to congregate living within the available level of resources for the home and community-based services waivers for persons with disabilities.

(2) Notwithstanding clause (1), for fiscal years 2012 and 2013 only, the appropriation of $250,000 for fiscal year 2012 carries forward to fiscal year 2013, effective the day following final enactment.

Of the total appropriations available for fiscal year 2013, $100,000 is for administrative functions related to the planning process required under Minnesota Statutes, sections 144A.351 and 245A.03, subdivision 7, paragraphs (e) and (g), and $400,000 is for grants required to accomplish that planning process.

(3) Base funding for the grants under clause (1) is not affected by the appropriations under clause (2).

Disability Linkage Line. Of this appropriation, $125,000 in fiscal year 2012

and $300,000 in fiscal year 2013 are for assistance to people with disabilities who are considering enrolling in managed care.

(l) **Adult Mental Health Grants**

	Appropriations by Fund	
General	70,570,000	70,570,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is increased by $200,000 in fiscal years 2014 and 2015.

(m) **Children's Mental Health Grants** 16,457,000 16,457,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is increased by $225,000 in fiscal years 2014 and 2015.

(n) **Chemical Dependency Nonentitlement Grants** 1,336,000 1,336,000

Sec. 33. **COMMISSIONER AUTHORITY TO REDUCE 2011 CONGREGATE CARE LOW NEED RATE CUT.**

During fiscal years 2013 and 2014, the commissioner shall reduce the 2011 reduction of rates for congregate living for individuals with lower needs to the extent the actions taken under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (g), produce savings beyond the amount needed to meet the licensed bed closure savings requirements of Minnesota Statutes, section 245A.03, subdivision 7, paragraph (e). Each February 1,

the commissioner shall report to the chairs and ranking minority members of the health and human services finance committees on any reductions provided under this section.

EFFECTIVE DATE. This section is effective July 1, 2012, and expires June 30, 2014.

Sec. 34. **COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

(a) By June 1, 2012, the commissioner of human services shall seek federal approval as part of the MA reform waiver request required under Minnesota Statutes, section 256B.021 to:

(1) authorize persons who have been eligible for medical assistance under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24 consecutive months prior to reaching age 65, to continue to qualify for medical assistance under Minnesota Statutes, section 256B.057, subdivision 9, beyond their 65th birthday as long as the other requirements of Minnesota Statutes, section 256B.057, subdivision 9, are met;

(2) authorize federal funding under the waiver from April 1, 2012, until federal approval is obtained for persons who turn age 65 in 2012 and who have been enrolled in medical assistance under Minnesota Statutes, section 256B.057, subdivision 9, for at least 20 months within the 24 months prior to reaching age 65 to continue to qualify for medical assistance under Minnesota Statutes, section 256B.057, subdivision 9. If federal approval of clause (1) is not granted, then for temporary federal funding until 30 days after any federal denial is made public through the disability stakeholders electronic notice list; and

(3) notwithstanding the requirements of clause (1), persons whose 65th birthday occurs in 2012 or 2013 are required to have qualified for medical assistance under Minnesota Statutes, section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

(b) Money shall be appropriated from the state general fund until federal approval is granted for individuals eligible for medical assistance under paragraph (a), clause (2).

This section shall expire when federal approval is granted or 30 days after a federal denial.

Sec. 35. **CONTINUATION OF MEDICAL ASSISTANCE FOR EMPLOYED PERSONS WITH DISABILITIES WHILE WAIVER REQUEST IS PENDING.**

Persons eligible for medical assistance under Minnesota Statutes, section 245A.07, subdivision 7, paragraph (a), clause (2), shall be allowed to continue to qualify for Minnesota Statutes, section 256B.057, subdivision 9, until the federal approval requested under Minnesota Statutes, section 245A.07, subdivision 7, is granted, or until 30 days after

any federal denial is made public through the disability stakeholders electronic notice list. This section shall expire June 30, 2013.

Sec. 36. **SCOPE OF FISCAL ANALYSIS.**

As provided in Minnesota Statutes, section 256B.021, subdivision 1, the fiscal analysis for sections 2 and 4 to 7 shall include the cost of other state agencies' services or programs, as well as federal programs used by persons who would have to spend down their retirement savings and monthly income if not allowed to continue using medical assistance for employed persons with disabilities income and asset provisions after age 65.

Sec. 37. **HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.**

(a) Individuals receiving services under a home and community-based waiver under Minnesota Statutes, section 256B.092 or 256B.49, may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care setting of up to five people; and

(3) community living settings as defined in Minnesota Statutes, section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units no more than the greater of four or 25 percent of the units in a multifamily building of more than four units.

The above settings must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability unless state or federal funding for housing requires it;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution, unless specifically required in the individual's plan developed with the lead agency case manager and legal guardian. The qualities of an institution include, but are not limited to:

(i) regimented meal and sleep times;

(ii) limitations on visitors; and

(iii) lack of privacy.

