

1.1 CONFERENCE COMMITTEE REPORT ON S.F. No. 760

1.2 A bill for an act  
1.3 relating to state government; establishing the health and human services budget;  
1.4 modifying provisions related to continuing care, chemical and mental health,  
1.5 children and family services, human services licensing, health care programs,  
1.6 the Department of Health, and health licensing boards; appropriating money to  
1.7 the departments of health and human services and other health-related boards  
1.8 and councils; making forecast adjustments; requiring reports; imposing fees;  
1.9 imposing criminal penalties; amending Minnesota Statutes 2010, sections 8.31,  
1.10 subdivisions 1, 3a; 62E.14, by adding a subdivision; 62J.04, subdivision 3;  
1.11 62J.17, subdivision 4a; 62J.692, subdivisions 4, 7; 103I.005, subdivisions  
1.12 2, 8, 12, by adding a subdivision; 103I.101, subdivisions 2, 5; 103I.105;  
1.13 103I.111, subdivision 8; 103I.205, subdivision 4; 103I.208, subdivision 2;  
1.14 103I.501; 103I.531, subdivision 5; 103I.535, subdivision 6; 103I.641; 103I.711,  
1.15 subdivision 1; 103I.715, subdivision 2; 119B.011, subdivision 13; 119B.09,  
1.16 subdivision 10, by adding subdivisions; 119B.125, by adding a subdivision;  
1.17 119B.13, subdivisions 1, 1a, 7; 144.125, subdivisions 1, 3; 144.128; 144.396,  
1.18 subdivisions 5, 6; 145.925, subdivision 1; 145.928, subdivisions 7, 8; 148.108, by  
1.19 adding a subdivision; 148.191, subdivision 2; 148.212, subdivision 1; 148.231;  
1.20 151.07; 151.101; 151.102, by adding a subdivision; 151.12; 151.13, subdivision  
1.21 1; 151.19; 151.25; 151.47, subdivision 1; 151.48; 152.12, subdivision 3;  
1.22 245A.10, subdivisions 1, 3, 4, by adding subdivisions; 245A.11, subdivision  
1.23 2b; 245A.143, subdivision 1; 245C.10, by adding a subdivision; 254B.03,  
1.24 subdivision 4; 254B.04, by adding a subdivision; 254B.06, subdivision 2; 256.01,  
1.25 subdivisions 14, 24, 29, by adding a subdivision; 256.969, subdivision 2b;  
1.26 256B.04, subdivision 18; 256B.056, subdivisions 1a, 3; 256B.057, subdivision  
1.27 9; 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8b, 8c, 12, 13e,  
1.28 17, 17a, 18, 19a, 25, 31a, by adding subdivisions; 256B.0651, subdivision 1;  
1.29 256B.0652, subdivision 6; 256B.0653, subdivisions 2, 6; 256B.0911, subdivision  
1.30 3a; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 6,  
1.31 10; 256B.14, by adding a subdivision; 256B.431, subdivisions 2r, 32, 42, by  
1.32 adding a subdivision; 256B.437, subdivision 6; 256B.441, subdivisions 50a,  
1.33 59; 256B.48, subdivision 1; 256B.49, subdivision 16a; 256B.69, subdivisions  
1.34 4, 5a, by adding a subdivision; 256B.76, subdivision 4; 256D.02, subdivision  
1.35 12a; 256D.031, subdivisions 6, 7, 9; 256D.44, subdivision 5; 256D.47; 256D.49,  
1.36 subdivision 3; 256E.30, subdivision 2; 256E.35, subdivisions 5, 6; 256J.12,  
1.37 subdivisions 1a, 2; 256J.37, by adding a subdivision; 256J.38, subdivision 1;  
1.38 256L.04, subdivision 7; 256L.05, by adding a subdivision; 256L.11, subdivision  
1.39 7; 256L.12, subdivision 9; 297F.10, subdivision 1; 393.07, subdivision 10;  
1.40 402A.10, subdivisions 4, 5; 402A.15; 518A.51; Laws 2008, chapter 363, article  
1.41 18, section 3, subdivision 5; Laws 2010, First Special Session chapter 1, article  
1.42 15, section 3, subdivision 6; article 25, section 3, subdivision 6; proposing  
1.43 coding for new law in Minnesota Statutes, chapters 1; 145; 148; 151; 214; 256;

2.1 256B; 256L; proposing coding for new law as Minnesota Statutes, chapter  
2.2 256N; repealing Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a,  
2.3 6a, 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 103I.005,  
2.4 subdivision 20; 144.1464; 144.147; 144.1487; 144.1488, subdivisions 1, 3,  
2.5 4; 144.1489; 144.1490; 144.1491; 144.1499; 144.1501; 144.6062; 145.925;  
2.6 145A.14, subdivisions 1, 2a; 245A.10, subdivision 5; 256.979, subdivisions  
2.7 5, 6, 7, 10; 256.9791; 256B.055, subdivision 15; 256B.0625, subdivision 8e;  
2.8 256B.0653, subdivision 5; 256B.0756; 256D.01, subdivisions 1, 1a, 1b, 1e,  
2.9 2; 256D.03, subdivisions 1, 2, 2a; 256D.031, subdivisions 5, 8; 256D.05,  
2.10 subdivisions 1, 2, 4, 5, 6, 7, 8; 256D.0513; 256D.053, subdivisions 1, 2, 3;  
2.11 256D.06, subdivisions 1, 1b, 2, 5, 7, 8; 256D.09, subdivisions 1, 2, 2a, 2b, 5, 6;  
2.12 256D.10; 256D.13; 256D.15; 256D.16; 256D.35, subdivision 8b; 256D.46; Laws  
2.13 2010, First Special Session chapter 1, article 16, sections 6; 7; Minnesota Rules,  
2.14 parts 3400.0130, subpart 8; 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,  
2.15 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, 23; 4651.0110, subparts 2, 2a, 3, 4, 5;  
2.16 4651.0120; 4651.0130; 4651.0140; 4651.0150; 9500.1243, subpart 3.

May 17, 2011

2.17  
2.18 The Honorable Michelle L. Fischbach  
2.19 President of the Senate

2.20 The Honorable Kurt Zellers  
2.21 Speaker of the House of Representatives

2.22 We, the undersigned conferees for S.F. No. 760 report that we have agreed upon the  
2.23 items in dispute and recommend as follows:

2.24 That the House recede from its amendments and that S.F. No. 760 be further  
2.25 amended as follows:

2.26 Delete everything after the enacting clause and insert:

## 2.27 "ARTICLE 1

### 2.28 CHILDREN AND FAMILY SERVICES

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

2.31 Subd. 13. **Family.** "Family" means parents, stepparents, guardians and their spouses,  
2.32 or other eligible relative caregivers and their spouses, and their blood related dependent  
2.33 children and adoptive siblings under the age of 18 years living in the same home including  
2.34 children temporarily absent from the household in settings such as schools, foster care, and  
2.35 residential treatment facilities or parents, stepparents, guardians and their spouses, or other  
2.36 relative caregivers and their spouses temporarily absent from the household in settings  
2.37 such as schools, military service, or rehabilitation programs. An adult family member who  
2.38 is not in an authorized activity under this chapter may be temporarily absent for up to 60  
2.39 days. When a minor parent or parents and his, her, or their child or children are living with  
2.40 other relatives, and the minor parent or parents apply for a child care subsidy, "family"  
2.41 means only the minor parent or parents and their child or children. An adult age 18 or  
2.42 older who meets this definition of family and is a full-time high school or postsecondary

3.1 student may be considered a dependent member of the family unit if 50 percent or more of  
3.2 the adult's support is provided by the parents, stepparents, guardians, and their spouses or  
3.3 eligible relative caregivers and their spouses residing in the same household.

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

3.5 Sec. 2. Minnesota Statutes 2010, section 119B.035, subdivision 4, is amended to read:

3.6 Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of  
3.7 assistance under subdivision 2. The maximum rate of assistance is equal to ~~90~~ 68 percent  
3.8 of the rate established under section 119B.13 for care of infants in licensed family child  
3.9 care in the applicant's county of residence.

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

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

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

3.17 **EFFECTIVE DATE.** This section is effective October 31, 2011.

3.18 Sec. 3. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision  
3.19 to read:

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

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

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

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

3.29 (c) If a child care provider satisfies the requirements for payment under paragraph  
3.30 (b), but the percentage of qualifying children under paragraph (a) for whom the provider  
3.31 is providing care falls below 50 percent, the provider shall have four weeks to raise the  
3.32 percentage of qualifying children for whom the provider is providing care to at least 50

4.1 percent before payments to the provider are discontinued for child care services provided  
4.2 for a child who is not a qualifying child.

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

4.4 Sec. 4. Minnesota Statutes 2010, section 119B.09, subdivision 10, is amended to read:

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

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

4.13 Sec. 5. Minnesota Statutes 2010, section 119B.09, is amended by adding a subdivision  
4.14 to read:

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

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

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

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

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

4.26 Sec. 6. Minnesota Statutes 2010, section 119B.125, is amended by adding a subdivision  
4.27 to read:

4.28 Subd. 1b. **Training required.** (a) Effective November 1, 2011, prior to initial  
4.29 authorization as required in subdivision 1, a legal nonlicensed family child care provider  
4.30 must complete first aid and CPR training and provide the verification of first aid and CPR  
4.31 training to the county. The training documentation must have valid effective dates as of

5.1 the date the registration request is submitted to the county and the training must have been  
5.2 provided by an individual approved to provide first aid and CPR instruction.

5.3 (b) Legal nonlicensed family child care providers with an authorization effective  
5.4 before November 1, 2011, must be notified of the requirements before October 1, 2011, or  
5.5 at authorization, and must meet the requirements upon renewal of an authorization that  
5.6 occurs on or after January 1, 2012.

5.7 (c) Upon each reauthorization after the authorization period when the initial first aid  
5.8 and CPR training requirements are met, a legal nonlicensed family child care provider  
5.9 must provide verification of at least eight hours of additional training listed in the  
5.10 Minnesota Center for Professional Development Registry.

5.11 (d) This subdivision only applies to legal nonlicensed family child care providers.

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

5.13 Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~July 1, 2006~~ October 31, 2011,  
5.14 the maximum rate paid for child care assistance in any county or multicounty region under  
5.15 the child care fund shall be the rate for like-care arrangements in the county effective  
5.16 ~~January~~ July 1, 2006, ~~increased~~ decreased by ~~six~~ five percent.

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

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

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

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

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

5.34 ~~(e)~~ (d) The department shall monitor the effect of this paragraph on provider rates.  
5.35 The county shall pay the provider's full charges for every child in care up to the maximum

6.1 established. The commissioner shall determine the maximum rate for each type of care  
6.2 on an hourly, full-day, and weekly basis, including special needs and disability care. The  
6.3 maximum payment to a provider for one day of care must not exceed the daily rate. The  
6.4 maximum payment to a provider for one week of care must not exceed the weekly rate.

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

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

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

6.13 **EFFECTIVE DATE.** Paragraph (d) is effective April 16, 2012. Paragraph (e)  
6.14 is effective September 3, 2012.

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

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

6.19 (b) The maximum rate paid to legal nonlicensed family child care providers must be  
6.20 ~~80~~ 68 percent of the county maximum hourly rate for licensed family child care providers.  
6.21 In counties where the maximum hourly rate for licensed family child care providers is  
6.22 higher than the maximum weekly rate for those providers divided by 50, the maximum  
6.23 hourly rate that may be paid to legal nonlicensed family child care providers is the rate  
6.24 equal to the maximum weekly rate for licensed family child care providers divided by 50  
6.25 and then multiplied by ~~0.80~~ 0.68. The maximum payment to a provider for one day of care  
6.26 must not exceed the maximum hourly rate times ten. The maximum payment to a provider  
6.27 for one week of care must not exceed the maximum hourly rate times 50.

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

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

6.32 **EFFECTIVE DATE.** This section is effective April 16, 2012, except the  
6.33 amendment changing 80 to 68 and 0.80 to 0.68 is effective October 31, 2011.

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

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

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

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

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

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

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

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

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

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

8.28 **Subd. 3. Prohibited purchases.** EBT debit cardholders in programs listed under  
8.29 subdivision 1 are prohibited from using the EBT debit card to purchase tobacco products  
8.30 and alcoholic beverages, as defined in section 340A.101, subdivision 2. It is unlawful for  
8.31 an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic  
8.32 beverages with the cardholder's EBT card. Violation of this subdivision is a petty  
8.33 misdemeanor. A retailer must not be held liable for the crime of another under section  
8.34 609.05, for actions taken under this subdivision.



9.1 **EFFECTIVE DATE.** Subdivisions 1 and 2 of this section are effective June 1, 2012.

9.2 Sec. 11. Minnesota Statutes 2010, section 256D.02, subdivision 12a, is amended to  
9.3 read:

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

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

9.12 (1) by showing that the applicant maintains a residence at a verified address, other  
9.13 than a place of public accommodation. An applicant may verify a residence address by  
9.14 presenting a valid state driver's license<sub>2</sub>; a state identification card<sub>2</sub>; a voter registration  
9.15 card<sub>2</sub>; a rent receipt<sub>2</sub>; a statement by the landlord, apartment manager, or homeowner  
9.16 verifying that the individual is residing at the address<sub>2</sub>; or other form of verification  
9.17 approved by the commissioner; or

9.18 (2) by verifying residence according to Minnesota Rules, part 9500.1219, subpart  
9.19 3, item C.

9.20 (c) For general assistance medical care, a county agency shall waive the 30-day  
9.21 residency requirement in cases of medical emergencies. ~~For general assistance, a county~~  
9.22 ~~shall waive the 30-day residency requirement where unusual hardship would result from~~  
9.23 ~~denial of general assistance. For purposes of this subdivision, "unusual hardship" means~~  
9.24 ~~the applicant is without shelter or is without available resources for food.~~

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

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

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

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

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

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

10.12            Sec. 12. Minnesota Statutes 2010, section 256D.05, subdivision 1, is amended to read:

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

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

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

10.23            ~~(3)~~ (2) a person who has been placed in, and is residing in, a licensed or certified  
10.24 facility for purposes of physical or mental health or rehabilitation, or in an approved  
10.25 chemical dependency domiciliary facility, if the placement is based on illness or incapacity  
10.26 and is according to a plan developed or approved by the county agency through its  
10.27 director or designated representative;

10.28            ~~(4)~~ (3) a person who resides in a shelter facility described in subdivision 3;

10.29            ~~(5)~~ (4) a person not described in clause (1) or ~~(3)~~ (2) who is diagnosed by a licensed  
10.30 physician, psychological practitioner, or other qualified professional, as developmentally  
10.31 disabled or mentally ill, and that condition prevents the person from obtaining or retaining  
10.32 employment;

10.33            ~~(6) a person who has an application pending for, or is appealing termination of~~  
10.34 ~~benefits from, the Social Security disability program or the program of supplemental~~  
10.35 ~~security income for the aged, blind, and disabled, provided the person has a professionally~~

11.1 ~~certified permanent or temporary illness, injury, or incapacity which is expected to~~  
11.2 ~~continue for more than 30 days and which prevents the person from obtaining or retaining~~  
11.3 ~~employment;~~

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

11.6 ~~(8)~~ (5) a person who has been assessed by a vocational specialist and, in consultation  
11.7 with the county agency, has been determined to be unemployable for purposes of this  
11.8 clause; a person is considered employable if there exist positions of employment in the  
11.9 local labor market, regardless of the current availability of openings for those positions,  
11.10 that the person is capable of performing. The person's eligibility under this category must  
11.11 be reassessed at least annually. The county agency must provide notice to the person not  
11.12 later than 30 days before annual eligibility under this item ends, informing the person of the  
11.13 date annual eligibility will end and the need for vocational assessment if the person wishes  
11.14 to continue eligibility under this clause. For purposes of establishing eligibility under this  
11.15 clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

11.16 ~~(9)~~ (6) a person who is determined by the county agency, according to permanent  
11.17 rules adopted by the commissioner, to ~~be learning disabled~~ have a condition that qualifies  
11.18 under Minnesota's special education rules as a specific learning disability, provided that ~~if~~  
11.19 a rehabilitation plan for the person is developed or approved by the county agency, and  
11.20 the person is following the plan;

11.21 ~~(10)~~ (7) a child under the age of 18 who is not living with a parent, stepparent, or  
11.22 legal custodian, and only if: the child is legally emancipated or living with an adult with  
11.23 the consent of an agency acting as a legal custodian; the child is at least 16 years of age  
11.24 and the general assistance grant is approved by the director of the county agency or a  
11.25 designated representative as a component of a social services case plan for the child; or the  
11.26 child is living with an adult with the consent of the child's legal custodian and the county  
11.27 agency. For purposes of this clause, "legally emancipated" means a person under the age  
11.28 of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of  
11.29 the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv)  
11.30 is otherwise considered emancipated under Minnesota law, and for whom county social  
11.31 services has not determined that a social services case plan is necessary, for reasons other  
11.32 than the child has failed or refuses to cooperate with the county agency in developing  
11.33 the plan;

11.34 ~~(11)~~ (8) a person who is eligible for displaced homemaker services, programs, or  
11.35 assistance under section 116L.96, but only if that person is enrolled as a full-time student;

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

12.3 ~~(13)~~ (9) a person who is involved with protective or court-ordered services that  
12.4 prevent the applicant or recipient from working at least four hours per day; or

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

12.7 ~~(15)~~ (10) a person whose alcohol and drug addiction is a material factor that  
12.8 contributes to the person's disability; applicants who assert this clause as a basis for  
12.9 eligibility must be assessed by the county agency to determine if they are amenable  
12.10 to treatment; if the applicant is determined to be not amenable to treatment, but is  
12.11 otherwise eligible for benefits, then general assistance must be paid in vendor form, for  
12.12 the individual's shelter costs up to the limit of the grant amount, with the residual, if  
12.13 any, paid according to section 256D.09, subdivision 2a; if the applicant is determined  
12.14 to be amenable to treatment, then in order to receive benefits, the applicant must be in  
12.15 a treatment program or on a waiting list and the benefits must be paid in vendor form,  
12.16 for the individual's shelter costs, up to the limit of the grant amount, with the residual, if  
12.17 any, paid according to section 256D.09, subdivision 2a.

12.18 (b) As a condition of eligibility under paragraph (a), clauses ~~(1)~~, ~~(3)~~ (2), ~~(5)~~ (4),  
12.19 ~~(8)~~ (5), and ~~(9)~~ (6), the recipient must complete an interim assistance agreement and  
12.20 must apply for other maintenance benefits as specified in section 256D.06, subdivision  
12.21 5, and must comply with efforts to determine the recipient's eligibility for those other  
12.22 maintenance benefits.

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

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

12.30 Sec. 13. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:

12.31 Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a  
12.32 grant of emergency general assistance shall, to the extent funds are available, be made to  
12.33 an eligible single adult, married couple, or family for an emergency need, ~~as defined in~~  
12.34 ~~rules promulgated by the commissioner,~~ where the recipient requests temporary assistance  
12.35 not exceeding 30 days if an emergency situation appears to exist ~~and the individual or~~

13.1 ~~family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP under~~  
13.2 ~~written criteria adopted by the county agency.~~ If an applicant or recipient relates facts  
13.3 to the county agency which may be sufficient to constitute an emergency situation, the  
13.4 county agency shall, to the extent funds are available, advise the person of the procedure  
13.5 for applying for assistance according to this subdivision.

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

13.10 (c) Funding for an emergency general assistance program is limited to the  
13.11 appropriation. Each fiscal year, the commissioner shall allocate to counties the money  
13.12 appropriated for emergency general assistance grants based on each county agency's  
13.13 average share of state's emergency general expenditures for the immediate past three fiscal  
13.14 years as determined by the commissioner, and may reallocate any unspent amounts to  
13.15 other counties. No county shall be allocated less than \$1,000 for a fiscal year.

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

13.18 **EFFECTIVE DATE.** This section is effective November 1, 2011.

13.19 Sec. 14. Minnesota Statutes 2010, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.13 ~~(c) A fee for guardian or conservator service is allowed at a reasonable rate~~  
14.14 ~~negotiated by the county or approved by the court. This rate shall not exceed five percent~~  
14.15 ~~of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the~~  
14.16 ~~guardian or conservator is a member of the county agency staff, no fee is allowed.~~

14.17 ~~(d) The county agency shall continue to pay a monthly allowance of \$68 for~~  
14.18 ~~restaurant meals for a person who was receiving a restaurant meal allowance on June 1,~~  
14.19 ~~1990, and who eats two or more meals in a restaurant daily. The allowance must continue~~  
14.20 ~~until the person has not received Minnesota supplemental aid for one full calendar month~~  
14.21 ~~or until the person's living arrangement changes and the person no longer meets the criteria~~  
14.22 ~~for the restaurant meal allowance, whichever occurs first.~~

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

14.28 ~~(f) (a)(1) Notwithstanding the language in this subdivision,~~ An amount equal to the  
14.29 maximum allotment authorized by the federal Food Stamp Program for a single individual  
14.30 which is in effect on the first day of July of each year will be added to the standards of  
14.31 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify  
14.32 as shelter needy and are: (i) relocating from an institution, or an adult mental health  
14.33 residential treatment program under section 256B.0622; (ii) eligible for the self-directed  
14.34 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and  
14.35 community-based waiver recipients living in their own home or rented or leased apartment

15.1 which is not owned, operated, or controlled by a provider of service not related by blood  
15.2 or marriage, unless allowed under paragraph ~~(g)~~ (b).

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

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

15.14 ~~(g) Notwithstanding this subdivision, (b)~~ To access housing and services as provided  
15.15 in paragraph ~~(f)~~ (a), the recipient may choose housing that may be owned, operated, or  
15.16 controlled by the recipient's service provider. In a multifamily building of four or more  
15.17 units, the maximum number of apartments that may be used by recipients of this program  
15.18 shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012.

15.19 **EFFECTIVE DATE.** This section is effective August 1, 2011.

15.20 Sec. 15. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

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

15.28 **EFFECTIVE DATE.** This section is effective November 1, 2011.

15.29 Sec. 16. Minnesota Statutes 2010, section 256D.47, is amended to read:

15.30 **256D.47 PAYMENT METHODS.**

15.31 Minnesota supplemental aid payments must be issued to the recipient, a protective  
15.32 payee, or a conservator or guardian of the recipient's estate in the form of county warrants  
15.33 immediately redeemable in cash, electronic benefits transfer, or by direct deposit into the

16.1 recipient's account in a financial institution. Minnesota supplemental aid payments must  
16.2 be issued regularly on the first day of the month. The supplemental aid warrants must be  
16.3 mailed only to the address at which the recipient resides, unless another address has been  
16.4 approved in advance by the county agency. Vendor payments must not be issued by the  
16.5 county agency except for nonrecurring emergency need payments; at the request of the  
16.6 recipient; ~~for special needs, other than special diets;~~ or when the agency determines the  
16.7 need for protective payments exist.

16.8 **EFFECTIVE DATE.** This section is effective August 1, 2011.

16.9 Sec. 17. Minnesota Statutes 2010, section 256E.35, subdivision 5, is amended to read:

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

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

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

16.20 Sec. 18. Minnesota Statutes 2010, section 256E.35, subdivision 6, is amended to read:

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

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

16.30 ~~(1) from state grant and TANF funds a matching contribution of \$1.50 for every \$1~~  
16.31 ~~of funds withdrawn from the family asset account equal to the lesser of \$720 per year or a~~  
16.32 ~~\$3,000 lifetime limit; and~~



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

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

17.6 Sec. 19. Minnesota Statutes 2010, section 256I.03, is amended by adding a subdivision  
17.7 to read:

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

17.13 Sec. 20. Minnesota Statutes 2010, section 256I.04, subdivision 1, is amended to read:

17.14 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for  
17.15 and entitled to a group residential housing payment to be made on the individual's behalf  
17.16 if the county agency has approved the individual's residence in a group residential housing  
17.17 setting and the individual meets the requirements in ~~paragraph (a) or (b)~~ this section.

17.18 (a) The individual is aged, blind, or is over 18 years of age and disabled as  
17.19 determined under the criteria used by the title II program of the Social Security Act,  
17.20 and meets the resource restrictions and standards of the supplemental security income  
17.21 program, and the individual's countable income after deducting the (1) exclusions and  
17.22 disregards of the SSI program, (2) the medical assistance personal needs allowance  
17.23 under section 256B.35, and (3) an amount equal to the income actually made available  
17.24 to a community spouse by an elderly waiver recipient under the provisions of sections  
17.25 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the  
17.26 monthly rate specified in the county agency's agreement with the provider of group  
17.27 residential housing in which the individual resides.

17.28 ~~(b) The individual meets a category of eligibility under section 256D.05, subdivision~~  
17.29 ~~1, paragraph (a), and the individual's resources are less than the standards specified by~~  
17.30 ~~section 256D.08, and the individual's countable income as determined under sections~~  
17.31 ~~256D.01 to 256D.21, less the medical assistance personal needs allowance under section~~  
17.32 ~~256B.35 is less than the monthly rate specified in the county agency's agreement with the~~  
17.33 ~~provider of group residential housing in which the individual resides.~~

18.1 (b) Each individual with income and resources less than the standard of assistance  
18.2 established by the commissioner and who is a resident of the state shall be eligible for and  
18.3 entitled to group residential housing if the assistance unit is:

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

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

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

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

18.26 (5) a person who is determined by the county agency, according to permanent rules  
18.27 adopted by the commissioner, to have a condition that qualifies under Minnesota's special  
18.28 education rules as a specific learning disability, provided that a rehabilitation plan for  
18.29 the person is developed or approved by the county agency, and the person is following  
18.30 the plan; or

18.31 (6) a person whose alcohol and drug addiction is a material factor that contributes  
18.32 to the person's disability.

18.33 (c) As a condition of eligibility under paragraph (b), the recipient must complete an  
18.34 interim assistance agreement and must apply for other maintenance benefits as specified in  
18.35 section 256N.35, and must comply with efforts to determine the recipient's eligibility for  
18.36 those other maintenance benefits.

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

19.8 (e) The burden of providing documentation for a county agency to use to verify  
19.9 eligibility under this section is upon the applicant or recipient. The county agency shall  
19.10 use documents already in its possession to verify eligibility, and shall help the applicant or  
19.11 recipient obtain other existing verification necessary to determine eligibility which the  
19.12 applicant or recipient does not have and is unable to obtain.

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

19.14 Sec. 21. Minnesota Statutes 2010, section 256I.04, subdivision 2b, is amended to read:

19.15 Subd. 2b. **Group residential housing agreements.** (a) Agreements between county  
19.16 agencies and providers of group residential housing must be in writing and must specify  
19.17 the name and address under which the establishment subject to the agreement does  
19.18 business and under which the establishment, or service provider, if different from the  
19.19 group residential housing establishment, is licensed by the Department of Health or the  
19.20 Department of Human Services; the specific license or registration from the Department  
19.21 of Health or the Department of Human Services held by the provider and the number  
19.22 of beds subject to that license; the address of the location or locations at which group  
19.23 residential housing is provided under this agreement; the per diem and monthly rates that  
19.24 are to be paid from group residential housing funds for each eligible resident at each  
19.25 location; the number of beds at each location which are subject to the group residential  
19.26 housing agreement; whether the license holder is a not-for-profit corporation under section  
19.27 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to  
19.28 the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.  
19.29 Group residential housing agreements may be terminated with or without cause by either  
19.30 the county or the provider with two calendar months prior notice.

19.31 (b) Counties must not enter into agreements with providers of group residential  
19.32 housing that are licensed as board and lodging with special services and that do not include  
19.33 a residency requirement of at least 20 hours per month of volunteer or paid work. A person  
19.34 who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a  
19.35 professionally certified illness, injury, disability, or incapacity must not be made ineligible

20.1 for group residential housing under this section. This paragraph does not apply to group  
20.2 residential housing providers who serve people aged 21 or younger if the residents are  
20.3 required to attend school or improve independent living skills.

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

20.5 Sec. 22. Minnesota Statutes 2010, section 256I.05, subdivision 1a, is amended to read:

20.6 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section  
20.7 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37  
20.8 for other services necessary to provide room and board provided by the group residence  
20.9 if the residence is licensed by or registered by the Department of Health, or licensed by  
20.10 the Department of Human Services to provide services in addition to room and board,  
20.11 and if the provider of services is not also concurrently receiving funding for services for  
20.12 a recipient under a home and community-based waiver under title XIX of the Social  
20.13 Security Act; or funding from the medical assistance program under section 256B.0659,  
20.14 for personal care services for residents in the setting; or residing in a setting which  
20.15 receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is  
20.16 available for other necessary services through a home and community-based waiver, or  
20.17 personal care services under section 256B.0659, then the GRH rate is limited to the rate  
20.18 set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary  
20.19 service rate exceed \$426.37. The registration and licensure requirement does not apply to  
20.20 establishments which are exempt from state licensure because they are located on Indian  
20.21 reservations and for which the tribe has prescribed health and safety requirements. Service  
20.22 payments under this section may be prohibited under rules to prevent the supplanting of  
20.23 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining  
20.24 the approval of the Secretary of Health and Human Services to provide home and  
20.25 community-based waiver services under title XIX of the Social Security Act for residents  
20.26 who are not eligible for an existing home and community-based waiver due to a primary  
20.27 diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is  
20.28 determined to be cost-effective.

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

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

21.3 (d) Counties must not negotiate supplementary service rates with providers of group  
21.4 residential housing that are licensed as board and lodging with special services and that  
21.5 do not encourage a policy of sobriety on their premises.

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

21.7 Sec. 23. Minnesota Statutes 2010, section 256J.12, subdivision 1a, is amended to read:

21.8 Subd. 1a. ~~30-day~~ 60-day **residency requirement.** An assistance unit is considered  
21.9 to have established residency in this state only when a child or caregiver has resided in this  
21.10 state for at least ~~30~~ 60 consecutive days with the intention of making the person's home  
21.11 here and not for any temporary purpose. The birth of a child in Minnesota to a member  
21.12 of the assistance unit does not automatically establish the residency in this state under  
21.13 this subdivision of the other members of the assistance unit. Time spent in a shelter for  
21.14 battered women shall count toward satisfying the ~~30-day~~ 60-day residency requirement.

21.15 Sec. 24. Minnesota Statutes 2010, section 256J.12, subdivision 2, is amended to read:

21.16 Subd. 2. **Exceptions.** (a) ~~A county shall waive the 30-day residency requirement~~  
21.17 ~~where unusual hardship would result from denial of assistance.~~

21.18 ~~(b) For purposes of this section, unusual hardship means an assistance unit:~~

21.19 ~~(1) is without alternative shelter; or~~

21.20 ~~(2) is without available resources for food.~~

21.21 ~~(c) For purposes of this subdivision, the following definitions apply (1) "metropolitan~~  
21.22 ~~statistical area" is as defined by the U.S. Census Bureau; (2) "alternative shelter" includes~~  
21.23 ~~any shelter that is located within the metropolitan statistical area containing the county and~~  
21.24 ~~for which the family is eligible, provided the assistance unit does not have to travel more~~  
21.25 ~~than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2)~~  
21.26 ~~does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.~~

21.27 ~~(d)~~ Applicants are considered to meet the residency requirement under subdivision  
21.28 1a if they once resided in Minnesota and:

21.29 (1) joined the United States armed services, returned to Minnesota within 30 days of  
21.30 leaving the armed services, and intend to remain in Minnesota; or

21.31 (2) left to attend school in another state, paid nonresident tuition or Minnesota  
21.32 tuition rates under a reciprocity agreement, and returned to Minnesota within 30 days of  
21.33 graduation with the intent to remain in Minnesota.

21.34 ~~(e)~~ (b) The ~~30-day~~ 60-day residence requirement is met when:

22.1 (1) a minor child or a minor caregiver moves from another state to the residence of  
22.2 a relative caregiver; and

22.3 (2) the relative caregiver has resided in Minnesota for at least ~~30~~ 60 consecutive  
22.4 days and:

22.5 (i) the minor caregiver applies for and receives MFIP; or

22.6 (ii) the relative caregiver applies for assistance for the minor child but does not  
22.7 choose to be a member of the MFIP assistance unit.

22.8 Sec. 25. Minnesota Statutes 2010, section 256J.20, subdivision 3, is amended to read:

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

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

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

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

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

22.33 (4) the value of personal property needed to produce earned income, including  
22.34 tools, implements, farm animals, inventory, business loans, business checking and  
22.35 savings accounts used at least annually and used exclusively for the operation of a

23.1 self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use  
23.2 is to produce income and if the vehicles are essential for the self-employment business;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24.1 **EFFECTIVE DATE.** This section is effective October 1, 2011.

24.2 Sec. 26. Minnesota Statutes 2010, section 256J.37, is amended by adding a subdivision  
24.3 to read:

24.4 Subd. 3c. **Treatment of Supplemental Security Income.** The county shall reduce  
24.5 the cash portion of the MFIP grant by \$50 per adult SSI recipient who resides in the  
24.6 household, and who would otherwise be included in the MFIP assistance unit under  
24.7 section 256J.24, subdivision 2, but is excluded solely due to the SSI recipient status under  
24.8 section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives less  
24.9 than \$50 of SSI, only the amount received shall be used in calculating the MFIP cash  
24.10 assistance payment. This provision does not apply to relative caregivers who could elect  
24.11 to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the  
24.12 caregiver's children or stepchildren are included in the MFIP assistance unit.

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

24.14 Sec. 27. Minnesota Statutes 2010, section 256J.49, subdivision 13, is amended to read:

24.15 Subd. 13. **Work activity.** (a) "Work activity" means any activity in a participant's  
24.16 approved employment plan that leads to employment. For purposes of the MFIP program,  
24.17 this includes activities that meet the definition of work activity under the participation  
24.18 requirements of TANF. Work activity includes:

24.19 (1) unsubsidized employment, including work study and paid apprenticeships or  
24.20 internships;

24.21 (2) subsidized private sector or public sector employment, including grant diversion  
24.22 as specified in section 256J.69, on-the-job training as specified in section 256J.66, paid  
24.23 work experience, and supported work when a wage subsidy is provided;

24.24 (3) unpaid work experience, including community service, volunteer work,  
24.25 the community work experience program as specified in section 256J.67, unpaid  
24.26 apprenticeships or internships, and supported work when a wage subsidy is not provided.  
24.27 Unpaid work experience is only an option if the participant has been unable to obtain or  
24.28 maintain paid employment in the competitive labor market, and no paid work experience  
24.29 programs are available to the participant. Prior to placing a participant in unpaid work,  
24.30 the county must inform the participant that the participant will be notified if a paid work  
24.31 experience or supported work position becomes available. Unless a participant consents in  
24.32 writing to participate in unpaid work experience, the participant's employment plan may  
24.33 only include unpaid work experience if including the unpaid work experience in the plan  
24.34 will meet the following criteria:



25.1 (i) the unpaid work experience will provide the participant specific skills or  
25.2 experience that cannot be obtained through other work activity options where the  
25.3 participant resides or is willing to reside; and

25.4 (ii) the skills or experience gained through the unpaid work experience will result  
25.5 in higher wages for the participant than the participant could earn without the unpaid  
25.6 work experience;

25.7 (4) job search including job readiness assistance, job clubs, job placement,  
25.8 job-related counseling, and job retention services;

25.9 (5) job readiness education, including English as a second language (ESL) or  
25.10 functional work literacy classes as limited by the provisions of section 256J.531,  
25.11 subdivision 2, general educational development (GED) course work, high school  
25.12 completion, and adult basic education as limited by the provisions of section 256J.531,  
25.13 subdivision 1;

25.14 (6) job skills training directly related to employment, including education and  
25.15 training that can reasonably be expected to lead to employment, as limited by the  
25.16 provisions of section 256J.53;

25.17 (7) providing child care services to a participant who is working in a community  
25.18 service program;

25.19 (8) activities included in the employment plan that is developed under section  
25.20 256J.521, subdivision 3; and

25.21 (9) preemployment activities including chemical and mental health assessments,  
25.22 treatment, and services; learning disabilities services; child protective services; family  
25.23 stabilization services; or other programs designed to enhance employability.