(b) The provisions of paragraph (a) do not apply to any setting in which residents receive services under a home and community-based waiver as of June 30, 2013, and which has been delivering those services for at least one year.

(c) Notwithstanding paragraph (b), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (b).

(d) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Sec. 38. **INDEPENDENT LIVING SERVICES BILLING.**

The commissioner shall allow for daily rate and 15-minute increment billing for independent living services under the brain injury (BI) and CADI waivers. If necessary to comply with this requirement, the commissioner shall submit a waiver amendment to the state plan no later than December 31, 2012.

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2010, sections 144A.073, subdivision 9; and 256B.48, subdivision 6, and Laws 2011, First Special Session chapter 9, article 7, section 54, are repealed.

(b) Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13, is repealed.

ARTICLE 5

MISCELLANEOUS

Section 1. Minnesota Statutes 2010, section 43A.316, subdivision 5, is amended to read:

Subd. 5. **Public employee participation.** (a) Participation in the program is subject to the conditions in this subdivision.

(b) Each exclusive representative for an eligible employer determines whether the employees it represents will participate in the program. The exclusive representative shall give the employer notice of intent to participate at least 30 days before the expiration date of the collective bargaining agreement preceding the collective bargaining agreement that covers the date of entry into the program. The exclusive representative and the eligible employer shall give notice to the commissioner of the determination to participate in the program at least 30 days before entry into the program. Entry into the program is governed by a schedule established by the commissioner. Employees of an eligible employer that is

not participating in the program as of the date of enactment shall not be allowed to enter the program until January 1, 2015, except that a city that has received a formal written bid from the program as of the date of enactment shall be allowed to enter the program based on the bid if the city so chooses.

(c) Employees not represented by exclusive representatives may become members of the program upon a determination of an eligible employer to include these employees in the program. Either all or none of the employer's unrepresented employees must participate. The eligible employer shall give at least 30 days' notice to the commissioner before entering the program. Entry into the program is governed by a schedule established by the commissioner. Employees of an eligible employer that is not participating in the program as of the date of enactment shall not be allowed to enter the program until January 1, 2015, except that a city that has received a formal written bid from the program as of the date of enactment shall be allowed to enter the program based on the bid if the city so chooses.

(d) Participation in the program is for a two-year term. Participation is automatically renewed for an additional two-year term unless the exclusive representative, or the employer for unrepresented employees, gives the commissioner notice of withdrawal at least 30 days before expiration of the participation period. A group that withdraws must wait two years before rejoining. An exclusive representative, or employer for unrepresented employees, may also withdraw if premiums increase 50 percent or more from one insurance year to the next.

(e) The exclusive representative shall give the employer notice of intent to withdraw to the commissioner at least 30 days before the expiration date of a collective bargaining agreement that includes the date on which the term of participation expires.

(f) Each participating eligible employer shall notify the commissioner of names of individuals who will be participating within two weeks of the commissioner receiving notice of the parties' intent to participate. The employer shall also submit other information as required by the commissioner for administration of the program.

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

Sec. 2. Minnesota Statutes 2010, section 62A.047, is amended to read:

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated

under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing in this section prohibits a health plan company that has a network of providers from imposing a deductible, co-payment, or other coinsurance or dollar limitation requirement for child health supervision services and prenatal care services that are delivered by an out-of-network provider. This section does not prohibit the use of policy waiting periods or preexisting condition limitations for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. ~~Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage~~ Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for child health supervision services and prenatal care services.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Sec. 3. Minnesota Statutes 2010, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. ~~In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee~~ The required premium amount for continuation of the coverage shall be calculated in the same manner as provided under section 4980B of the Internal Revenue Code, its implementing regulations and Internal Revenue Service rulings on section 4980B.

Upon request by the insured's former spouse or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

Sec. 4. Minnesota Statutes 2010, section 62D.101, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every health maintenance contract as described in subdivision 1 shall contain a provision which permits continuation of coverage under the contract for the enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the enrollee's former spouse becomes covered under another group plan or Medicare; or

(b) the date coverage would otherwise terminate under the health maintenance contract.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder to be paid to the health maintenance organization. The contract must require the group contract holder to, upon request, provide the enrollee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. ~~In no event shall the fee charged exceed 102 percent of the cost to the plan for the period of coverage for other similarly situated~~

~~spouses and dependent children when the marital relationship has not dissolved, regardless of whether the cost is paid by the employer or employee~~ The required premium amount for continuation of the coverage shall be calculated in the same manner as provided under section 4980B in the Internal Revenue Code, its implementing regulations and Internal Revenue Service rulings on section 4980B.

Sec. 5. Minnesota Statutes 2010, section 62J.26, subdivision 3, is amended to read:

Subd. 3. **Requests for evaluation.** (a) Whenever a legislative measure containing a mandated health benefit proposal is introduced as a bill or offered as an amendment to a bill, ~~or is likely to be introduced as a bill or offered as an amendment, a~~ the chair of ~~any standing~~ the legislative committee that has jurisdiction over the subject matter of the proposal ~~may~~ must request that the commissioner complete an evaluation of the proposal under this section~~, to inform any committee of floor action by either house of the legislature~~.

(b) The commissioner must conduct an evaluation described in subdivision 2 of each mandated health benefit proposal ~~for which an evaluation is requested under paragraph (a), unless the commissioner determines under paragraph (c) or subdivision 4 that priorities and resources do not permit its evaluation~~ introduced as a bill or offered as an amendment to a bill as requested under paragraph (a).

~~(c) If requests for evaluation of multiple proposals are received, the commissioner must consult with the chairs of the standing legislative committees having jurisdiction over the subject matter of the mandated health benefit proposals to prioritize the requests and establish a reporting date for each proposal to be evaluated. The commissioner is not required to direct an unreasonable quantity of the commissioner's resources to these evaluations.~~

Sec. 6. Minnesota Statutes 2010, section 62J.26, subdivision 5, is amended to read:

Subd. 5. **Report to legislature.** The commissioner must submit a written report on the evaluation to the legislature no later than ~~180~~ 30 days after the request. The report must be submitted in compliance with sections 3.195 and 3.197.

Sec. 7. Minnesota Statutes 2010, section 62J.26, is amended by adding a subdivision to read:

Subd. 6. **Evaluation of mandated health benefits.** (a) The commissioner of commerce, in consultation with the commissioners of health and management and budget,

shall evaluate each mandated health benefit currently required in Minnesota Statutes or Rules in accordance with the evaluation process described in subdivision 2.

(b) For purposes of this subdivision, a "mandated health benefit" means a statutory or administrative requirement that a health plan do the following:

(1) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(2) provide coverage or increase the amount of coverage of a particular type of health care treatment or service, or of equipment, supplies, or drugs used in connection with a health care treatment or service; or

(3) provide coverage for care delivered by a specific type of provider.

(c) The commissioner must submit a written report on the evaluation of existing state mandated health benefits to the legislature by December 31, 2015.

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

Sec. 8. **[148.2855] NURSE LICENSURE COMPACT.**

The Nurse Licensure Compact is enacted into law and entered into with all other jurisdictions legally joining in it, in the form substantially as follows:

ARTICLE 1

DEFINITIONS

As used in this compact:

(a) "Adverse action" means a home or remote state action.

(b) "Alternative program" means a voluntary, nondisciplinary monitoring program approved by a nurse licensing board.

(c) "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards.

(d) "Current significant investigative information" means:

(1) investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(2) investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

(e) "Home state" means the party state which is the nurse's primary state of residence.

(f) "Home state action" means any administrative, civil, equitable, or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as revocation, suspension, probation, or any other action which affects a nurse's authorization to practice.

(g) "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

(h) "Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in the party state. All party states have the authority, according to existing state due process law, to take actions against the nurse's privilege such as revocation, suspension, probation, or any other action which affects a nurse's authorization to practice.

(i) "Nurse" means a registered nurse or licensed practical/vocational nurse as those terms are defined by each party state's practice laws.

(j) "Party state" means any state that has adopted this compact.

(k) "Remote state" means a party state other than the home state:

(1) where the patient is located at the time nursing care is provided; or

(2) in the case of the practice of nursing not involving a patient, in the party state where the recipient of nursing practice is located.

(l) "Remote state action" means:

(1) any administrative, civil, equitable, or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state; and

(2) cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards of those states.

(m) "State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(n) "State practice laws" means individual party state laws and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. State practice laws does not include the initial qualifications for licensure or requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE 2

GENERAL PROVISIONS AND JURISDICTION

(a) A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in the party state. A license to practice licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical/vocational nurse in the party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.

(b) Party states may, according to state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

(c) Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board, the courts, and the laws in the party state.

(d) This compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.

(e) Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

ARTICLE 3

APPLICATIONS FOR LICENSURE IN A PARTY STATE

(a) Upon application for a license, the licensing board in a party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held or is the holder of a license issued by any other state, whether there are any restrictions on the multistate licensure privilege, and whether any other adverse action by a state has been taken against the license.

(b) A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.

(c) A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of the change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.

(d) When a nurse changes primary state of residence by:

(1) moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;

(2) moving from a nonparty state to a party state, and obtains a license from the new home state, the individual state license issued by the nonparty state is not affected and will remain in full force if so provided by the laws of the nonparty state; or

(3) moving from a party state to a nonparty state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

ARTICLE 4

ADVERSE ACTIONS

In addition to the general provisions described in article 2, the provisions in this article apply.

(a) The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for the action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any reports.