25.24 (b) "Work activity" does not include activities done for political purposes as defined  
25.25 in section 211B.01, subdivision 6.

25.26 Sec. 28. Minnesota Statutes 2010, section 256J.53, subdivision 2, is amended to read:

25.27 Subd. 2. **Approval of postsecondary education or training.** (a) In order for a  
25.28 postsecondary education or training program to be an approved activity in an employment  
25.29 plan, the ~~plan must include additional work activities if the education and training~~  
25.30 ~~activities do not meet the minimum hours required to meet the federal work participation~~  
25.31 ~~rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35~~ participant  
25.32 must be working in unsubsidized employment at least 10 hours per week.

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

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

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

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

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

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

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

26.12 Sec. 29. **[256N.10] ADULT ASSISTANCE GRANT PROGRAM.**

26.13 The adult assistance grant program is a capped allocation to counties that can be  
26.14 spent in a flexible manner, to the extent funds are available, for adult assistance.

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

26.16 Sec. 30. **[256N.20] DEFINITIONS.**

26.17 Subdivision 1. **Scope.** For the purposes of sections 256N.01 to 256N.80, the terms  
26.18 defined in this section have the meanings given them.

26.19 Subd. 2. **Adult assistance.** "Adult assistance" means a capped allocation provided  
26.20 or arranged for by county boards for ongoing emergency needs, special diets, or special  
26.21 needs as determined by the county.

26.22 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human  
26.23 services.

26.24 Subd. 4. **County board.** "County board" means the board of county commissioners  
26.25 in each county.

26.26 Subd. 5. **Eligible participant.** "Eligible participant" means low-income adults who  
26.27 meet the residency requirements under section 256N.22, and who were previously eligible  
26.28 for programs under subdivision 6 are eligible for adult assistance. The commissioner may  
26.29 develop more specific eligibility criteria.

26.30 Subd. 6. **Former programs.** "Former programs" means funding for:

26.31 (1) general assistance;

26.32 (2) emergency general assistance;

26.33 (3) emergency supplemental aid; and

26.34 (4) Minnesota supplemental aid special needs and special diets.

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

27.2 Sec. 31. **[256N.22] RESIDENCY.**

27.3 (a) For purposes of eligibility for adult assistance, a person must be a resident of  
27.4 this state.

27.5 (b) A "resident" is a person living in the state for at least 60 days with the intention of  
27.6 making the person's home here and not for any temporary purpose. Time spent in a shelter  
27.7 for battered women shall count toward satisfying the 60-day residency requirement. All  
27.8 applicants for these programs are required to demonstrate the requisite intent and may do  
27.9 so in any of the following ways:

27.10 (1) by showing that the applicant maintains a residence at a verified address, other  
27.11 than a place of public accommodation. An applicant may verify a residence address by  
27.12 presenting a valid state driver's license, a state identification card, a voter registration  
27.13 card, or a rent receipt; or

27.14 (2) by verifying residence according to Minnesota Rules, part 9500.1219, subpart  
27.15 3, item C.

27.16 (c) The county shall not deny an application solely because the applicant does not  
27.17 meet at least one of the criteria in this subdivision, but shall continue to process the  
27.18 application and leave the application pending until the residency requirement is met or  
27.19 until eligibility or ineligibility is established.

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

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

27.24 Sec. 32. **[256N.25] PROGRAM EVALUATION.**

27.25 Subdivision 1. **County evaluation.** Each county shall submit to the commissioner  
27.26 data from the past calendar year on the outcomes and performance indicators, and  
27.27 information as to how grant funds are being spent on the target population. The  
27.28 commissioner shall prescribe standard methods to be used by the counties in providing  
27.29 the data. The data shall be submitted no later than March 1 of each year, beginning with  
27.30 March 1, 2013. The commissioner shall define outcomes and performance indicators.

27.31 Subd. 2. **Statewide evaluation.** Six months after the end of the first full calendar  
27.32 year and biennially thereafter, the commissioner shall prepare a report on the counties'  
27.33 progress in improving the outcomes of adults related to safety and well-being. This report  
27.34 shall be disseminated electronically throughout the state.

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

28.2 Sec. 33. **[256N.30] FUNDING.**

28.3 Subdivision 1. **Assistance.** (a) Counties may use the capped allocation for adult  
28.4 assistance for individuals under section 256N.20, subdivision 2.

28.5 (b) The county agency shall, within available appropriations, provide a personal  
28.6 needs allowance to individuals eligible for group residential housing under section  
28.7 256I.04, subdivision 1, paragraph (b), and to other individuals who reside in licensed  
28.8 residential facilities other than group residential housing. The county may determine the  
28.9 amount of the personal needs allowance based on the individual's net income and need.

28.10 (c) In determining the amount of assistance, the county shall disregard the first  
28.11 \$150 of earned income per month. In addition, the county shall disregard additional  
28.12 earned income up to a maximum of \$500 per month for individuals residing in facilities or  
28.13 group residential housing for whom the county agency has approved a discharge plan that  
28.14 includes work. The additional amount disregarded must be placed in a separate savings  
28.15 account by the eligible individual, to be used upon discharge from the residential facility  
28.16 into the community, up to a maximum of \$2,000.

28.17 (d) The county shall give priority to eligible individuals who are enrolled in a  
28.18 12-month residential chemical dependency treatment program.

28.19 Subd. 2. **Allocation.** Funding for the adult assistance grant program is limited to the  
28.20 appropriation. The commissioner shall allocate to counties the money appropriated for the  
28.21 program based on each county agency's average share of the state's former programs under  
28.22 section 256N.20, subdivision 6. The commissioner may reallocate any unspent amounts  
28.23 to other counties. No county shall be allocated less than \$1,000 for the fiscal year. Any  
28.24 adult assistance aid expenditures by a county above the amount of the commissioner's  
28.25 allocation to the county must be made from county funds.

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

28.27 Sec. 34. **[256N.35] APPLICANT REQUIREMENTS.**

28.28 (a) Any applicant, otherwise eligible for adult assistance and possibly eligible for  
28.29 federal maintenance benefits from any other source shall: (1) make application for those  
28.30 benefits within 30 days of the adult assistance application; and (2) execute an interim  
28.31 assistance authorization on a form as directed by the commissioner.

28.32 (b) The commissioner shall review a denial of an application for other federal  
28.33 maintenance benefits and may require a recipient of adult assistance to file an appeal of  
28.34 the denial if appropriate.

29.1 (c) If found eligible for maintenance benefits, and maintenance benefits were  
29.2 received during the period in which adult assistance was also being received, the recipient  
29.3 shall be required to reimburse the state for the interim assistance paid. Reimbursement  
29.4 shall not exceed the amount of adult assistance paid during the time period to which the  
29.5 other maintenance benefits apply.

29.6 (d) The commissioner may contract with the county agencies, qualified agencies,  
29.7 organizations, or persons to provide advocacy and support services to process claims for  
29.8 federal disability benefits for applicants or recipients of services or benefits supervised by  
29.9 the commissioner using money retained under this section.

29.10 (e) The commissioner may provide methods by which county agencies shall identify,  
29.11 refer, and assist recipients who may be eligible for benefits under federal programs for the  
29.12 disabled.

29.13 (f) The total amount of interim assistance recoveries retained under this section  
29.14 for advocacy, support, and claim processing services shall not exceed 35 percent of the  
29.15 interim assistance recoveries in the prior fiscal year.

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

29.17 Sec. 35. Minnesota Statutes 2010, section 260C.157, subdivision 3, is amended to read:

29.18 Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services  
29.19 agency shall establish a juvenile treatment screening team to conduct screenings and  
29.20 prepare case plans under ~~this subdivision~~ section 245.487, subdivision 3, and chapters  
29.21 260C and 260D. Screenings shall be conducted within 15 days of a request for a screening.  
29.22 The team, which may be the team constituted under section 245.4885 or 256B.092 or  
29.23 Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile  
29.24 justice professionals, and persons with expertise in the treatment of juveniles who are  
29.25 emotionally disabled, chemically dependent, or have a developmental disability. ~~The team~~  
29.26 ~~shall involve parents or guardians in the screening process as appropriate, and the child's~~  
29.27 parent, guardian, or permanent legal custodian under section 260C.201, subdivision 11.

29.28 The team may be the same team as defined in section 260B.157, subdivision 3.

29.29 (b) The social services agency shall determine whether a child brought to its  
29.30 attention for the purposes described in this section is an Indian child, as defined in section  
29.31 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as  
29.32 defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child,  
29.33 the team provided in paragraph (a) shall include a designated representative of the Indian  
29.34 child's tribe, unless the child's tribal authority declines to appoint a representative. The

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

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

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

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

30.16 (d) ~~If the screening team has elected to screen and evaluate the child,~~ The child  
30.17 may not be placed for the primary purpose of treatment for an emotional disturbance, a  
30.18 developmental disability, or chemical dependency, in a residential treatment facility out of  
30.19 state nor in a residential treatment facility within the state that is licensed under chapter  
30.20 245A, unless one of the following conditions applies:

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

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

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

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

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

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

31.10 Sec. 36. Minnesota Statutes 2010, section 260D.01, is amended to read:

31.11 **260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.**

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

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

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

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

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

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

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

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

32.3 (ii) due to a determination regarding the level of services needed by the responsible  
32.4 social services' screening team under section 256B.092, and Minnesota Rules, parts  
32.5 9525.0004 to 9525.0016.

32.6 (d) This chapter does not apply when there is a current determination under section  
32.7 626.556 that the child requires child protective services or when the child is in foster care  
32.8 for any reason other than treatment for the child's emotional disturbance or developmental  
32.9 disability or related condition. When there is a determination under section 626.556 that  
32.10 the child requires child protective services based on an assessment that there are safety  
32.11 and risk issues for the child that have not been mitigated through the parent's engagement  
32.12 in services or otherwise, or when the child is in foster care for any reason other than  
32.13 the child's emotional disturbance or developmental disability or related condition, the  
32.14 provisions of chapter 260C apply.

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

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

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

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

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



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

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

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

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

33.12 Sec. 37. Minnesota Statutes 2010, section 393.07, subdivision 10a, is amended to read:

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

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

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

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

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

33.26 Sec. 38. Minnesota Statutes 2010, section 518A.51, is amended to read:

33.27 **518A.51 FEES FOR IV-D SERVICES.**

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

34.1 (b) An application fee of \$25 shall be paid by the person who applies for child  
34.2 support and maintenance collection services, except persons who are receiving public  
34.3 assistance as defined in section 256.741 and the diversionary work program under section  
34.4 256J.95, persons who transfer from public assistance to nonpublic assistance status, and  
34.5 minor parents and parents enrolled in a public secondary school, area learning center, or  
34.6 alternative learning program approved by the commissioner of education.

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

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

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

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

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

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

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

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

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

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

35.22 Sec. 39. **REQUIREMENT FOR LIQUOR STORES, TOBACCO STORES,**  
35.23 **GAMBLING ESTABLISHMENTS, AND TATTOO PARLORS.**

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

35.28 Sec. 40. **MINNESOTA EBT BUSINESS TASK FORCE.**

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

35.31 (1) two members of the Minnesota house of representatives appointed by the speaker  
35.32 of the house;

35.33 (2) two members of the Minnesota senate appointed by the senate majority leader;

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

- 36.1 (4) an appointee of the Minnesota Grocers Association; and
- 36.2 (5) a credit card processor, appointed by the commissioner of human services.

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

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

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

36.13 Sec. 41. **STREAMLINING CHILDREN AND COMMUNITY SERVICES ACT**  
36.14 **REPORTING REQUIREMENTS.**

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

36.21 Sec. 42. **REVISOR'S INSTRUCTION.**

36.22 The revisor of statutes shall make conforming amendments and correct statutory  
36.23 cross-references as necessitated by the creation of Minnesota Statutes, chapter 256N, and  
36.24 related repealers in this article.

36.25 Sec. 43. **REPEALER.**

36.26 (a) Minnesota Statutes 2010, section 256.9862, subdivision 2, is repealed effective  
36.27 February 1, 2012.

36.28 (b) Minnesota Statutes 2010, sections 256.979, subdivisions 5, 6, 7, and 10;  
36.29 256.9791; 256D.01, subdivisions 1, 1a, 1b, 1e, and 2; 256D.03, subdivisions 1, 2, and 2a;  
36.30 256D.05, subdivisions 1, 2, 4, 5, 6, 7, and 8; 256D.0513; 256D.06, subdivisions 1, 1b, 2,  
36.31 5, 7, and 8; 256D.09, subdivisions 1, 2, 2a, 2b, 5, and 6; 256D.10; 256D.13; 256D.15;  
36.32 256D.16; 256D.35, subdivision 8b; and 256D.46, are repealed effective October 1, 2012.

37.1 (c) Minnesota Rules, part 3400.0130, subpart 8, is repealed effective September  
37.2 3, 2012.

37.3 (d) Minnesota Rules, part 9500.1261, subparts 3, items D and E, 4, and 5, are  
37.4 repealed effective November 1, 2011.

## 37.5 ARTICLE 2

### 37.6 DEPARTMENT OF HEALTH

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

37.8 Subd. 7. **Consistent administrative expenses and investment income reporting.**

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

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

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

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

37.23 (1) establish statewide and regional cost containment goals for total health care  
37.24 spending under this section and collect data as described in sections 62J.38 ~~to 62J.41~~ and  
37.25 62J.40 to monitor statewide achievement of the cost containment goals;

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

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

37.33 (4) issue recommendations regarding uniform billing forms, uniform electronic  
37.34 billing procedures and data interchanges, patient identification cards, and other uniform

38.1 claims and administrative procedures for health care providers and private and public  
38.2 sector payers. In developing the recommendations, the commissioner shall review the  
38.3 work of the work group on electronic data interchange (WEDI) and the American National  
38.4 Standards Institute (ANSI) at the national level, and the work being done at the state and  
38.5 local level. The commissioner may adopt rules requiring the use of the Uniform Bill  
38.6 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic  
38.7 version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized  
38.8 forms or procedures;

38.9 (5) undertake health planning responsibilities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39.18 Sec. 5. Minnesota Statutes 2010, section 62J.692, is amended to read:

39.19 **62J.692 MEDICAL EDUCATION.**

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

39.22 (a) "Accredited clinical training" means the clinical training provided by a  
39.23 medical education program that is accredited through an organization recognized by the  
39.24 Department of Education, the Centers for Medicare and Medicaid Services, or another  
39.25 national body who reviews the accrediting organizations for multiple disciplines and  
39.26 whose standards for recognizing accrediting organizations are reviewed and approved by  
39.27 the commissioner of health in consultation with the Medical Education and Research  
39.28 Advisory Committee.

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

39.30 (c) "Clinical medical education program" means the accredited clinical training of  
39.31 physicians (medical students and residents), doctor of pharmacy practitioners, doctors  
39.32 of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified

40.1 registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and  
40.2 physician assistants.

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

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

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

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

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

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

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

40.24 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

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

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

40.34 (c) Applications must be submitted to the commissioner by a sponsoring institution  
40.35 on behalf of an eligible clinical medical education program and must be received by



41.1 October 31 of each year for distribution in the following year. An application for funds  
41.2 must contain the following information:

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

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

41.8 (3) for each clinical medical education program for which funds are being sought;  
41.9 the type and specialty orientation of trainees in the program; the name, site address, and  
41.10 medical assistance provider number and national provider identification number of each  
41.11 training site used in the program; the federal tax identification number of each training site  
41.12 used in the program, where available; the total number of trainees at each training site; and  
41.13 the total number of eligible trainee FTEs at each site; and

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

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

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

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

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

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

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

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

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

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

42.21 (b) ~~\$5,350,000~~ \$2,680,000 of the available medical education funds shall be  
42.22 distributed as follows:

42.23 (1) ~~\$1,475,000~~ \$740,000 to the University of Minnesota Medical Center-Fairview;

42.24 (2) ~~\$2,075,000~~ \$970,000 to the University of Minnesota School of Dentistry; and

42.25 (3) ~~\$1,800,000~~ \$970,000 to the Academic Health Center. \$150,000 of the funds  
42.26 distributed to the Academic Health Center under this paragraph shall be used for a  
42.27 program to assist internationally trained physicians who are legal residents and who  
42.28 commit to serving underserved Minnesota communities in a health professional shortage  
42.29 area to successfully compete for family medicine residency programs at the University  
42.30 of Minnesota.

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

42.33 (d) Funds shall be distributed to the sponsoring institutions indicating the amount  
42.34 to be distributed to each of the sponsor's clinical medical education programs based on  
42.35 the criteria in this subdivision and in accordance with the commissioner's approval letter.  
42.36 Each clinical medical education program must distribute funds allocated under paragraph

43.1 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring  
43.2 institutions, which are accredited through an organization recognized by the Department  
43.3 of Education or the Centers for Medicare and Medicaid Services, may contract directly  
43.4 with training sites to provide clinical training. To ensure the quality of clinical training,  
43.5 those accredited sponsoring institutions must:

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

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

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

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

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

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

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

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

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

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

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

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

44.6 Subd. 6. **Other available funds.** The commissioner is authorized to distribute, in  
44.7 accordance with subdivision 4 or 11, as appropriate, funds made available through:

44.8 (1) voluntary contributions by employers or other entities;

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

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

44.13 Subd. 7. **Transfers from the commissioner of human services.** Of the amount  
44.14 transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4),  
44.15 \$21,714,000 shall be distributed as follows:

44.16 (1) \$2,157,000 shall be distributed by the commissioner to the University of  
44.17 Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

44.18 (2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County  
44.19 Medical Center for clinical medical education;

44.20 (3) \$17,400,000 shall be distributed by the commissioner to the University of  
44.21 Minnesota Board of Regents for purposes of medical education;

44.22 (4) \$1,121,640 shall be distributed by the commissioner to clinical medical education  
44.23 dental innovation grants in accordance with subdivision 7a; and

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

44.28 Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner  
44.29 shall award grants to teaching institutions and clinical training sites for projects that  
44.30 increase dental access for underserved populations and promote innovative clinical  
44.31 training of dental professionals. In awarding the grants, the commissioner, in consultation  
44.32 with the commissioner of human services, shall consider the following:

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

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

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

45.1 (4) the efficiency in the use of the funding; and  
45.2 (5) the priority level of the project in relation to state clinical education, access,  
45.3 and workforce goals.