(b) The licensing board of a party state shall have the authority to complete any pending investigation for a nurse who changes primary state of residence during the course of the investigation. The board shall also have the authority to take appropriate action, and shall promptly report the conclusion of the investigation to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any action.

(c) A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.

(d) For purposes of imposing adverse actions, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as

it would if the conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.

(e) The home state may take adverse action based on the factual findings of the remote state, provided each state follows its own procedures for imposing the adverse action.

(f) Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that participation shall remain nonpublic if required by the party state's laws.

Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from the other party state.

ARTICLE 5

ADDITIONAL AUTHORITIES INVESTED IN

PARTY STATE NURSE LICENSING BOARDS

Notwithstanding any other laws, party state nurse licensing boards shall have the authority to:

(1) if otherwise permitted by state law, recover from the affected nurse the costs of investigation and disposition of cases resulting from any adverse action taken against that nurse;

(2) issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and evidence are located;

(3) issue cease and desist orders to limit or revoke a nurse's authority to practice in the nurse's state; and

(4) adopt uniform rules and regulations as provided for in article 7, paragraph (c).

ARTICLE 6

COORDINATED LICENSURE INFORMATION SYSTEM

(a) All party states shall participate in a cooperative effort to create a coordinated database of all licensed registered nurses and licensed practical/vocational nurses. This system shall include information on the licensure and disciplinary history of each

nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(b) Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for the denials to the coordinated licensure information system.

(c) Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(d) Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.

(e) Any personally identifiable information obtained by a party state's licensing board from the coordinated licensure information system may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(f) Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

(g) The compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this compact.

ARTICLE 7

COMPACT ADMINISTRATION AND

INTERCHANGE OF INFORMATION

(a) The head or designee of the nurse licensing board of each party state shall be the administrator of this compact for that state.

(b) The compact administrator of each party state shall furnish to the compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this compact.

(c) Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this compact. These uniform rules shall be adopted by party states under the authority in article 5, clause (4).

ARTICLE 8

IMMUNITY

A party state or the officers, employees, or agents of a party state's nurse licensing board who acts in good faith according to the provisions of this compact shall not be liable for any act or omission while engaged in the performance of their duties under this compact. Good faith shall not include willful misconduct, gross negligence, or recklessness.

ARTICLE 9

ENACTMENT, WITHDRAWAL, AND AMENDMENT

(a) This compact shall become effective for each state when it has been enacted by that state. Any party state may withdraw from this compact by repealing the nurse licensure compact, but no withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.

(b) No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the compact of any report of adverse action occurring prior to the withdrawal.

(c) Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made according to the other provisions of this compact.

(d) This compact may be amended by the party states. No amendment to this compact shall become effective and binding upon the party states until it is enacted into the laws of all party states.

ARTICLE 10

CONSTRUCTION AND SEVERABILITY

(a) This compact shall be liberally construed to effectuate the purposes of the compact. The provisions of this compact shall be severable and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this compact and the applicability of it to any government, agency, person, or circumstance shall not be affected by it. If this compact is held contrary to the constitution of any party state, the compact shall remain in full force and effect for the remaining party states and in full force and effect for the party state affected as to all severable matters.

(b) In the event party states find a need for settling disputes arising under this compact:

(1) the party states may submit the issues in dispute to an arbitration panel which shall be comprised of an individual appointed by the compact administrator in the home state, an individual appointed by the compact administrator in the remote states involved, and an individual mutually agreed upon by the compact administrators of the party states involved in the dispute; and

(2) the decision of a majority of the arbitrators shall be final and binding.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in section 148.2855, but no sooner than July 1, 2013.

Sec. 9. **[148.2856] APPLICATION OF NURSE LICENSURE COMPACT TO EXISTING LAWS.**

(a) A nurse practicing professional or practical nursing in Minnesota under the authority of section 148.2855 shall have the same obligations, privileges, and rights as if the nurse was licensed in Minnesota. Notwithstanding any contrary provisions in section 148.2855, the Board of Nursing shall comply with and follow all laws and rules with respect to registered and licensed practical nurses practicing professional or practical nursing in Minnesota under the authority of section 148.2855, and all such individuals shall be governed and regulated as if they were licensed by the board.

(b) Section 148.2855 does not relieve employers of nurses from complying with statutorily imposed obligations.

(c) Section 148.2855 does not supersede existing state labor laws.

(d) For purposes of the Minnesota Government Data Practices Act, chapter 13, an individual not licensed as a nurse under sections 148.171 to 148.285 who practices professional or practical nursing in Minnesota under the authority of section 148.2855 is considered to be a licensee of the board.

(e) Uniform rules developed by the compact administrators shall not be subject to the provisions of sections 14.05 to 14.389, except for sections 14.07, 14.08, 14.101, 14.131, 14.18, 14.22, 14.23, 14.27, 14.28, 14.365, 14.366, 14.37, and 14.38.

(f) Proceedings brought against an individual's multistate privilege shall be adjudicated following the procedures listed in sections 14.50 to 14.62 and shall be subject to judicial review as provided for in sections 14.63 to 14.69.

(g) For purposes of sections 62M.09, subdivision 2; 121A.22, subdivision 4; 144.051; 144.052; 145A.02, subdivision 18; 148.975; 151.37; 152.12; 154.04; 256B.0917, subdivision 8; 595.02, subdivision 1, paragraph (g); 604.20, subdivision 5; and 631.40, subdivision 2; and chapters 319B and 364, holders of a multistate privilege who are

licensed as registered or licensed practical nurses in the home state shall be considered to be licensees in Minnesota. If any of the statutes listed in this paragraph are limited to registered nurses or the practice of professional nursing, then only holders of a multistate privilege who are licensed as registered nurses in the home state shall be considered licensees.

(h) The reporting requirements of sections 144.4175, 148.263, 626.52, and 626.557 apply to individuals not licensed as registered or licensed practical nurses under sections 148.171 to 148.285 who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(i) The board may take action against an individual's multistate privilege based on the grounds listed in section 148.261, subdivision 1, and any other statute authorizing or requiring the board to take corrective or disciplinary action.

(j) The board may take all forms of disciplinary action provided for in section 148.262, subdivision 1, and corrective action provided for in section 214.103, subdivision 6, against an individual's multistate privilege.

(k) The immunity provisions of section 148.264, subdivision 1, apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(l) The cooperation requirements of section 148.265 apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(m) The provisions of section 148.283 shall not apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

(n) Complaints against individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855 shall be handled as provided in sections 214.10 and 214.103.

(o) All provisions of section 148.2855 authorizing or requiring the board to provide data to party states are authorized by section 214.10, subdivision 8, paragraph (d).

(p) Except as provided in section 13.41, subdivision 6, the board shall not report to a remote state any active investigative data regarding a complaint investigation against a nurse licensed under sections 148.171 to 148.285, unless the board obtains reasonable assurances from the remote state that the data will be maintained with the same protections as provided in Minnesota law.

(q) The provisions of sections 214.17 to 214.25 apply to individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855 when the practice involves direct physical contact between the nurse and a patient.

(r) A nurse practicing professional or practical nursing in Minnesota under the authority of section 148.2855 must comply with any criminal background check required under Minnesota law.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in section 148.2855, but no sooner than July 1, 2013.

Sec. 10. **[148.2857] WITHDRAWAL FROM COMPACT.**

The governor may withdraw the state from the compact in section 148.2855 if the Board of Nursing notifies the governor that a party state to the compact changed the party state's requirements for nurse licensure after July 1, 2012, and that the party state's requirements, as changed, are substantially lower than the requirements for nurse licensure in this state.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in section 148.2855, but no sooner than July 1, 2013.

Sec. 11. **[148.2858] MISCELLANEOUS PROVISIONS.**

(a) For the purposes of section 148.2855, "head of the Nurse Licensing Board" means the executive director of the board.

(b) The Board of Nursing shall have the authority to recover from a nurse practicing professional or practical nursing in Minnesota under the authority of section 148.2855 the costs of investigation and disposition of cases resulting from any adverse action taken against the nurse.

(c) The board may implement a system of identifying individuals who practice professional or practical nursing in Minnesota under the authority of section 148.2855.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in section 148.2855, but no sooner than July 1, 2013.

Sec. 12. **[148.2859] NURSE LICENSURE COMPACT ADVISORY COMMITTEE.**

Subdivision 1. **Establishment; membership.** A Nurse Licensure Compact Advisory Committee is established to advise the compact administrator in the implementation of section 148.2855. Members of the advisory committee shall be appointed by the board

and shall be composed of representatives of Minnesota nursing organizations, Minnesota licensed nurses who practice in nursing facilities or hospitals, Minnesota licensed nurses who provide home care, Minnesota licensed advanced practice registered nurses, and public members as defined in section 214.02.

Subd. 2. **Duties.** The advisory committee shall advise the compact administrator in the implementation of section 148.2855.

Subd. 3. **Organization.** The advisory committee shall be organized and administered under section 15.059.

EFFECTIVE DATE. This section is effective upon implementation of the coordinated licensure information system defined in section 148.2855, but no sooner than July 1, 2013.

Sec. 13. Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing Home Administrators**	2,153,000	2,145,000

Rulemaking. Of this appropriation, $44,000 in fiscal year 2012 is for rulemaking. This is a onetime appropriation.

Electronic Licensing System Adaptors. Of this appropriation, $761,000 in fiscal year 2013 from the state government special revenue fund is to the administrative services unit to cover the costs to connect to the e-licensing system. Minnesota Statutes, section 16E.22. Base level funding for this activity in fiscal year 2014 shall be $100,000. Base level funding for this activity in fiscal year 2015 shall be $50,000.