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

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

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

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

45.18 Subd. 11. **Distribution of funds.** (a) Upon receiving federal approval, the  
45.19 commissioner shall annually distribute the available medical education funds to all  
45.20 qualifying applicants based on the distribution formula provided in this subdivision, which  
45.21 supersedes the formula described in subdivision 4, paragraph (a).

45.22 (1) Following the distribution of funds described under subdivision 4, paragraph  
45.23 (b), the commissioner shall annually distribute the available medical education funds  
45.24 to all qualifying applicants based on a distribution formula that reflects a summation  
45.25 of two factors:

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

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

46.1 Public program revenue for the distribution formula includes revenue from medical  
46.2 assistance, prepaid medical assistance, general assistance medical care, and prepaid  
46.3 general assistance medical care. Training sites that receive no public program revenue are  
46.4 ineligible for funds available under this subdivision. For purposes of determining training  
46.5 site level grants to be distributed under paragraph (a), total statewide average costs per  
46.6 trainee for medical residents is based on audited clinical training costs per trainee in  
46.7 primary care clinical medical education programs for medical residents. Total statewide  
46.8 average costs per trainee for dental residents is based on audited clinical training costs  
46.9 per trainee in clinical medical education programs for dental students. Total statewide  
46.10 average costs per trainee for pharmacy residents is based on audited clinical training costs  
46.11 per trainee in clinical medical education programs for pharmacy students.

46.12 (2) Ten percent of available medical education funds shall be used to create a primary  
46.13 care bonus pool. Grants to eligible training sites under this clause shall be determined by  
46.14 dividing the total number of eligible FTE trainees from primary care medicine, advanced  
46.15 practice nursing, or physician assistant programs at all eligible training sites by the amount  
46.16 of funds available in the primary care bonus pool to determine a grant per primary care  
46.17 FTE; each eligible training site shall receive a grant equal to the grant per primary care  
46.18 FTE multiplied by the number of eligible primary care FTE's at the training site.

46.19 (3) After determining the grant amount for each training site under clause (1), items  
46.20 (i) and (ii), and clause (2), the commissioner shall calculate a grant per eligible trainee for  
46.21 each training site. Any training site whose grant per eligible trainee is greater than the  
46.22 95th percentile grant per eligible trainee shall have the grant amount reduced to the 95th  
46.23 percentile grant per eligible trainee. Grants in excess of this amount for any training site  
46.24 shall be redistributed based on the criteria in clause (4).

46.25 Any training site with fewer than 0.1 FTE eligible trainees from all programs or a  
46.26 calculated grant less than \$1,000 based on the formula described in clauses (1) and (2)  
46.27 shall be eliminated from the distribution; the calculated grants for these training sites shall  
46.28 be redistributed based on the criteria in clause (4).

46.29 (4) The commissioner shall award from available funds appropriated for this purpose  
46.30 and equally divided between the following programs:

46.31 (i) the community mental health center grants program under section 145.9272; and

46.32 (ii) the community health centers development grants program under section  
46.33 145.987.

46.34 If federal approval for this funding mechanism is not received for either of the grant  
46.35 programs described in this paragraph, available funds will be provided to the remaining  
46.36 grant program described in this paragraph. If none of the grant programs described in this

47.1 paragraph receive federal approval, available funds will be distributed to eligible training  
47.2 sites based on the formula in clauses (1) to (3).

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

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

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

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

47.19 (d) Any funds not distributed according to the commissioner's approval letter must  
47.20 be returned to the medical education and research fund within 30 days of receiving  
47.21 notice from the commissioner. The commissioner shall distribute returned funds to the  
47.22 appropriate training sites according to the commissioner's approval letter.

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

47.26 **Sec. 6. [62U.15] ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING**  
47.27 **MEASURES.**

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

47.34 (b) The commissioner may contract with a private entity to complete the  
47.35 requirements in this subdivision. If the commissioner contracts with a private entity

48.1 already under contract through section 62U.02, then the commissioner may use a sole  
48.2 source contract and is exempt from competitive procurement processes.

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

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

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

48.15 (2) improved support of family caregivers; and

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

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

48.21 Sec. 7. Minnesota Statutes 2010, section 144.1501, subdivision 1, is amended to read:

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

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

48.25 (c) "Designated rural area" means:

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

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



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

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

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

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

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

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

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

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

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

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

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

49.27 Sec. 8. Minnesota Statutes 2010, section 144.396, subdivision 5, is amended to read:

49.28 Subd. 5. **Statewide tobacco prevention grants.** (a) To the extent funds are  
49.29 appropriated for the purposes of this subdivision, the commissioner of health shall, within  
49.30 available appropriations, award competitive grants to eligible applicants for projects and  
49.31 initiatives directed at the prevention of tobacco use. The project areas for grants include:

49.32 (1) statewide public education and information campaigns which include  
49.33 implementation at the local level; and

49.34 (2) coordinated special projects, including training and technical assistance, a  
49.35 resource clearinghouse, and contracts with ethnic and minority communities.

50.1 (b) Eligible applicants may include, but are not limited to, nonprofit organizations,  
50.2 colleges and universities, professional health associations, community health boards, and  
50.3 other health care organizations. Applicants must submit proposals to the commissioner.  
50.4 The proposals must specify the strategies to be implemented to target tobacco use among  
50.5 youth, and must take into account the need for a coordinated statewide tobacco prevention  
50.6 effort.

50.7 (c) The commissioner must give priority to applicants who demonstrate that the  
50.8 proposed project:

50.9 (1) is research based or based on proven effective strategies;

50.10 (2) is designed to coordinate with other activities and education messages related  
50.11 to other health initiatives;

50.12 (3) utilizes and enhances existing prevention activities and resources; or

50.13 (4) involves innovative approaches preventing tobacco use among youth.

50.14 Sec. 9. Minnesota Statutes 2010, section 144.396, subdivision 6, is amended to read:

50.15 Subd. 6. **Local tobacco prevention grants.** (a) The commissioner shall award  
50.16 grants, within available appropriations, to eligible applicants for local and regional  
50.17 projects and initiatives directed at tobacco prevention in coordination with other health  
50.18 areas aimed at reducing high-risk behaviors in youth that lead to adverse health-related  
50.19 problems. The project areas for grants include:

50.20 (1) school-based tobacco prevention programs aimed at youth and parents;

50.21 (2) local public awareness and education projects aimed at tobacco prevention in  
50.22 coordination with locally assessed community public health needs pursuant to chapter  
50.23 145A; or

50.24 (3) local initiatives aimed at reducing high-risk behavior in youth associated with  
50.25 tobacco use and the health consequences of these behaviors.

50.26 (b) Eligible applicants may include, but are not limited to, community health boards,  
50.27 school districts, community clinics, Indian tribes, nonprofit organizations, and other health  
50.28 care organizations. Applicants must submit proposals to the commissioner. The proposals  
50.29 must specify the strategies to be implemented to target tobacco use among youth, and must  
50.30 be targeted to achieve the outcomes established in subdivision 2.

50.31 (c) The commissioner must give priority to applicants who demonstrate that the  
50.32 proposed project or initiative is:

50.33 (1) supported by the community in which the applicant serves;

50.34 (2) is based on research or on proven effective strategies;

51.1 (3) is designed to coordinate with other community activities related to other health  
51.2 initiatives;

51.3 (4) incorporates an understanding of the role of community in influencing behavioral  
51.4 changes among youth regarding tobacco use and other high-risk health-related behaviors;  
51.5 or

51.6 (5) addresses disparities among populations of color related to tobacco use and  
51.7 other high-risk health-related behaviors.

51.8 (d) The commissioner shall divide the state into specific geographic regions and  
51.9 allocate a percentage of the money available for distribution to projects or initiatives  
51.10 aimed at that geographic region. If the commissioner does not receive a sufficient number  
51.11 of grant proposals from applicants that serve a particular region or the proposals submitted  
51.12 do not meet the criteria developed by the commissioner, the commissioner shall provide  
51.13 technical assistance and expertise to ensure the development of adequate proposals  
51.14 aimed at addressing the public health needs of that region. In awarding the grants, the  
51.15 commissioner shall consider locally assessed community public health needs pursuant to  
51.16 chapter 145A.

51.17 Sec. 10. Minnesota Statutes 2010, section 144.98, subdivision 2a, is amended to read:

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

51.23 Sec. 11. Minnesota Statutes 2010, section 144.98, subdivision 7, is amended to read:

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

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

51.33 (c) Applications for renewal of accreditation must be received by November 1 and  
51.34 no earlier than October 1 of each year. The commissioner shall send annual renewal

52.1 notices to laboratories 90 days before expiration. Failure to receive a renewal notice does  
52.2 not exempt laboratories from meeting the annual November 1 renewal date.

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

52.5 (e) The accreditation of any laboratory that fails to submit a renewal application  
52.6 and fees to the commissioner expires automatically on December 31 without notice or  
52.7 further proceeding. Any person who operates a laboratory as accredited after expiration of  
52.8 accreditation or without having submitted an application and paid the fees is in violation  
52.9 of the provisions of this section and is subject to enforcement action under sections  
52.10 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired  
52.11 accreditation may reapply under subdivision 6.

52.12 Sec. 12. Minnesota Statutes 2010, section 144.98, is amended by adding a subdivision  
52.13 to read:

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

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

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

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

52.28 Sec. 13. Minnesota Statutes 2010, section 144.98, is amended by adding a subdivision  
52.29 to read:

52.30 **Subd. 9. Exemption from national standards for proficiency testing frequency.**

52.31 (a) Effective January 1, 2012, a laboratory applying for or requesting accreditation under  
52.32 the exemption in subdivision 8 must obtain an acceptable proficiency test result for each  
52.33 of the laboratory's accredited or requested fields of testing. The laboratory must analyze

53.1 proficiency samples selected from one of two annual proficiency testing studies scheduled  
53.2 by the commissioner.

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

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

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

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

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

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

53.18 Sec. 14. Minnesota Statutes 2010, section 144A.102, is amended to read:

53.19 **144A.102 WAIVER FROM FEDERAL RULES AND REGULATIONS;**  
53.20 **PENALTIES.**

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

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

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

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

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

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

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

54.5 Sec. 15. Minnesota Statutes 2010, section 144A.61, is amended by adding a  
54.6 subdivision to read:

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

54.10 Sec. 16. Minnesota Statutes 2010, section 144E.123, is amended to read:

54.11 **144E.123 PREHOSPITAL CARE DATA.**

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

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

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

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

54.25 Subd. 5. **Working group.** By October 1, 2011, the board must convene a working  
54.26 group composed of six members, three of which must be appointed by the board and three  
54.27 of which must be appointed by the Minnesota Ambulance Association, to redesign the  
54.28 board's policies related to collection of data from licenses. The issues to be considered  
54.29 include, but are not limited to, the following: user-friendly reporting requirements; data  
54.30 sets; improved accuracy of reported information; appropriate use of information gathered  
54.31 through the reporting system; and methods for minimizing the financial impact of data  
54.32 reporting on licenses, particularly for rural volunteer services. The working group must  
54.33 report its findings and recommendations to the board no later than July 1, 2012.

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

55.2 Sec. 17. **[145.4221] HUMAN CLONING PROHIBITED.**

55.3 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms  
55.4 have the meanings given.

55.5 (b) "Human cloning" means human asexual reproduction accomplished by  
55.6 introducing nuclear material from one or more human somatic cells into a fertilized  
55.7 or unfertilized oocyte whose nuclear material has been removed or inactivated so as  
55.8 to produce a living organism at any stage of development that is genetically virtually  
55.9 identical to an existing or previously existing human organism.

55.10 (c) "Somatic cell" means a diploid cell, having a complete set of chromosomes,  
55.11 obtained or derived from a living or deceased human body at any stage of development.

55.12 Subd. 2. **Prohibition on cloning.** No person or entity, whether public or private,  
55.13 may:

55.14 (1) perform or attempt to perform human cloning;

55.15 (2) participate in an attempt to perform human cloning;

55.16 (3) ship, import, or receive for any purpose an embryo produced by human cloning  
55.17 or any product derived from such an embryo; or

55.18 (4) ship or receive, in whole or in part, any oocyte, embryo, fetus, or human somatic  
55.19 cell, for the purpose of human cloning.

55.20 Subd. 3. **Scientific research.** Nothing in this section shall restrict areas of scientific  
55.21 research not specifically prohibited by this section, including research in the use of nuclear  
55.22 transfer or other cloning techniques to produce molecules, DNA, cells other than human  
55.23 embryos, tissues, organs, plants, or animals other than humans. In addition, nothing in this  
55.24 section shall restrict, inhibit, or make unlawful the scientific field of stem cell research,  
55.25 unless explicitly prohibited.

55.26 Subd. 4. **Penalties.** Any person or entity that knowingly or recklessly violates  
55.27 subdivision 2 is guilty of a misdemeanor.

55.28 Subd. 5. **Severability.** If any provision, section, subdivision, sentence, clause,  
55.29 phrase, or word in this section or the application thereof to any person or circumstance is  
55.30 found to be unconstitutional, the same is hereby declared to be severable and the remainder  
55.31 of this section shall remain effective notwithstanding such unconstitutional provision. The  
55.32 legislature declares that it would have passed this section and each provision, subdivision,  
55.33 sentence, clause, phrase, or word thereof, regardless of the fact that any provision, section,  
55.34 subdivision, sentence, clause, phrase, or word is declared unconstitutional.

56.1 **EFFECTIVE DATE.** This section is effective August 1, 2011, and applies to crimes  
56.2 committed on or after that date.

56.3 Sec. 18. Minnesota Statutes 2010, section 145.925, subdivision 1, is amended to read:

56.4 Subdivision 1. **Eligible organizations; purpose.** The commissioner of health may,  
56.5 within available appropriations, make special grants to cities, counties, groups of cities or  
56.6 counties, or nonprofit corporations to provide prepregnancy family planning services.

56.7 Sec. 19. Minnesota Statutes 2010, section 145.925, subdivision 2, is amended to read:

56.8 Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to  
56.9 this section to any ~~nonprofit corporation which performs abortions~~ eligible organization  
56.10 that performs abortions or provides referrals for abortion services. No state funds shall be  
56.11 used under contract from a grantee to any ~~nonprofit corporation which performs abortions.~~  
56.12 ~~This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56,~~  
56.13 ~~or health maintenance organizations certified pursuant to chapter 62D~~ eligible organization  
56.14 that performs abortions or provides referrals for abortion services.

56.15 Sec. 20. **[145.9271] WHITE EARTH BAND URBAN CLINIC.**

56.16 Subdivision 1. **Establish urban clinic.** The White Earth Band of Ojibwe Indians  
56.17 shall establish and operate one or more health care clinics in the Minneapolis area or  
56.18 greater Minnesota to serve members of the White Earth Tribe and may use funds received  
56.19 under this section for application to qualify as a federally qualified health center.

56.20 Subd. 2. **Grant agreements.** Before receiving the funds under this section, the  
56.21 White Earth Band of Ojibwe Indians is requested to submit to the commissioner of health  
56.22 a work plan and budget that describes its annual plan for the funds. The commissioner will  
56.23 incorporate the work plan and budget into a grant agreement between the commissioner  
56.24 and the White Earth Band of Ojibwe Indians. Before each successive disbursement, the  
56.25 White Earth Band of Ojibwe Indians is requested to submit a narrative progress report and  
56.26 an expenditure report to the commissioner.

56.27 Sec. 21. **[145.9272] COMMUNITY MENTAL HEALTH CENTER GRANTS.**

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

56.31 Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute, from  
56.32 money appropriated for this purpose, grants to community mental health centers operating



57.1 in the state on July 1 of the year 2011 and each subsequent year for community mental  
57.2 health center services to low-income consumers and patients with mental illness. The  
57.3 amount of each grant shall be in proportion to each community mental health center's  
57.4 revenues received from state health care programs in the most recent calendar year for  
57.5 which data is available.

57.6 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal  
57.7 approval of the funding mechanism set out in Minnesota Statutes, section 62J.692,  
57.8 subdivision 11, whichever is later.

57.9 Sec. 22. Minnesota Statutes 2010, section 145.928, subdivision 7, is amended to read:

57.10 Subd. 7. **Community grant program; immunization rates and infant mortality**  
57.11 **rates.** (a) The commissioner shall, within available appropriations, award grants to  
57.12 eligible applicants for local or regional projects and initiatives directed at reducing health  
57.13 disparities in one or both of the following priority areas:

57.14 (1) decreasing racial and ethnic disparities in infant mortality rates; or

57.15 (2) increasing adult and child immunization rates in nonwhite racial and ethnic  
57.16 populations.

57.17 (b) The commissioner may award up to 20 percent of the funds available as planning  
57.18 grants. Planning grants must be used to address such areas as community assessment,  
57.19 coordination activities, and development of community supported strategies.

57.20 (c) Eligible applicants may include, but are not limited to, faith-based organizations,  
57.21 social service organizations, community nonprofit organizations, community health  
57.22 boards, tribal governments, and community clinics. Applicants must submit proposals to  
57.23 the commissioner. A proposal must specify the strategies to be implemented to address  
57.24 one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the  
57.25 outcomes established according to subdivision 3.

57.26 (d) The commissioner shall give priority to applicants who demonstrate that their  
57.27 proposed project or initiative:

57.28 (1) is supported by the community the applicant will serve;

57.29 (2) is research-based or based on promising strategies;

57.30 (3) is designed to complement other related community activities;

57.31 (4) utilizes strategies that positively impact both priority areas;

57.32 (5) reflects racially and ethnically appropriate approaches; and

57.33 (6) will be implemented through or with community-based organizations that reflect  
57.34 the race or ethnicity of the population to be reached.