Development and Implementation of a Disciplinary, Regulatory, Licensing and Information Management System. Of this appropriation, $800,000 in fiscal year 2012 and $300,000 in fiscal year 2013 are for the development of a shared system. Base level

funding for this activity in fiscal year 2014 shall be $50,000.

Administrative Services Unit - Operating Costs. Of this appropriation, $526,000 in fiscal year 2012 and $526,000 in fiscal year 2013 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year 2012, $225,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2012 and $150,000 in fiscal year 2013 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2012 and $200,000 in fiscal year 2013 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred

and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Base Adjustment. The State Government Special Revenue Fund base is decreased by $911,000 in fiscal year 2014 and ~~$1,011,000~~ $961,000 in fiscal year 2015.

Sec. 14. **BIENNIAL BUDGET REQUEST; UNIVERSITY OF MINNESOTA.**

Beginning in 2013, as part of the biennial budget request submitted to the Department of Management and Budget, and the legislature, the Board of Regents of the University of Minnesota is encouraged to include a request for funding for rural primary care training by family practice residence programs to prepare doctors for the practice of primary care medicine in rural areas of the state. The funding request should provide for ongoing support of rural primary care training through the University of Minnesota's general operation and maintenance funding or through dedicated health science funding.

ARTICLE 6

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending

June 30, 2012, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2012	**2013**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 69,000**	**$ 3,833,000**
Appropriations by Fund		
2012		2013
General -0-		46,000
Health Care Access -0-		23,000
Federal TANF 69,000		3,764,000
Subd. 2. **Central Office Operations**		
(a) **Operations**	-0-	502,000
Base Level Adjustment. The general fund base is decreased by $104,000 in fiscal year 2014 and $107,000 in fiscal year 2015.		
(b) **Health Care**	-0-	473,000
This is a onetime appropriation.		
(c) **Continuing Care**	-0-	275,000
Base Level Adjustment. The general fund base is decreased by $149,000 in fiscal year 2014 and $169,000 in fiscal year 2015.		
Subd. 3. **Forecasted Programs**		
(a) **MFIP/DWP Grants**		
Appropriations by Fund		
2012		2013
General (69,000)		(3,769,000)
Federal TANF 69,000		3,764,000
(b) **MFIP Child Care Assistance Grants**	-0-	2,000
(c) **General Assistance Grants**	-0-	(41,000)

(d) **Minnesota Supplemental Aid Grants**	-0-	154,000
(e) **Group Residential Housing Grants**	-0-	(199,000)
(f) **MinnesotaCare Grants**	-0-	23,000

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants**	69,000	2,583,000

Continuing Care Provider Fiscal Year 2013 Payment Delay. The commissioner of human services shall delay the last payment or payments in fiscal year 2013 by up to $22,854,000 to the following service providers:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services, including consumer-directed community

supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) managed care organizations under Minnesota Statutes, section 256B.69, receiving state payments for services in clauses (1) to (10); and

(12) intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, section 256B.5012, subdivision 13.

In calculating the actual payment amounts to be delayed, the commissioner must reduce the $22,854,000 amount by any cash basis state share savings to be realized in fiscal

year 2013 from implementing the long-term care realignment waiver before July 1, 2013. The commissioner shall make the delayed payments in July 2013. Notwithstanding any contrary provisions in this article, this provision expires on August 1, 2013.

Critical Access Nursing Facilities Designation. $1,000,000 is appropriated in fiscal year 2013 from the general fund to the commissioner of human services for the purposes of critical access nursing facilities under Minnesota Statutes, section 256B.441, subdivision 63. This appropriation is ongoing and is added to the base.

Subd. 4. **Grant Programs**

(a) **Basic Sliding Fee Child Care Grants**	-0-	1,000

Base Level Adjustment. The general fund base is increased by $5,000 in fiscal years 2014 and 2015.

(b) **Disabilities Grants**	-0-	65,000

This appropriation is for living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689, article 2, section 251. This appropriation is ongoing and added to the general fund base.

Base Level Adjustment. The general fund base is increased by $411,000 in fiscal year 2014.

Sec. 3. **COMMISSIONER OF HEALTH**

Policy Quality and Compliance	-0-	(1,185,000)

	Appropriations by Fund	
	2012	2013
General	-0-	127,000
State Government Special Revenue	-0-	(1,449,000)
Health Care Access	-0-	137,000

In fiscal year 2013, $137,000 from the health care access fund is for a study of radiation therapy facilities capacity. This is a onetime appropriation.

In fiscal year 2015, the commissioner shall transfer from the general fund $59,000, including $40,000 for SEGIP activities to the commissioner of management and budget for actuarial and consulting services to support the Department of Commerce evaluation of mandated health benefits under Minnesota Statutes, section 62J.26, subdivision 6. This is a onetime transfer.

The general fund base is decreased by $105,000 in fiscal year 2014 and $46,000 in fiscal year 2015.

Sec. 4. **BOARD OF NURSING** **$** **-0-** **$** **149,000**

This appropriation is from the state government special revenue fund for the nurse licensure compact.

Base Level Adjustment. The state government special revenue fund base is decreased by $143,000 in fiscal years 2014 and 2015.

Sec. 5. **COMMISSIONER OF COMMERCE**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **1,727,000**

	Appropriations by Fund	
	2012	2013

General	-0-	60,000
State Government		
Special Revenue	-0-	1,449,000
Special Revenue	-0-	218,000

In fiscal year 2013, $8,000 from the general fund is for additional form review filings under Minnesota Statutes, section 62A.047. This is a onetime appropriation.

In fiscal year 2013, $22,000 from the general fund is for relocation costs related to the transfer of health maintenance organization regulatory activities. This is a onetime appropriation.

In fiscal year 2013, $30,000 from the general fund is for ongoing information technology expenses related to the transfer of health maintenance organization regulatory activities.

$1,449,000 from the state government special revenue fund is for health maintenance organization regulatory activities transferred from the Department of Health. This is an ongoing appropriation.

$218,000 from the special revenue fund is for expenses related to health maintenance organization regulatory activities for the interagency agreement with the Department of Human Services.

The general fund base is increased by $960,000 in fiscal years 2014 and 2015 for the evaluation of mandated health benefits under Minnesota Statutes, section 62J.26, subdivision 6. The base for this purpose beginning in fiscal year 2016 is $330,000.

Sec. 6. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ -0- $ 10,000**

This appropriation is to provide a grant to the Minnesota Ambulance Association to coordinate and prepare an assessment of the extent and costs of uncompensated care as a direct result of emergency responses on interstate highways in Minnesota. The study will collect appropriate information from medical response units and ambulance services regulated under Minnesota Statutes, chapter 144E, and to the extent possible, firefighting agencies. In preparing the assessment, the Minnesota Ambulance Association shall consult with its membership, the Minnesota Fire Chiefs Association, the Office of the State Fire Marshal, and the Emergency Medical Services Regulatory Board. The findings of the assessment will be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over health and public safety by January 1, 2013.

Sec. 7. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 8. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2012, unless a different effective date is explicit.

ARTICLE 7

CONTINGENT APPROPRIATIONS

Section 1. **APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2012, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2012	**2013**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$ 721,000**	**$ 21,153,000**
(a) **Operations**	118,000	11,000
In fiscal years 2012 and 2013 only, the commissioner shall transfer $11,000 to the commissioner of education for activities related to developing a plan for a residential campus for individuals with autism.		
Base Adjustment. The general fund base is reduced by $11,000 in fiscal years 2014 and 2015.		
(b) **Health Care**	24,000	(110,000)
Base Adjustment. The general fund base is increased by $110,000 in fiscal years 2014 and 2015.		
(c) **Continuing Care**	19,000	-0-
This is a onetime appropriation.		
(d) **Chemical and Mental Health**	19,000	68,000

Base Adjustment. The general fund base is decreased by $68,000 in fiscal years 2014 and 2015.

(e) **Medical Assistance Grants**	541,000	19,935,000
(f) **Aging and Adult Services Grants**	-0-	999,000

In fiscal year 2013, upon federal approval to implement the nursing facility level of care under Minnesota Statutes, section 144.0724, subdivision 11, $999,000 is for essential community supports grants. This is a onetime appropriation.

(g) **Disabilities Grants**	-0-	250,000

This is a onetime appropriation.

EFFECTIVE DATE. This section is effective upon receipt by the commissioner of money from managed care organizations pursuant to contract agreements to return any surplus in excess of one percent. If the money is received after June 30, 2012, amounts appropriated in fiscal year 2012 are available in fiscal year 2013.

Sec. 3. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

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

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

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

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

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

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

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

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

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

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

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

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

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

(e) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division, and the department shall immediately decrease the statewide licensed capacity for ~~the home~~ foster care settings where the physical location is not the primary residence of the license holder. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter. A needs determination process, managed at the state level, with county input, will determine where the reduced capacity will occur.

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

Sec. 4. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 275 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. This rate reduction is delayed until July 1, 2013. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

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

Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills

and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or traumatic brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home,

the vacated bed shall not be filled with another recipient of waiver services and group residential housing, unless provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), and the statewide licensed capacity shall be reduced accordingly. If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by June 30, ~~2012~~ 2013. The results of the assessments shall be used in the statewide needs determination process. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013.