58.1 Sec. 23. Minnesota Statutes 2010, section 145.928, subdivision 8, is amended to read:

58.2 Subd. 8. **Community grant program; other health disparities.** (a) The  
58.3 commissioner shall, within available appropriations, award grants to eligible applicants  
58.4 for local or regional projects and initiatives directed at reducing health disparities in  
58.5 one or more of the following priority areas:

58.6 (1) decreasing racial and ethnic disparities in morbidity and mortality rates from  
58.7 breast and cervical cancer;

58.8 (2) decreasing racial and ethnic disparities in morbidity and mortality rates from  
58.9 HIV/AIDS and sexually transmitted infections;

58.10 (3) decreasing racial and ethnic disparities in morbidity and mortality rates from  
58.11 cardiovascular disease;

58.12 (4) decreasing racial and ethnic disparities in morbidity and mortality rates from  
58.13 diabetes; or

58.14 (5) decreasing racial and ethnic disparities in morbidity and mortality rates from  
58.15 accidental injuries or violence.

58.16 (b) The commissioner may award up to 20 percent of the funds available as planning  
58.17 grants. Planning grants must be used to address such areas as community assessment,  
58.18 determining community priority areas, coordination activities, and development of  
58.19 community supported strategies.

58.20 (c) Eligible applicants may include, but are not limited to, faith-based organizations,  
58.21 social service organizations, community nonprofit organizations, community health  
58.22 boards, and community clinics. Applicants shall submit proposals to the commissioner.  
58.23 A proposal must specify the strategies to be implemented to address one or more of  
58.24 the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes  
58.25 established according to subdivision 3.

58.26 (d) The commissioner shall give priority to applicants who demonstrate that their  
58.27 proposed project or initiative:

58.28 (1) is supported by the community the applicant will serve;

58.29 (2) is research-based or based on promising strategies;

58.30 (3) is designed to complement other related community activities;

58.31 (4) utilizes strategies that positively impact more than one priority area;

58.32 (5) reflects racially and ethnically appropriate approaches; and

58.33 (6) will be implemented through or with community-based organizations that reflect  
58.34 the race or ethnicity of the population to be reached.

59.1 Sec. 24. [145.987] COMMUNITY HEALTH CENTERS DEVELOPMENT

59.2 GRANTS.

59.3 (a) The commissioner of health shall award grants from money appropriated for this  
59.4 purpose to expand community health centers, as defined in section 145.9269, subdivision  
59.5 1, in the state through the establishment of new community health centers or sites in  
59.6 areas defined as small rural areas or isolated rural areas according to the four category  
59.7 classification of the Rural Urban Commuting Area system developed for the United States  
59.8 Health Resources and Services Administration or serving underserved patient populations.

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

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

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

59.14 Funds may not be used for operating costs.

59.15 (c) The commissioner shall award grants on a competitive basis.

59.16 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal  
59.17 approval of the funding mechanism set out in Minnesota Statutes, section 62J.692,  
59.18 subdivision 11, whichever is later.

59.19 Sec. 25. Minnesota Statutes 2010, section 145A.17, subdivision 3, is amended to read:

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

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

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

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

59.28 (4) a description of the community demographics;

59.29 (5) a plan for meeting outcome measures; and

59.30 (6) a proposed work plan that includes:

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

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

59.34 (iii) collaboration with multidisciplinary partners including public health,  
59.35 ECFE, Head Start, community health workers, social workers, community home

60.1 visiting programs, school districts, and other relevant partners. Letters of intent from  
60.2 multidisciplinary partners must be submitted with the plan.

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

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

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

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

60.13 (4) provide information on and referrals to health care services, if needed, including  
60.14 information on and assistance in applying for health care coverage for which the child or  
60.15 family may be eligible; and provide information on preventive services, developmental  
60.16 assessments, and the availability of public assistance programs as appropriate;

60.17 (5) provide youth development programs when appropriate;

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

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

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

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

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

60.31 (c) When available, programs that receive funds under this section must offer or  
60.32 provide the family with a referral to center-based or group meetings that meet at least  
60.33 once per month for those families identified with additional needs. The meetings must  
60.34 focus on further enhancing the information, activities, and skill-building addressed during  
60.35 home visitation; offering opportunities for parents to meet with and support each other;

61.1 and offering infants and toddlers a safe, nurturing, and stimulating environment for  
61.2 socialization and supervised play with qualified teachers.

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

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

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

61.22 Sec. 26. Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision  
61.23 to read:

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

61.30 **EFFECTIVE DATE.** This section is effective July 1, 2011, and applies to  
61.31 applications for licensure submitted on or after that date.

61.32 Sec. 27. Minnesota Statutes 2010, section 157.20, is amended by adding a subdivision  
61.33 to read:

62.1 Subd. 5. Variance requests. (a) A person may request a variance from all parts of  
62.2 Minnesota Rules, chapter 4626, except as provided in paragraph (b) or Minnesota Rules,  
62.3 chapter 4626. At the time of application for plan review, the person, operator, or submitter  
62.4 must be notified of the right to request variances.

62.5 (b) No variance may be requested or approved for the following parts of Minnesota  
62.6 Rules, chapter 4626:

- 62.7 (1) Minnesota Rules, part 4626.0020, subpart 35;  
62.8 (2) Minnesota Rules, parts 4626.0040 to 4626.0060;  
62.9 (3) Minnesota Rules, parts 4626.0065 to 4626.0100;  
62.10 (4) Minnesota Rules, parts 4626.0105 to 4626.0120;  
62.11 (5) Minnesota Rules, part 4626.1565;  
62.12 (6) Minnesota Rules, parts 4626.1590 and 4626.1595; and  
62.13 (7) Minnesota Rules, parts 4626.1600 to 4626.1675.

62.14 Sec. 28. Minnesota Statutes 2010, section 297F.10, subdivision 1, is amended to read:

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

62.19 (1) \$22,220,000 for fiscal year 2006 and \$22,250,000 for fiscal year 2007 and each  
62.20 year thereafter must be credited to the Academic Health Center special revenue fund  
62.21 hereby created and is annually appropriated to the Board of Regents at the University of  
62.22 Minnesota for Academic Health Center funding at the University of Minnesota; and

62.23 (2) ~~\$8,553,000 for fiscal year 2006 and \$8,550,000 for fiscal year years 2007 and~~  
62.24 ~~each year thereafter~~ through fiscal year 2011 and \$6,244,000 each fiscal year thereafter  
62.25 must be credited to the medical education and research costs account hereby created in  
62.26 the special revenue fund and is annually appropriated to the commissioner of health for  
62.27 distribution under section 62J.692, subdivision 4 or 11, as appropriate; and

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

62.31 Sec. 29. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY**  
62.32 **RESPONSIBILITIES.**

62.33 (a) The commissioner of health, in consultation with the commissioner of human  
62.34 services, shall evaluate and recommend options for reorganizing health and human

63.1 services regulatory responsibilities in both agencies to provide better efficiency and  
63.2 operational cost savings while maintaining the protection of the health, safety, and welfare  
63.3 of the public. Regulatory responsibilities that are to be evaluated are those found in  
63.4 Minnesota Statutes, chapters 62D, 62N, 62R, 62T, 144A, 144D, 144G, 146A, 146B,  
63.5 149A, 153A, 245A, 245B, and 245C, and sections 62Q.19, 144.058, 144.0722, 144.50,  
63.6 144.651, 148.511, 148.6401, 148.995, 256B.692, 626.556, and 626.557.

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

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

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

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

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

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

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

63.21 **Sec. 30. STUDY OF FOR-PROFIT HEALTH MAINTENANCE**  
63.22 **ORGANIZATIONS.**

63.23 The commissioner of health shall contract with an entity with expertise in health  
63.24 economics and health care delivery and quality to study the efficiency, costs, service  
63.25 quality, and enrollee satisfaction of for-profit health maintenance organizations, relative to  
63.26 not-for-profit health maintenance organizations operating in Minnesota and other states.

63.27 The study findings must address whether the state of Minnesota could: (1) reduce medical  
63.28 assistance and MinnesotaCare costs and costs of providing coverage to state employees;  
63.29 and (2) maintain or improve the quality of care provided to state health care program  
63.30 enrollees and state employees if for-profit health maintenance organizations were allowed  
63.31 to operate in the state. The commissioner shall require the entity under contract to report  
63.32 study findings to the commissioner and the legislature by January 15, 2012.

63.33 **Sec. 31. MINNESOTA TASK FORCE ON PREMATUREITY.**

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

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

64.6            (1) 15 representatives of the Minnesota Prematurity Coalition including, but not  
64.7 limited to, health care providers who treat pregnant women or neonates, organizations  
64.8 focused on preterm births, early childhood education and development professionals, and  
64.9 families affected by prematurity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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



65.1 (7) a review of the potential improvements in health status related to the use of  
65.2 health care homes to provide and coordinate pregnancy-related services; and

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

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

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

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

65.13 **Sec. 32. NURSING HOME REGULATORY EFFICIENCY.**

65.14 The commissioner of health must work with long-term care providers, provider  
65.15 associations, and consumer advocates to clarify for the benefit of providers, survey  
65.16 teams, and investigators from the office of health facility complaints all of the situations  
65.17 that providers must report and are required to report to the department under federal  
65.18 certification regulations and to the common entry point under the Minnesota Vulnerable  
65.19 Adults Act. The commissioner must produce decision trees, flow sheets, or other  
65.20 reproducible materials to guide the parties and to reduce the number of unnecessary  
65.21 reports.

65.22 **Sec. 33. REPEALER.**

65.23 (a) Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8;  
65.24 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; 144.1464; 144.147; and  
65.25 144.1499, are repealed.

65.26 (b) Minnesota Rules, parts 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12,  
65.27 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, and 23; 4651.0110, subparts 2, 2a, 3, 4, and 5;  
65.28 4651.0120; 4651.0130; 4651.0140; and 4651.0150, are repealed effective July 1, 2011.

65.29 **ARTICLE 3**

65.30 **MISCELLANEOUS**

65.31 **Section 1.** Minnesota Statutes 2010, section 245A.14, subdivision 4, is amended to  
65.32 read:

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

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

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

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

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

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

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

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

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

66.27 (4) the facility has square footage required per child under Minnesota Rules, part  
66.28 9502.0425;

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

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

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

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

67.4 (7) any age and capacity limitations required by the fire code inspection and square  
67.5 footage determinations shall be printed on the license; or

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

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

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

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

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

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

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

67.23 Sec. 2. Minnesota Statutes 2010, section 245C.03, is amended by adding a subdivision  
67.24 to read:

67.25 Subd. 7. **Children's therapeutic services and supports providers.** The  
67.26 commissioner shall conduct background studies according to this chapter when initiated  
67.27 by a children's therapeutic services and supports provider under section 256B.0943.

67.28 Sec. 3. Minnesota Statutes 2010, section 245C.10, is amended by adding a subdivision  
67.29 to read:

67.30 Subd. 8. **Children's therapeutic services and supports providers.** The  
67.31 commissioner shall recover the cost of background studies required under section  
67.32 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports  
67.33 under section 256B.0943, through a fee of no more than \$20 per study charged to

68.1 the license holder. The fees collected under this subdivision are appropriated to the  
68.2 commissioner for the purpose of conducting background studies.

68.3 Sec. 4. Minnesota Statutes 2010, section 256B.04, subdivision 14a, is amended to read:

68.4 Subd. 14a. **Level of need determination.** Nonemergency medical transportation  
68.5 level of need determinations must be performed by a physician, a registered nurse working  
68.6 under direct supervision of a physician, a physician's assistant, a nurse practitioner, a  
68.7 licensed practical nurse, or a discharge planner.

68.8 Nonemergency medical transportation level of need determinations must not be  
68.9 performed more than annually on any individual, unless the individual's circumstances  
68.10 have sufficiently changed so as to require a new level of need determination. No entity  
68.11 shall charge, and the commissioner shall pay, no more than \$25 for performing a level of  
68.12 need determination regarding any person receiving nonemergency medical transportation,  
68.13 including special transportation.

68.14 Special transportation services to eligible persons who need a stretcher-accessible  
68.15 vehicle from an inpatient or outpatient hospital are exempt from a level of need  
68.16 determination if the special transportation services have been ordered by the eligible  
68.17 person's physician, registered nurse working under direct supervision of a physician,  
68.18 physician's assistant, nurse practitioner, licensed practical nurse, or discharge planner  
68.19 pursuant to Medicare guidelines.

68.20 Individuals transported to or residing in licensed nursing facilities are exempt from a  
68.21 level of need determination and are eligible for special transportation services until the  
68.22 individual no longer resides in a licensed nursing facility. If a person authorized by this  
68.23 subdivision to perform a level of need determination determines that an individual requires  
68.24 stretcher transportation, the individual is presumed to maintain that level of need until  
68.25 otherwise determined by a person authorized to perform a level of need determination, or  
68.26 for six months, whichever is sooner.

68.27 Sec. 5. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to  
68.28 read:

68.29 Subd. 17. **Transportation costs.** (a) Medical assistance covers medical  
68.30 transportation costs incurred solely for obtaining emergency medical care or transportation  
68.31 costs incurred by eligible persons in obtaining emergency or nonemergency medical  
68.32 care when paid directly to an ambulance company, common carrier, or other recognized  
68.33 providers of transportation services. Medical transportation must be provided by:

68.34 (1) an ambulance, as defined in section 144E.001, subdivision 2;

- 69.1 (2) special transportation; or  
69.2 (3) common carrier including, but not limited to, bus, taxicab, other commercial  
69.3 carrier, or private automobile.

69.4 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,  
69.5 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that  
69.6 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial  
69.7 transportation, or private automobile.

69.8 The commissioner may use an order by the recipient's attending physician to certify that  
69.9 the recipient requires special transportation services. Special transportation providers  
69.10 shall perform driver-assisted services for eligible individuals. Driver-assisted service  
69.11 includes passenger pickup at and return to the individual's residence or place of business,  
69.12 assistance with admittance of the individual to the medical facility, and assistance in  
69.13 passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special  
69.14 transportation providers must obtain written documentation from the health care service  
69.15 provider who is serving the recipient being transported, identifying the time that the  
69.16 recipient arrived. Special transportation providers may not bill for separate base rates for  
69.17 the continuation of a trip beyond the original destination. Special transportation providers  
69.18 must take recipients to the nearest appropriate health care provider, using the most direct  
69.19 route as determined by a commercially available mileage software program approved by  
69.20 the commissioner. The minimum medical assistance reimbursement rates for special  
69.21 transportation services are:

- 69.22 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to  
69.23 eligible persons who need a wheelchair-accessible van;  
69.24 (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to  
69.25 eligible persons who do not need a wheelchair-accessible van; and  
69.26 (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for  
69.27 special transportation services to eligible persons who need a stretcher-accessible vehicle;  
69.28 (2) the base rates for special transportation services in areas defined under RUCA  
69.29 to be super rural shall be equal to the reimbursement rate established in clause (1) plus  
69.30 11.3 percent; and  
69.31 (3) for special transportation services in areas defined under RUCA to be rural  
69.32 or super rural areas:  
69.33 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125  
69.34 percent of the respective mileage rate in clause (1); and  
69.35 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to  
69.36 112.5 percent of the respective mileage rate in clause (1).

70.1 (c) For purposes of reimbursement rates for special transportation services under  
70.2 paragraph (b), the zip code of the recipient's place of residence shall determine whether  
70.3 the urban, rural, or super rural reimbursement rate applies.

70.4 (d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"  
70.5 means a census-tract based classification system under which a geographical area is  
70.6 determined to be urban, rural, or super rural.

70.7 Sec. 6. Minnesota Statutes 2010, section 256B.0943, is amended by adding a  
70.8 subdivision to read:

70.9 Subd. 5a. **Background studies.** The requirements for background studies under  
70.10 this section may be met by a children's therapeutic services and supports services agency  
70.11 through the commissioner's NETStudy system as provided under sections 245C.03,  
70.12 subdivision 7, and 245C.10, subdivision 8.

70.13 Sec. 7. Minnesota Statutes 2010, section 256B.14, is amended by adding a subdivision  
70.14 to read:

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

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

70.18 (2) "community spouse" means the spouse, who lives in the community, of an  
70.19 individual receiving long-term care services in a long-term care facility or home care  
70.20 services pursuant to the Medicaid waiver for elderly services under section 256B.0915  
70.21 or the alternative care program under section 256B.0913. A community spouse does not  
70.22 include a spouse living in the community who receives a monthly income allowance under  
70.23 section 256B.058, subdivision 2, or who receives home and community-based services  
70.24 under section 256B.0915, 256B.092, or 256B.49, or the alternative care program under  
70.25 section 256B.0913;

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

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

70.29 (5) "disabled child" means a blind or permanently and totally disabled son or  
70.30 daughter of any age based on the Social Security Administration disability standards;

70.31 (6) "income" means earned and unearned income, attributable to the community  
70.32 spouse, used to calculate the adjusted gross income on the prior year's income tax return.

70.33 Evidence of income includes, but is not limited to, W-2 and 1099 forms; and

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

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

71.10 (c) For a community spouse with an income equal to or greater than 250 percent of  
71.11 the federal poverty guidelines for a family of two and less than 545 percent of the federal  
71.12 poverty guidelines for a family of two, the spousal contribution shall be determined using  
71.13 a sliding fee scale established by the commissioner that begins at 7.5 percent of the  
71.14 community spouse's income and increases to 15 percent for those with an income of up to  
71.15 545 percent of the federal poverty guidelines for a family of two.

71.16 (d) For a community spouse with an income equal to or greater than 545 percent of  
71.17 the federal poverty guidelines for a family of two and less than 750 percent of the federal  
71.18 poverty guidelines for a family of two, the spousal contribution shall be determined using  
71.19 a sliding fee scale established by the commissioner that begins at 15 percent of the  
71.20 community spouse's income and increases to 25 percent for those with an income of up to  
71.21 750 percent of the federal poverty guidelines for a family of two.

71.22 (e) For a community spouse with an income equal to or greater than 750 percent of  
71.23 the federal poverty guidelines for a family of two and less than 975 percent of the federal  
71.24 poverty guidelines for a family of two, the spousal contribution shall be determined using  
71.25 a sliding fee scale established by the commissioner that begins at 25 percent of the  
71.26 community spouse's income and increases to 33 percent for those with an income of up to  
71.27 975 percent of the federal poverty guidelines for a family of two.

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

71.31 (g) The spousal contribution shall be explained in writing at the time eligibility  
71.32 for medical assistance or alternative care is being determined. In addition to explaining  
71.33 the formula used to determine the fee, the county or tribal agency shall provide written  
71.34 information describing how to request a variance for undue hardship, how a contribution  
71.35 may be reviewed or redetermined, the right to appeal a contribution determination, and  
71.36 that the consequences for not complying with a request to provide information shall be

72.1 an assessment against the community spouse for the full cost of care for the long-term  
72.2 care spouse.

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

72.6 (i) The spousal contribution shall be reviewed at least once every 12 months and  
72.7 when there is a loss or gain in income in excess of ten percent. Thirty days prior to a  
72.8 review or redetermination, written notice must be provided to the community spouse  
72.9 and must contain the amount the spouse is required to contribute, notice of the right to  
72.10 redetermination and appeal, and the telephone number of the division at the agency that is  
72.11 responsible for redetermination and review. If, after review, the contribution amount is to  
72.12 be adjusted, the county or tribal agency shall mail a written notice to the community spouse  
72.13 30 days in advance of the effective date of the change in the amount of the contribution.

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

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

72.20 (3) No action shall be taken on a review or redetermination until the required  
72.21 information is received by the county or tribal agency.

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

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

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

72.29 (j) In no case shall the spousal contribution exceed the amount of medical assistance  
72.30 expended or the cost of alternative care services for the care of the long-term care spouse.  
72.31 Annually, upon redetermination, or at termination of eligibility, the total amount of  
72.32 medical assistance paid or costs of alternative care for the care of the long-term care spouse  
72.33 and the total amount of the spousal contribution shall be compared. If the total amount  
72.34 of the spousal contribution exceeds the total amount of medical assistance expended or  
72.35 cost of alternative care, then the agency shall reimburse the community spouse the excess



73.1 amount if the long-term care spouse is no longer receiving services, or apply the excess  
73.2 amount to the spousal contribution due until the excess amount is exhausted.

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

73.11 (1) A spouse who requests a variance from a notice of an increase in the amount  
73.12 of spousal contribution shall continue to make monthly payments at the lower amount  
73.13 pending determination of the variance request. A spouse who requests a variance from  
73.14 the initial determination shall not be required to make a payment pending determination  
73.15 of the variance request. Payments made pending outcome of the variance request that  
73.16 result in overpayment must be returned to the spouse, if the long-term care spouse is no  
73.17 longer receiving services, or applied to the spousal contribution in the current year. If the  
73.18 variance is denied, the spouse shall pay the additional amount due from the effective date  
73.19 of the increase or the total amount due from the effective date of the original notice of  
73.20 determination of the spousal contribution.

73.21 (2) A spouse who is granted a variance shall sign a written agreement in which the  
73.22 spouse agrees to report to the county or tribal agency any changes in circumstances that  
73.23 gave rise to the undue hardship variance.

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

73.33 (4) If a variance is granted, the term of the variance shall not exceed 12 months  
73.34 unless otherwise determined by the county or tribal agency.

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

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

74.14 (m) If the county or tribal agency finds that notice of the payment obligation was  
74.15 given to the community spouse and the spouse was determined to be able to pay, but that  
74.16 the spouse failed or refused to pay, a cause of action exists against the community spouse  
74.17 for that portion of medical assistance payment of long-term care services or alternative  
74.18 care services granted after notice was given to the community spouse. The action may be  
74.19 brought by the county or tribal agency in the county where assistance was granted for the  
74.20 assistance together with the costs of disbursements incurred due to the action. In addition  
74.21 to granting the county or tribal agency a money judgment, the court may, upon a motion or  
74.22 order to show cause, order continuing contributions by a community spouse found able to  
74.23 repay the county or tribal agency. The order shall be effective only for the period of time  
74.24 during which a contribution shall be assessed.

74.25 (n) Counties and tribes are entitled to one-half of the nonfederal share of  
74.26 contributions made under this section for long-term care spouses on medical assistance  
74.27 that are directly attributed to county or tribal efforts. Counties and tribes are entitled to  
74.28 25 percent of the contributions made under this section for long-term care spouses on  
74.29 alternative care directly attributed to county or tribal efforts.

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

74.31 Sec. 8. Minnesota Statutes 2010, section 326B.175, is amended to read:

74.32 **326B.175 ELEVATORS, ENTRANCES SEALED.**

74.33 Except as provided in section 326B.188, it shall be the duty of the department and  
74.34 the licensing authority of any municipality which adopts any such ordinance whenever

75.1 it finds any such elevator under its jurisdiction in use in violation of any provision of  
75.2 sections 326B.163 to 326B.178 to seal the entrances of such elevator and attach a notice  
75.3 forbidding the use of such elevator until the provisions thereof are complied with.

75.4 **Sec. 9. [326B.188] COMPLIANCE WITH ELEVATOR CODE CHANGES.**

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

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

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

75.21 **Sec. 10. NONEMERGENCY MEDICAL TRANSPORTATION SINGLE**  
75.22 **ADMINISTRATIVE STRUCTURE PROPOSAL.**

75.23 (a) The commissioner of human services shall develop a proposal to create a single  
75.24 administrative structure for providing nonemergency medical transportation services to  
75.25 fee-for-service medical assistance recipients. This proposal must consolidate access and  
75.26 special transportation into one administrative structure with the goal of standardizing  
75.27 eligibility determination processes, scheduling arrangements, billing procedures, data  
75.28 collection, and oversight mechanisms in order to enhance coordination, improve  
75.29 accountability, and lessen confusion.

75.30 (b) In developing the proposal, the commissioner shall:

75.31 (1) examine the current responsibilities performed by the counties and the  
75.32 Department of Human Services and consider the shift in costs if these responsibilities are  
75.33 changed;

76.1 (2) identify key performance measures to assess the cost effectiveness of  
76.2 nonemergency medical transportation statewide, including a process to collect, audit,  
76.3 and report data;

76.4 (3) develop a statewide complaint system for medical assistance recipients using  
76.5 special transportation;

76.6 (4) establish a standardized billing process;

76.7 (5) establish a process that provides public input from interested parties before  
76.8 special transportation eligibility policies are implemented or significantly changed;

76.9 (6) establish specific eligibility criteria that include the frequency of eligibility  
76.10 assessments and the length of time a recipient remains eligible for special transportation;

76.11 (7) develop a reimbursement method to compensate volunteers for no-load miles  
76.12 when transporting recipients to or from health-related appointments; and

76.13 (8) establish specific eligibility criteria to maximize the use of public transportation  
76.14 by recipients who are without a physical, mental, or other impairment that would prohibit  
76.15 safely accessing and using public transportation.

76.16 (c) In developing the proposal, the commissioner shall consult with the  
76.17 nonemergency medical transportation advisory council established under paragraph (d).

76.18 (d) The commissioner shall establish the nonemergency medical transportation  
76.19 advisory council to assist the commissioner in developing a single administrative structure  
76.20 for providing nonemergency medical transportation services. The council shall be  
76.21 comprised of:

76.22 (1) one representative each from the departments of human services and  
76.23 transportation;

76.24 (2) one representative each from the following organizations: the Minnesota State  
76.25 Council on Disability, the Minnesota Consortium for Citizens with Disabilities, ARC  
76.26 of Minnesota, the Association of Minnesota Counties, the Metropolitan Inter-County  
76.27 Association, the R-80 Medical Transportation Coalition, the Minnesota Paratransit  
76.28 Association, legal aid, the Minnesota Ambulance Association, the National Alliance on  
76.29 Mental Illness, Medical Transportation Management, and other transportation providers;  
76.30 and

76.31 (3) four members from the house of representatives, two from the majority party  
76.32 and two from the minority party, appointed by the speaker, and four members from the  
76.33 senate, two from the majority party and two from the minority party, appointed by the  
76.34 Subcommittee on Committees of the Committee on Rules and Administration.

77.1 The council is governed by Minnesota Statutes, section 15.509, except that members  
77.2 shall not receive per diems. The commissioner of human services shall fund all costs  
77.3 related to the council from existing resources.

77.4 (e) The commissioner shall submit the proposal and draft legislation necessary for  
77.5 implementation to the chairs and ranking minority members of the senate and house of  
77.6 representatives committees or divisions with jurisdiction over health care policy and  
77.7 finance by January 15, 2012.

## 77.8 ARTICLE 4

### 77.9 HEALTH RELATED LICENSING

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

77.11 Subdivision 1. **Renewal fees.** All persons practicing chiropractic within this state,  
77.12 or licensed so to do, shall pay, on or before the date of expiration of their licenses, to the  
77.13 Board of Chiropractic Examiners a renewal fee set ~~by the board~~ in accordance with section  
77.14 16A.1283, with a penalty set by the board for each month or portion thereof for which a  
77.15 license fee is in arrears and upon payment of the renewal and upon compliance with all the  
77.16 rules of the board, shall be entitled to renewal of their license.

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

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

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

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

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

77.23 Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise  
77.24 rules not inconsistent with the law, as may be necessary to enable it to carry into effect the  
77.25 provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula  
77.26 and standards for schools and courses preparing persons for licensure under sections  
77.27 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses  
77.28 at such times as it may deem necessary. It shall approve such schools and courses as  
77.29 meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine,  
77.30 license, and renew the license of duly qualified applicants. It shall hold examinations  
77.31 at least once in each year at such time and place as it may determine. It shall by rule  
77.32 adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for  
77.33 registration and renewal of registration as defined in section 148.231. It shall maintain a

78.1 record of all persons licensed by the board to practice professional or practical nursing and  
78.2 all registered nurses who hold Minnesota licensure and registration and are certified as  
78.3 advanced practice registered nurses. It shall cause the prosecution of all persons violating  
78.4 sections 148.171 to 148.285 and have power to incur such necessary expense therefor.  
78.5 It shall register public health nurses who meet educational and other requirements  
78.6 established by the board by rule, including payment of a fee. ~~Prior to the adoption of rules,~~  
78.7 ~~the board shall use the same procedures used by the Department of Health to certify public~~  
78.8 ~~health nurses.~~ It shall have power to issue subpoenas, and to compel the attendance of  
78.9 witnesses and the production of all necessary documents and other evidentiary material.  
78.10 Any board member may administer oaths to witnesses, or take their affirmation. It shall  
78.11 keep a record of all its proceedings.

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

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

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

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

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

78.32 ~~(a) The applicant for licensure by examination under section 148.211, subdivision~~  
78.33 ~~1, has graduated from an approved nursing program within the 60 days preceding board~~  
78.34 ~~receipt of an affidavit of graduation or transcript and has been authorized by the board to~~  
78.35 ~~write the licensure examination for the first time in the United States. The permit holder~~

79.1 ~~must practice professional or practical nursing under the direct supervision of a registered~~  
79.2 ~~nurse. The permit is valid from the date of issue until the date the board takes action on~~  
79.3 ~~the application or for 60 days whichever occurs first.~~

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

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

79.12 (d) ~~The applicant for licensure by examination under section 148.211, subdivision~~  
79.13 ~~1, who graduated from a nursing program in a country other than the United States or~~  
79.14 ~~Canada has completed all requirements for licensure except registering for and taking the~~  
79.15 ~~nurse licensure examination for the first time in the United States. The permit holder must~~  
79.16 ~~practice professional nursing under the direct supervision of a registered nurse. The permit~~  
79.17 ~~is valid from the date of issue until the date the board takes action on the application or for~~  
79.18 ~~60 days, whichever occurs first.~~

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

79.20 **148.231 REGISTRATION; FAILURE TO REGISTER; REREGISTRATION;**  
79.21 **VERIFICATION.**

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

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

80.1 Subd. 4. **Failure to register.** Any person licensed under the provisions of sections  
80.2 148.171 to 148.285 who fails to register within the required period shall not be entitled to  
80.3 practice nursing in this state as a registered nurse or licensed practical nurse.

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

80.11 Subd. 6. **Verification.** A person licensed under the provisions of sections 148.171 to  
80.12 148.285 who requests the board to verify a Minnesota license to another state, territory,  
80.13 or country or to an agency, facility, school, or institution shall pay a fee ~~to the board~~  
80.14 for each verification.

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

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

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

80.19 Subdivision 1. **Licensure by examination.** The fee for licensure by examination is  
80.20 \$105.

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

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

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

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

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

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

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

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

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



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

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

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

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

81.11 Subd. 15. **Practicing without current APRN certification.** The fee for practicing  
81.12 without current APRN certification is \$200 for the first month or any part thereof, plus  
81.13 \$100 for each subsequent month or part thereof.

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

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

81.19 Sec. 8. **[148.2855] NURSE LICENSURE COMPACT.**

81.20 The Nurse Licensure Compact is enacted into law and entered into with all other  
81.21 jurisdictions legally joining in it, in the form substantially as follows:

81.22 ARTICLE 1

81.23 DEFINITIONS

81.24 As used in this compact:

81.25 (a) "Adverse action" means a home or remote state action.

81.26 (b) "Alternative program" means a voluntary, nondisciplinary monitoring program  
81.27 approved by a nurse licensing board.

81.28 (c) "Coordinated licensure information system" means an integrated process for  
81.29 collecting, storing, and sharing information on nurse licensure and enforcement activities  
81.30 related to nurse licensure laws, which is administered by a nonprofit organization  
81.31 composed of and controlled by state nurse licensing boards.

81.32 (d) "Current significant investigative information" means:

81.33 (1) investigative information that a licensing board, after a preliminary inquiry that  
81.34 includes notification and an opportunity for the nurse to respond if required by state law,

82.1 has reason to believe is not groundless and, if proved true, would indicate more than a  
82.2 minor infraction; or

82.3 (2) investigative information that indicates that the nurse represents an immediate  
82.4 threat to public health and safety regardless of whether the nurse has been notified and  
82.5 had an opportunity to respond.

82.6 (e) "Home state" means the party state which is the nurse's primary state of residence.

82.7 (f) "Home state action" means any administrative, civil, equitable, or criminal  
82.8 action permitted by the home state's laws which are imposed on a nurse by the home  
82.9 state's licensing board or other authority including actions against an individual's license  
82.10 such as revocation, suspension, probation, or any other action which affects a nurse's  
82.11 authorization to practice.

82.12 (g) "Licensing board" means a party state's regulatory body responsible for issuing  
82.13 nurse licenses.

82.14 (h) "Multistate licensure privilege" means current, official authority from a  
82.15 remote state permitting the practice of nursing as either a registered nurse or a licensed  
82.16 practical/vocational nurse in the party state. All party states have the authority, according  
82.17 to existing state due process law, to take actions against the nurse's privilege such as  
82.18 revocation, suspension, probation, or any other action which affects a nurse's authorization  
82.19 to practice.

82.20 (i) "Nurse" means a registered nurse or licensed practical/vocational nurse as those  
82.21 terms are defined by each party state's practice laws.

82.22 (j) "Party state" means any state that has adopted this compact.

82.23 (k) "Remote state" means a party state other than the home state:

82.24 (1) where the patient is located at the time nursing care is provided; or

82.25 (2) in the case of the practice of nursing not involving a patient, in the party state  
82.26 where the recipient of nursing practice is located.

82.27 (l) "Remote state action" means:

82.28 (1) any administrative, civil, equitable, or criminal action permitted by a remote  
82.29 state's laws which are imposed on a nurse by the remote state's licensing board or other  
82.30 authority including actions against an individual's multistate licensure privilege to practice  
82.31 in the remote state; and

82.32 (2) cease and desist and other injunctive or equitable orders issued by remote states  
82.33 or the licensing boards of those states.

82.34 (m) "State" means a state, territory, or possession of the United States, the District of  
82.35 Columbia, or the Commonwealth of Puerto Rico.

83.1 (n) "State practice laws" means individual party state laws and regulations that  
83.2 govern the practice of nursing, define the scope of nursing practice, and create the  
83.3 methods and grounds for imposing discipline. State practice laws does not include the  
83.4 initial qualifications for licensure or requirements necessary to obtain and retain a license,  
83.5 except for qualifications or requirements of the home state.

## 83.6 ARTICLE 2

### 83.7 GENERAL PROVISIONS AND JURISDICTION

83.8 (a) A license to practice registered nursing issued by a home state to a resident in  
83.9 that state will be recognized by each party state as authorizing a multistate licensure  
83.10 privilege to practice as a registered nurse in the party state. A license to practice licensed  
83.11 practical/vocational nursing issued by a home state to a resident in that state will be  
83.12 recognized by each party state as authorizing a multistate licensure privilege to practice  
83.13 as a licensed practical/vocational nurse in the party state. In order to obtain or retain a  
83.14 license, an applicant must meet the home state's qualifications for licensure and license  
83.15 renewal as well as all other applicable state laws.

83.16 (b) Party states may, according to state due process laws, limit or revoke the  
83.17 multistate licensure privilege of any nurse to practice in their state and may take any other  
83.18 actions under their applicable state laws necessary to protect the health and safety of  
83.19 their citizens. If a party state takes such action, it shall promptly notify the administrator  
83.20 of the coordinated licensure information system. The administrator of the coordinated  
83.21 licensure information system shall promptly notify the home state of any such actions by  
83.22 remote states.

83.23 (c) Every nurse practicing in a party state must comply with the state practice laws of  
83.24 the state in which the patient is located at the time care is rendered. In addition, the practice  
83.25 of nursing is not limited to patient care, but shall include all nursing practice as defined by  
83.26 the state practice laws of the party state. The practice of nursing will subject a nurse to the  
83.27 jurisdiction of the nurse licensing board, the courts, and the laws in the party state.

83.28 (d) This compact does not affect additional requirements imposed by states for  
83.29 advanced practice registered nursing. However, a multistate licensure privilege to practice  
83.30 registered nursing granted by a party state shall be recognized by other party states as a  
83.31 license to practice registered nursing if one is required by state law as a precondition for  
83.32 qualifying for advanced practice registered nurse authorization.