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

Sec. 6. Minnesota Statutes 2011 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, ~~2013~~ 2012, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, ~~2013~~ 2012, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

Sec. 8. Minnesota Statutes 2011 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical

therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, ~~2013~~ 2012, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, ~~2013~~ 2012, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, anesthesia services, and hospice services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

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

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) **MFIP Child Care Assistance Grants**	55,456,000	30,923,000
(c) **General Assistance Grants**	49,192,000	46,938,000

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 $6,689,812 in fiscal year 2012 and $6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid Grants**	38,095,000	39,120,000
(e) **Group Residential Housing Grants**	121,080,000	129,238,000
(f) **MinnesotaCare Grants**	295,046,000	317,272,000

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants**	4,501,582,000	4,437,282,000

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~~ up to five percent for individuals

with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI. Lead agencies 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 and DD waivers and customized living settings for CADI.

Reduce customized living and 24-hour customized living component rates. Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the

commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental Disability Waiver. The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Limit Growth in the Community Alternatives for Disabled Individuals Waiver. The commissioner shall limit growth in the community alternatives for disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section

256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Personal Care Assistance Relative Care. The commissioner shall adjust the capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11. This rate reduction is delayed until July 1, 2013.

(h) **Alternative Care Grants**	46,421,000	46,035,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) **Chemical Dependency Entitlement Grants**	94,675,000	93,298,000

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

Sec. 10. **EMERGENCY MEDICAL ASSISTANCE STUDY.**

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

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

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

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

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

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

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

Sec. 11. **EMERGENCY MEDICAL CONDITION CANCER TREATMENT COVERAGE EXCEPTION.**

(a) Notwithstanding Minnesota Statutes, section 256B.06, subdivision 4, paragraph (h), clause (2), surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer shall be covered as an emergency medical condition under Minnesota Statutes, section 256B.06, paragraph (f), if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment.

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

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

Sec. 12. **INSTRUCTIONS TO THE COMMISSIONERS TO DEVELOP A PLAN FOR AN AUTISM RESIDENTIAL CAMPUS.**

(a) The commissioner of human services, in consultation with the commissioners of education and employment and economic development, shall develop a plan to create a residential campus providing 24-hour supervision for individuals with a diagnosis of autistic disorder as defined by diagnostic code 299.0 in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This plan must identify how the costs and programming will be shared between the agencies so that the social, educational, sensory, and vocational needs of the individuals served by the program will be met.

(b) The plan must be developed no later than August 31, 2012.

Sec. 13. **INSTRUCTIONS TO THE COMMISSIONER TO REQUEST A WAIVER AND CREATE AND FUND AN AUTISM RESIDENTIAL CAMPUS.**

(a) The commissioner of human services shall develop a proposal to the United States Department of Health and Human Services which shall include any necessary waivers, state plan amendments, and any other federal authority that may be necessary to create and fund the program in paragraph (b).

(b) The commissioner shall request authority to create and fund a residential campus program to serve individuals to age 21 who are diagnosed with autistic disorder as defined by diagnostic code 299.0 in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and who are able to live in a supported housing environment that provides 24-hour supervision. The program must:

(1) provide continuous on-site supervision;

(2) provide sensory or other therapeutic programming as appropriate for each resident; and

(3) incorporate independent living skills, socialization skills, and vocational skills, as appropriate for each resident.

(c) The commissioner shall submit the proposal no later than January 1, 2013.

Sec. 14. **STUDY OF PERSONAL CARE ASSISTANCE AND OTHER UNLICENSED ATTENDANT SERVICES PROCEDURES.**

The commissioner of human services shall assign the department's office of inspector general to evaluate and make recommendations regarding state policies and statutory directives to control improper billing and fraud in personal care attendant and other unlicensed attendant services reimbursed through the department. The evaluation must review:

(1) the care provided by personal care attendants, behavioral aides, and other unlicensed attendant care services reimbursed through the department;

(2) investigations completed in recent years by the department's surveillance and integrity review division and the attorney general's office Medicaid fraud control unit to determine patterns of improper billing and fraud;

(3) whether there are appropriate standards for an objective assessment or for determining a medical basis for client service eligibility; and

(4) current policies and other requirements related to supervision and verification of services to clients.

The study may involve unannounced site visits to enrolled providers and recipients of services in this study. The commissioner shall report to the chairs and ranking minority

members of the legislative committees with jurisdiction over these issues with draft legislation to implement these recommendations by February 15, 2013.

Sec. 15. **STUDY OF PERSONAL CARE ASSISTANCE SERVICE MODEL.**

The commissioner of human services shall study the current service model of personal care assistance services and any current gaps that exist in the program. The report shall include an analysis of the utilization of additional services by personal care assistance recipients, the effects of access to care coordination services, eligibility criteria, and the results of reductions in personal care assistance services. The results of this study will become part of medical assistance reform work under Minnesota Statutes, section 256B.021. The commissioner shall report the findings of this study to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by February 15, 2013.

APPENDIX
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