83.33 (e) Individuals not residing in a party state shall continue to be able to apply for  
83.34 nurse licensure as provided for under the laws of each party state. However, the license  
83.35 granted to these individuals will not be recognized as granting the privilege to practice  
83.36 nursing in any other party state unless explicitly agreed to by that party state.

84.1 ARTICLE 3

84.2 APPLICATIONS FOR LICENSURE IN A PARTY STATE

84.3 (a) Upon application for a license, the licensing board in a party state shall ascertain,  
84.4 through the coordinated licensure information system, whether the applicant has ever held  
84.5 or is the holder of a license issued by any other state, whether there are any restrictions  
84.6 on the multistate licensure privilege, and whether any other adverse action by a state  
84.7 has been taken against the license.

84.8 (b) A nurse in a party state shall hold licensure in only one party state at a time,  
84.9 issued by the home state.

84.10 (c) A nurse who intends to change primary state of residence may apply for licensure  
84.11 in the new home state in advance of the change. However, new licenses will not be  
84.12 issued by a party state until after a nurse provides evidence of change in primary state of  
84.13 residence satisfactory to the new home state's licensing board.

84.14 (d) When a nurse changes primary state of residence by:

84.15 (1) moving between two party states, and obtains a license from the new home state,  
84.16 the license from the former home state is no longer valid;

84.17 (2) moving from a nonparty state to a party state, and obtains a license from the new  
84.18 home state, the individual state license issued by the nonparty state is not affected and will  
84.19 remain in full force if so provided by the laws of the nonparty state; or

84.20 (3) moving from a party state to a nonparty state, the license issued by the prior  
84.21 home state converts to an individual state license, valid only in the former home state,  
84.22 without the multistate licensure privilege to practice in other party states.

84.23 ARTICLE 4

84.24 ADVERSE ACTIONS

84.25 In addition to the general provisions described in article 2, the provisions in this  
84.26 article apply.

84.27 (a) The licensing board of a remote state shall promptly report to the administrator  
84.28 of the coordinated licensure information system any remote state actions including the  
84.29 factual and legal basis for the action, if known. The licensing board of a remote state shall  
84.30 also promptly report any significant current investigative information yet to result in a  
84.31 remote state action. The administrator of the coordinated licensure information system  
84.32 shall promptly notify the home state of any reports.

84.33 (b) The licensing board of a party state shall have the authority to complete any  
84.34 pending investigation for a nurse who changes primary state of residence during the  
84.35 course of the investigation. The board shall also have the authority to take appropriate  
84.36 action, and shall promptly report the conclusion of the investigation to the administrator

85.1 of the coordinated licensure information system. The administrator of the coordinated  
85.2 licensure information system shall promptly notify the new home state of any action.

85.3 (c) A remote state may take adverse action affecting the multistate licensure  
85.4 privilege to practice within that party state. However, only the home state shall have the  
85.5 power to impose adverse action against the license issued by the home state.

85.6 (d) For purposes of imposing adverse actions, the licensing board of the home state  
85.7 shall give the same priority and effect to reported conduct received from a remote state as  
85.8 it would if the conduct had occurred within the home state. In so doing, it shall apply its  
85.9 own state laws to determine appropriate action.

85.10 (e) The home state may take adverse action based on the factual findings of the  
85.11 remote state, provided each state follows its own procedures for imposing the adverse  
85.12 action.

85.13 (f) Nothing in this compact shall override a party state's decision that participation  
85.14 in an alternative program may be used in lieu of licensure action and that participation  
85.15 shall remain nonpublic if required by the party state's laws.

85.16 Party states must require nurses who enter any alternative programs to agree not to  
85.17 practice in any other party state during the term of the alternative program without prior  
85.18 authorization from the other party state.

#### 85.19 ARTICLE 5

#### 85.20 ADDITIONAL AUTHORITIES INVESTED IN

#### 85.21 PARTY STATE NURSE LICENSING BOARDS

85.22 Notwithstanding any other laws, party state nurse licensing boards shall have the  
85.23 authority to:

85.24 (1) if otherwise permitted by state law, recover from the affected nurse the costs of  
85.25 investigation and disposition of cases resulting from any adverse action taken against  
85.26 that nurse;

85.27 (2) issue subpoenas for both hearings and investigations which require the attendance  
85.28 and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse  
85.29 licensing board in a party state for the attendance and testimony of witnesses, and the  
85.30 production of evidence from another party state, shall be enforced in the latter state by  
85.31 any court of competent jurisdiction according to the practice and procedure of that court  
85.32 applicable to subpoenas issued in proceedings pending before it. The issuing authority  
85.33 shall pay any witness fees, travel expenses, mileage, and other fees required by the service  
85.34 statutes of the state where the witnesses and evidence are located;

85.35 (3) issue cease and desist orders to limit or revoke a nurse's authority to practice  
85.36 in the nurse's state; and

86.1 (4) adopt uniform rules and regulations as provided for in article 7, paragraph (c).

86.2 ARTICLE 6

86.3 COORDINATED LICENSURE INFORMATION SYSTEM

86.4 (a) All party states shall participate in a cooperative effort to create a coordinated  
86.5 database of all licensed registered nurses and licensed practical/vocational nurses. This  
86.6 system shall include information on the licensure and disciplinary history of each  
86.7 nurse, as contributed by party states, to assist in the coordination of nurse licensure and  
86.8 enforcement efforts.

86.9 (b) Notwithstanding any other provision of law, all party states' licensing boards shall  
86.10 promptly report adverse actions, actions against multistate licensure privileges, any current  
86.11 significant investigative information yet to result in adverse action, denials of applications,  
86.12 and the reasons for the denials to the coordinated licensure information system.

86.13 (c) Current significant investigative information shall be transmitted through the  
86.14 coordinated licensure information system only to party state licensing boards.

86.15 (d) Notwithstanding any other provision of law, all party states' licensing boards  
86.16 contributing information to the coordinated licensure information system may designate  
86.17 information that may not be shared with nonparty states or disclosed to other entities or  
86.18 individuals without the express permission of the contributing state.

86.19 (e) Any personally identifiable information obtained by a party state's licensing  
86.20 board from the coordinated licensure information system may not be shared with nonparty  
86.21 states or disclosed to other entities or individuals except to the extent permitted by the  
86.22 laws of the party state contributing the information.

86.23 (f) Any information contributed to the coordinated licensure information system that  
86.24 is subsequently required to be expunged by the laws of the party state contributing that  
86.25 information shall also be expunged from the coordinated licensure information system.

86.26 (g) The compact administrators, acting jointly with each other and in consultation  
86.27 with the administrator of the coordinated licensure information system, shall formulate  
86.28 necessary and proper procedures for the identification, collection, and exchange of  
86.29 information under this compact.

86.30 ARTICLE 7

86.31 COMPACT ADMINISTRATION AND

86.32 INTERCHANGE OF INFORMATION

86.33 (a) The head or designee of the nurse licensing board of each party state shall be the  
86.34 administrator of this compact for that state.

86.35 (b) The compact administrator of each party state shall furnish to the compact  
86.36 administrator of each other party state any information and documents including, but not

87.1 limited to, a uniform data set of investigations, identifying information, licensure data, and  
87.2 disclosable alternative program participation information to facilitate the administration of  
87.3 this compact.

87.4 (c) Compact administrators shall have the authority to develop uniform rules to  
87.5 facilitate and coordinate implementation of this compact. These uniform rules shall be  
87.6 adopted by party states under the authority in article 5, clause (4).

## 87.7 ARTICLE 8

### 87.8 IMMUNITY

87.9 A party state or the officers, employees, or agents of a party state's nurse licensing  
87.10 board who acts in good faith according to the provisions of this compact shall not be  
87.11 liable for any act or omission while engaged in the performance of their duties under  
87.12 this compact. Good faith shall not include willful misconduct, gross negligence, or  
87.13 recklessness.

## 87.14 ARTICLE 9

### 87.15 ENACTMENT, WITHDRAWAL, AND AMENDMENT

87.16 (a) This compact shall become effective for each state when it has been enacted by  
87.17 that state. Any party state may withdraw from this compact by repealing the nurse licensure  
87.18 compact, but no withdrawal shall take effect until six months after the withdrawing state  
87.19 has given notice of the withdrawal to the executive heads of all other party states.

87.20 (b) No withdrawal shall affect the validity or applicability by the licensing boards  
87.21 of states remaining party to the compact of any report of adverse action occurring prior  
87.22 to the withdrawal.

87.23 (c) Nothing contained in this compact shall be construed to invalidate or prevent any  
87.24 nurse licensure agreement or other cooperative arrangement between a party state and a  
87.25 nonparty state that is made according to the other provisions of this compact.

87.26 (d) This compact may be amended by the party states. No amendment to this  
87.27 compact shall become effective and binding upon the party states until it is enacted into  
87.28 the laws of all party states.

## 87.29 ARTICLE 10

### 87.30 CONSTRUCTION AND SEVERABILITY

87.31 (a) This compact shall be liberally construed to effectuate the purposes of the  
87.32 compact. The provisions of this compact shall be severable and if any phrase, clause,  
87.33 sentence, or provision of this compact is declared to be contrary to the constitution of any  
87.34 party state or of the United States or the applicability thereof to any government, agency,  
87.35 person, or circumstance is held invalid, the validity of the remainder of this compact and  
87.36 the applicability of it to any government, agency, person, or circumstance shall not be

88.1 affected by it. If this compact is held contrary to the constitution of any party state, the  
88.2 compact shall remain in full force and effect for the remaining party states and in full force  
88.3 and effect for the party state affected as to all severable matters.

88.4 (b) In the event party states find a need for settling disputes arising under this  
88.5 compact:

88.6 (1) the party states may submit the issues in dispute to an arbitration panel which  
88.7 shall be comprised of an individual appointed by the compact administrator in the home  
88.8 state, an individual appointed by the compact administrator in the remote states involved,  
88.9 and an individual mutually agreed upon by the compact administrators of the party states  
88.10 involved in the dispute; and

88.11 (2) the decision of a majority of the arbitrators shall be final and binding.

88.12 **Sec. 9. [148.2856] APPLICATION OF NURSE LICENSURE COMPACT TO**  
88.13 **EXISTING LAWS.**

88.14 (a) A nurse practicing professional or practical nursing in Minnesota under the  
88.15 authority of section 148.2855 shall have the same obligations, privileges, and rights as if  
88.16 the nurse was licensed in Minnesota. Notwithstanding any contrary provisions in section  
88.17 148.2855, the Board of Nursing shall comply with and follow all laws and rules with  
88.18 respect to registered and licensed practical nurses practicing professional or practical  
88.19 nursing in Minnesota under the authority of section 148.2855, and all such individuals  
88.20 shall be governed and regulated as if they were licensed by the board.

88.21 (b) Section 148.2855 does not relieve employers of nurses from complying with  
88.22 statutorily imposed obligations.

88.23 (c) Section 148.2855 does not supersede existing state labor laws.

88.24 (d) For purposes of the Minnesota Government Data Practices Act, chapter 13,  
88.25 an individual not licensed as a nurse under sections 148.171 to 148.285 who practices  
88.26 professional or practical nursing in Minnesota under the authority of section 148.2855 is  
88.27 considered to be a licensee of the board.

88.28 (e) Uniform rules developed by the compact administrators shall not be subject  
88.29 to the provisions of sections 14.05 to 14.389, except for sections 14.07, 14.08, 14.101,  
88.30 14.131, 14.18, 14.22, 14.23, 14.27, 14.28, 14.365, 14.366, 14.37, and 14.38.

88.31 (f) Proceedings brought against an individual's multistate privilege shall be  
88.32 adjudicated following the procedures listed in sections 14.50 to 14.62 and shall be subject  
88.33 to judicial review as provided for in sections 14.63 to 14.69.

88.34 (g) For purposes of sections 62M.09, subdivision 2; 121A.22, subdivision 4;  
88.35 144.051; 144.052; 145A.02, subdivision 18; 148.975; 151.37; 152.12; 154.04; 256B.0917,



89.1 subdivision 8; 595.02, subdivision 1, paragraph (g); 604.20, subdivision 5; and 631.40,  
89.2 subdivision 2; and chapters 319B and 364, holders of a multistate privilege who are  
89.3 licensed as registered or licensed practical nurses in the home state shall be considered  
89.4 to be licensees in Minnesota. If any of the statutes listed in this paragraph are limited to  
89.5 registered nurses or the practice of professional nursing, then only holders of a multistate  
89.6 privilege who are licensed as registered nurses in the home state shall be considered  
89.7 licensees.

89.8 (h) The reporting requirements of sections 144.4175, 148.263, 626.52, and 626.557  
89.9 apply to individuals not licensed as registered or licensed practical nurses under sections  
89.10 148.171 to 148.285 who practice professional or practical nursing in Minnesota under  
89.11 the authority of section 148.2855.

89.12 (i) The board may take action against an individual's multistate privilege based on  
89.13 the grounds listed in section 148.261, subdivision 1, and any other statute authorizing or  
89.14 requiring the board to take corrective or disciplinary action.

89.15 (j) The board may take all forms of disciplinary action provided for in section  
89.16 148.262, subdivision 1, and corrective action provided for in section 214.103, subdivision  
89.17 6, against an individual's multistate privilege.

89.18 (k) The immunity provisions of section 148.264, subdivision 1, apply to individuals  
89.19 who practice professional or practical nursing in Minnesota under the authority of section  
89.20 148.2855.

89.21 (l) The cooperation requirements of section 148.265 apply to individuals who  
89.22 practice professional or practical nursing in Minnesota under the authority of section  
89.23 148.2855.

89.24 (m) The provisions of section 148.283 shall not apply to individuals who practice  
89.25 professional or practical nursing in Minnesota under the authority of section 148.2855.

89.26 (n) Complaints against individuals who practice professional or practical nursing  
89.27 in Minnesota under the authority of section 148.2855 shall be handled as provided in  
89.28 sections 214.10 and 214.103.

89.29 (o) All provisions of section 148.2855 authorizing or requiring the board to provide  
89.30 data to party states are authorized by section 214.10, subdivision 8, paragraph (d).

89.31 (p) Except as provided in section 13.41, subdivision 6, the board shall not report to a  
89.32 remote state any active investigative data regarding a complaint investigation against a  
89.33 nurse licensed under sections 148.171 to 148.285, unless the board obtains reasonable  
89.34 assurances from the remote state that the data will be maintained with the same protections  
89.35 as provided in Minnesota law.

90.1 (q) The provisions of sections 214.17 to 214.25 apply to individuals who practice  
90.2 professional or practical nursing in Minnesota under the authority of section 148.2855  
90.3 when the practice involves direct physical contact between the nurse and a patient.

90.4 (r) A nurse practicing professional or practical nursing in Minnesota under the  
90.5 authority of section 148.2855 must comply with any criminal background check required  
90.6 under Minnesota law.

90.7 Sec. 10. **[148.2857] WITHDRAWAL FROM COMPACT.**

90.8 The governor may withdraw the state from the compact in section 148.2855 if  
90.9 the Board of Nursing notifies the governor that a party state to the compact changed  
90.10 the party state's requirements for nurse licensure after July 1, 2009, and that the party  
90.11 state's requirements, as changed, are substantially lower than the requirements for nurse  
90.12 licensure in this state.

90.13 Sec. 11. **[148.2858] MISCELLANEOUS PROVISIONS.**

90.14 (a) For the purposes of section 148.2855, "head of the Nurse Licensing Board"  
90.15 means the executive director of the board.

90.16 (b) The Board of Nursing shall have the authority to recover from a nurse practicing  
90.17 professional or practical nursing in Minnesota under the authority of section 148.2855  
90.18 the costs of investigation and disposition of cases resulting from any adverse action  
90.19 taken against the nurse.

90.20 (c) The board may implement a system of identifying individuals who practice  
90.21 professional or practical nursing in Minnesota under the authority of section 148.2855.

90.22 Sec. 12. **[148.2859] NURSE LICENSURE COMPACT ADVISORY**  
90.23 **COMMITTEE.**

90.24 Subdivision 1. **Establishment; membership.** A Nurse Licensure Compact Advisory  
90.25 Committee is established to advise the compact administrator in the implementation of  
90.26 section 148.2855. Members of the advisory committee shall be appointed by the board  
90.27 and shall be composed of representatives of Minnesota nursing organizations, Minnesota  
90.28 licensed nurses who practice in nursing facilities or hospitals, Minnesota licensed nurses  
90.29 who provide home care, Minnesota licensed advanced practice registered nurses, and  
90.30 public members as defined in section 214.02.

90.31 Subd. 2. **Duties.** The advisory committee shall advise the compact administrator in  
90.32 the implementation of section 148.2855.

91.1 Subd. 3. **Organization.** The advisory committee shall be organized and  
91.2 administered under section 15.059.

91.3 Sec. 13. Minnesota Statutes 2010, section 148B.17, is amended to read:

91.4 **148B.17 FEES.**

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

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

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

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

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

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

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

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

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

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

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

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

91.26 (11) fee for emeritus status is \$125.

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

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

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

91.30 (3) duplicate license fee is \$25;

91.31 (4) duplicate renewal card fee is \$10;

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

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

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

92.1 Sec. 14. Minnesota Statutes 2010, section 148B.33, subdivision 2, is amended to read:

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

92.4 Sec. 15. Minnesota Statutes 2010, section 148B.52, is amended to read:

92.5 **148B.52 DUTIES OF THE BOARD.**

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

92.7 (1) establish by rule appropriate techniques, including examinations and other  
92.8 methods, for determining whether applicants and licensees are qualified under sections  
92.9 148B.50 to 148B.593;

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

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

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

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

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

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

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

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

92.29 Sec. 16. Minnesota Statutes 2010, section 150A.091, subdivision 2, is amended to read:

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

92.33 (1) dentist, \$140;

92.34 (2) full faculty dentist, \$140;

- 93.1           ~~(2)~~ (3) limited faculty dentist, \$140;  
93.2           ~~(3)~~ (4) resident dentist or dental provider, \$55;  
93.3           (5) advanced dental therapist, \$100;  
93.4           ~~(4)~~ (6) dental therapist, \$100;  
93.5           ~~(5)~~ (7) dental hygienist, \$55;  
93.6           ~~(6)~~ (8) licensed dental assistant, \$55; and  
93.7           ~~(7)~~ (9) dental assistant with a permit as described in Minnesota Rules, part  
93.8           3100.8500, subpart 3, \$15.

93.9           Sec. 17. Minnesota Statutes 2010, section 150A.091, subdivision 3, is amended to read:

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

- 93.15           (1) dentist or full faculty dentist, \$14 times the number of months of the initial term;  
93.16           (2) dental therapist, \$10 times the number of months of the initial term;  
93.17           (3) dental hygienist, \$5 times the number of months of the initial term;  
93.18           (4) licensed dental assistant, \$3 times the number of months of the initial term; and  
93.19           (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,  
93.20           subpart 3, \$1 times the number of months of the initial term.

93.21           Sec. 18. Minnesota Statutes 2010, section 150A.091, subdivision 4, is amended to read:

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

- 93.25           (1) limited faculty dentist, \$168; and  
93.26           (2) resident dentist or dental provider, \$59.

93.27           Sec. 19. Minnesota Statutes 2010, section 150A.091, subdivision 5, is amended to read:

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

- 93.31           (1) dentist or full faculty dentist, \$336;  
93.32           (2) dental therapist, \$180;  
93.33           (3) dental hygienist, \$118;

- 94.1 (4) licensed dental assistant, \$80; and  
94.2 (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500,  
94.3 subpart 3, \$24.

94.4 Sec. 20. Minnesota Statutes 2010, section 150A.091, subdivision 8, is amended to read:

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

- 94.8 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental  
94.9 assistant license, \$35; and  
94.10 (2) annual or biennial renewal certificates, \$10.

94.11 Sec. 21. Minnesota Statutes 2010, section 150A.091, is amended by adding a  
94.12 subdivision to read:

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

94.17 Sec. 22. [151.065] FEE AMOUNTS.

94.18 Subdivision 1. **Application fees.** Application fees for licensure and registration  
94.19 are as follows:

- 94.20 (1) pharmacist licensed by examination, \$130;  
94.21 (2) pharmacist licensed by reciprocity, \$225;  
94.22 (3) pharmacy intern, \$30;  
94.23 (4) pharmacy technician, \$30;  
94.24 (5) pharmacy, \$190;  
94.25 (6) drug wholesaler, legend drugs only, \$200;  
94.26 (7) drug wholesaler, legend and nonlegend drugs, \$200;  
94.27 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;  
94.28 (9) drug wholesaler, medical gases, \$150;  
94.29 (10) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;  
94.30 (11) drug manufacturer, legend drugs only, \$200;  
94.31 (12) drug manufacturer, legend and nonlegend drugs, \$200;  
94.32 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$175;  
94.33 (14) drug manufacturer, medical gases, \$150;

95.1 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;

95.2 (16) medical gas distributor, \$75;

95.3 (17) controlled substance researcher, \$50; and

95.4 (18) pharmacy professional corporation, \$100.

95.5 Subd. 2. **Original license fee.** The pharmacist original licensure fee, \$130.

95.6 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees

95.7 are as follows:

95.8 (1) pharmacist, \$130;

95.9 (2) pharmacy technician, \$30;

95.10 (3) pharmacy, \$190;

95.11 (4) drug wholesaler, legend drugs only, \$200;

95.12 (5) drug wholesaler, legend and nonlegend drugs, \$200;

95.13 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$175;

95.14 (7) drug wholesaler, medical gases, \$150;

95.15 (8) drug wholesaler, also licensed as a pharmacy in Minnesota, \$125;

95.16 (9) drug manufacturer, legend drugs only, \$200;

95.17 (10) drug manufacturer, legend and nonlegend drugs, \$200;

95.18 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$175;

95.19 (12) drug manufacturer, medical gases, \$150;

95.20 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$125;

95.21 (14) medical gas distributor, \$75;

95.22 (15) controlled substance researcher, \$50; and

95.23 (16) pharmacy professional corporation, \$45.

95.24 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses  
95.25 and certificates are as follows:

95.26 (1) intern affidavit, \$15;

95.27 (2) duplicate small license, \$15; and

95.28 (3) duplicate large certificate, \$25.

95.29 Subd. 5. **Late fees.** All annual renewal fees are subject to a 50 percent late fee if  
95.30 the renewal fee and application are not received by the board prior to the date specified  
95.31 by the board.

95.32 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's  
95.33 license to lapse may reinstate the license with board approval and upon payment of any  
95.34 fees and late fees in arrears, up to a maximum of \$1,000.

96.1 (b) A pharmacy technician who has allowed the technician's registration to lapse  
96.2 may reinstate the registration with board approval and upon payment of any fees and late  
96.3 fees in arrears, up to a maximum of \$90.

96.4 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical  
96.5 gas distributor who has allowed the license of the establishment to lapse may reinstate the  
96.6 license with board approval and upon payment of any fees and late fees in arrears.

96.7 (d) A controlled substance researcher who has allowed the researcher's registration  
96.8 to lapse may reinstate the registration with board approval and upon payment of any fees  
96.9 and late fees in arrears.

96.10 (e) A pharmacist owner of a professional corporation who has allowed the  
96.11 corporation's registration to lapse may reinstate the registration with board approval and  
96.12 upon payment of any fees and late fees in arrears.

96.13 Sec. 23. Minnesota Statutes 2010, section 151.07, is amended to read:

96.14 **151.07 MEETINGS; EXAMINATION FEE.**

96.15 The board shall meet at times as may be necessary and as it may determine to  
96.16 examine applicants for licensure and to transact its other business, giving reasonable  
96.17 notice of all examinations by mail to known applicants therefor. The secretary shall record  
96.18 the names of all persons licensed by the board, together with the grounds upon which  
96.19 the right of each to licensure was claimed. The fee for examination shall be in ~~such the~~  
96.20 amount ~~as the board may determine~~ specified in section 151.065, which fee may in the  
96.21 discretion of the board be returned to applicants not taking the examination.

96.22 Sec. 24. Minnesota Statutes 2010, section 151.101, is amended to read:

96.23 **151.101 INTERNSHIP.**

96.24 Upon payment of the fee specified in section 151.065, the board may ~~license~~ register  
96.25 as an intern any natural persons who have satisfied the board that they are of good moral  
96.26 character, not physically or mentally unfit, and who have successfully completed the  
96.27 educational requirements for intern ~~licensure~~ registration prescribed by the board. The  
96.28 board shall prescribe standards and requirements for interns, pharmacist-preceptors, and  
96.29 internship training but may not require more than one year of such training.

96.30 The board in its discretion may accept internship experience obtained in another  
96.31 state provided the internship requirements in such other state are in the opinion of the  
96.32 board equivalent to those herein provided.



97.1 Sec. 25. Minnesota Statutes 2010, section 151.102, is amended by adding a subdivision  
97.2 to read:

97.3 Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy  
97.4 technician unless all applicable fees specified in section 151.065 have been paid.

97.5 Sec. 26. Minnesota Statutes 2010, section 151.12, is amended to read:

97.6 **151.12 RECIPROCITY; LICENSURE.**

97.7 The board may in its discretion grant licensure without examination to any  
97.8 pharmacist licensed by the Board of Pharmacy or a similar board of another state which  
97.9 accords similar recognition to licensees of this state; provided, the requirements for  
97.10 licensure in such other state are in the opinion of the board equivalent to those herein  
97.11 provided. The fee for licensure shall be in ~~such the amount as the board may determine by~~  
97.12 rule specified in section 151.065.

97.13 Sec. 27. Minnesota Statutes 2010, section 151.13, subdivision 1, is amended to read:

97.14 Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist  
97.15 shall pay to the board a the annual renewal fee to be fixed by it specified in section  
97.16 151.065. The board may ~~promulgate by rule a charge to be assessed for the delinquent~~  
97.17 ~~payment of a fee.~~ the late fee specified in section 151.065 if the renewal fee and  
97.18 application are not received by the board prior to the date specified by the board. It shall  
97.19 be unlawful for any person licensed as a pharmacist who refuses or fails to pay ~~such any~~  
97.20 applicable renewal or late fee to practice pharmacy in this state. Every certificate and  
97.21 license shall expire at the time therein prescribed.

97.22 Sec. 28. Minnesota Statutes 2010, section 151.19, is amended to read:

97.23 **151.19 REGISTRATION; FEES.**

97.24 Subdivision 1. **Pharmacy registration.** The board shall require and provide for the  
97.25 annual registration of every pharmacy now or hereafter doing business within this state.  
97.26 Upon the payment of ~~a any applicable fee to be set by the board~~ specified in section  
97.27 151.065, the board shall issue a registration certificate in such form as it may prescribe to  
97.28 such persons as may be qualified by law to conduct a pharmacy. Such certificate shall be  
97.29 displayed in a conspicuous place in the pharmacy for which it is issued and expire on the  
97.30 30th day of June following the date of issue. It shall be unlawful for any person to conduct  
97.31 a pharmacy unless such certificate has been issued to the person by the board.

97.32 Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an  
97.33 annual nonresident special pharmacy registration for all pharmacies located outside of this

98.1 state that regularly dispense medications for Minnesota residents and mail, ship, or deliver  
98.2 prescription medications into this state. Nonresident special pharmacy registration shall  
98.3 be granted by the board upon payment of any applicable fee specified in section 151.065  
98.4 and the disclosure and certification by a pharmacy:

98.5 (1) that it is licensed in the state in which the dispensing facility is located and from  
98.6 which the drugs are dispensed;

98.7 (2) the location, names, and titles of all principal corporate officers and all  
98.8 pharmacists who are dispensing drugs to residents of this state;

98.9 (3) that it complies with all lawful directions and requests for information from  
98.10 the Board of Pharmacy of all states in which it is licensed or registered, except that it  
98.11 shall respond directly to all communications from the board concerning emergency  
98.12 circumstances arising from the dispensing of drugs to residents of this state;

98.13 (4) that it maintains its records of drugs dispensed to residents of this state so that the  
98.14 records are readily retrievable from the records of other drugs dispensed;

98.15 (5) that it cooperates with the board in providing information to the Board of  
98.16 Pharmacy of the state in which it is licensed concerning matters related to the dispensing  
98.17 of drugs to residents of this state;

98.18 (6) that during its regular hours of operation, but not less than six days per week, for  
98.19 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate  
98.20 communication between patients in this state and a pharmacist at the pharmacy who has  
98.21 access to the patients' records; the toll-free number must be disclosed on the label affixed  
98.22 to each container of drugs dispensed to residents of this state; and

98.23 (7) that, upon request of a resident of a long-term care facility located within the  
98.24 state of Minnesota, the resident's authorized representative, or a contract pharmacy or  
98.25 licensed health care facility acting on behalf of the resident, the pharmacy will dispense  
98.26 medications prescribed for the resident in unit-dose packaging or, alternatively, comply  
98.27 with the provisions of section 151.415, subdivision 5.

98.28 Subd. 3. **Sale of federally restricted medical gases.** The board shall require and  
98.29 provide for the annual registration of every person or establishment not licensed as a  
98.30 pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted  
98.31 medical gases. Upon the payment of ~~a~~ any applicable fee to be set by the board specified  
98.32 in section 151.065, the board shall issue a registration certificate in such form as it may  
98.33 prescribe to those persons or places that may be qualified to sell or distribute federally  
98.34 restricted medical gases. The certificate shall be displayed in a conspicuous place in the  
98.35 business for which it is issued and expire on the date set by the board. It is unlawful for

99.1 a person to sell or distribute federally restricted medical gases unless a certificate has  
99.2 been issued to that person by the board.

99.3 Sec. 29. Minnesota Statutes 2010, section 151.25, is amended to read:

99.4 **151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.**

99.5 The board shall require and provide for the annual registration of every person  
99.6 engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes,  
99.7 now or hereafter doing business with accounts in this state. Upon a payment of ~~a~~ any  
99.8 applicable fee as set by the board specified in section 151.065, the board shall issue a  
99.9 registration certificate in such form as it may prescribe to such manufacturer. Such  
99.10 registration certificate shall be displayed in a conspicuous place in such manufacturer's  
99.11 or wholesaler's place of business for which it is issued and expire on the date set by the  
99.12 board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals,  
99.13 or poisons for medicinal purposes unless such a certificate has been issued to the person  
99.14 by the board. It shall be unlawful for any person engaged in the manufacture of drugs,  
99.15 medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell  
99.16 legend drugs to other than a pharmacy, except as provided in this chapter.

99.17 Sec. 30. Minnesota Statutes 2010, section 151.47, subdivision 1, is amended to read:

99.18 Subdivision 1. **Requirements.** All wholesale drug distributors are subject to the  
99.19 requirements in paragraphs (a) to (f).

99.20 (a) No person or distribution outlet shall act as a wholesale drug distributor without  
99.21 first obtaining a license from the board and paying ~~the required~~ any applicable fee  
99.22 specified in section 151.065.

99.23 (b) No license shall be issued or renewed for a wholesale drug distributor to operate  
99.24 unless the applicant agrees to operate in a manner prescribed by federal and state law and  
99.25 according to the rules adopted by the board.

99.26 (c) The board may require a separate license for each facility directly or indirectly  
99.27 owned or operated by the same business entity within the state, or for a parent entity  
99.28 with divisions, subsidiaries, or affiliate companies within the state, when operations  
99.29 are conducted at more than one location and joint ownership and control exists among  
99.30 all the entities.

99.31 (d) As a condition for receiving and retaining a wholesale drug distributor license  
99.32 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has  
99.33 and will continuously maintain:

99.34 (1) adequate storage conditions and facilities;

100.1 (2) minimum liability and other insurance as may be required under any applicable  
100.2 federal or state law;

100.3 (3) a viable security system that includes an after hours central alarm, or comparable  
100.4 entry detection capability; restricted access to the premises; comprehensive employment  
100.5 applicant screening; and safeguards against all forms of employee theft;

100.6 (4) a system of records describing all wholesale drug distributor activities set forth  
100.7 in section 151.44 for at least the most recent two-year period, which shall be reasonably  
100.8 accessible as defined by board regulations in any inspection authorized by the board;

100.9 (5) principals and persons, including officers, directors, primary shareholders,  
100.10 and key management executives, who must at all times demonstrate and maintain their  
100.11 capability of conducting business in conformity with sound financial practices as well  
100.12 as state and federal law;

100.13 (6) complete, updated information, to be provided to the board as a condition for  
100.14 obtaining and retaining a license, about each wholesale drug distributor to be licensed,  
100.15 including all pertinent corporate licensee information, if applicable, or other ownership,  
100.16 principal, key personnel, and facilities information found to be necessary by the board;

100.17 (7) written policies and procedures that assure reasonable wholesale drug distributor  
100.18 preparation for, protection against, and handling of any facility security or operation  
100.19 problems, including, but not limited to, those caused by natural disaster or government  
100.20 emergency, inventory inaccuracies or product shipping and receiving, outdated product  
100.21 or other unauthorized product control, appropriate disposition of returned goods, and  
100.22 product recalls;

100.23 (8) sufficient inspection procedures for all incoming and outgoing product  
100.24 shipments; and

100.25 (9) operations in compliance with all federal requirements applicable to wholesale  
100.26 drug distribution.

100.27 (e) An agent or employee of any licensed wholesale drug distributor need not seek  
100.28 licensure under this section.

100.29 (f) A wholesale drug distributor shall file with the board an annual report, in a  
100.30 form and on the date prescribed by the board, identifying all payments, honoraria,  
100.31 reimbursement or other compensation authorized under section 151.461, clauses (3) to  
100.32 (5), paid to practitioners in Minnesota during the preceding calendar year. The report  
100.33 shall identify the nature and value of any payments totaling \$100 or more, to a particular  
100.34 practitioner during the year, and shall identify the practitioner. Reports filed under this  
100.35 provision are public data.

101.1 Sec. 31. Minnesota Statutes 2010, section 151.48, is amended to read:

101.2 **151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.**

101.3 (a) It is unlawful for an out-of-state wholesale drug distributor to conduct business  
101.4 in the state without first obtaining a license from the board and paying ~~the required~~ any  
101.5 applicable fee specified in section 151.065.

101.6 (b) Application for an out-of-state wholesale drug distributor license under this  
101.7 section shall be made on a form furnished by the board.

101.8 (c) No person acting as principal or agent for any out-of-state wholesale drug  
101.9 distributor may sell or distribute drugs in the state unless the distributor has obtained  
101.10 a license.

101.11 (d) The board may adopt regulations that permit out-of-state wholesale drug  
101.12 distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state  
101.13 wholesale drug distributor:

101.14 (1) possesses a valid license granted by another state under legal standards  
101.15 comparable to those that must be met by a wholesale drug distributor of this state as  
101.16 prerequisites for obtaining a license under the laws of this state; and

101.17 (2) can show that the other state would extend reciprocal treatment under its own  
101.18 laws to a wholesale drug distributor of this state.

101.19 Sec. 32. Minnesota Statutes 2010, section 152.12, subdivision 3, is amended to read:

101.20 Subd. 3. **Research project use of controlled substances.** Any qualified person  
101.21 may use controlled substances in the course of a bona fide research project but cannot  
101.22 administer or dispense such drugs to human beings unless such drugs are prescribed,  
101.23 dispensed and administered by a person lawfully authorized to do so. Every person  
101.24 who engages in research involving the use of such substances shall apply annually for  
101.25 registration by the state Board of Pharmacy and shall pay any applicable fee specified in  
101.26 section 151.065, provided that such registration shall not be required if the person is  
101.27 covered by and has complied with federal laws covering such research projects.

101.28 Sec. 33. **[214.107] HEALTH-RELATED LICENSING BOARDS**

101.29 **ADMINISTRATIVE SERVICES UNIT.**

101.30 Subdivision 1. Establishment. An administrative services unit is established  
101.31 for the health-related licensing boards in section 214.01, subdivision 2, to perform  
101.32 administrative, financial, and management functions common to all the boards in a manner  
101.33 that streamlines services, reduces expenditures, targets the use of state resources, and  
101.34 meets the mission of public protection.

102.1 Subd. 2. **Authority.** The administrative services unit shall act as an agent of the  
102.2 boards.

102.3 Subd. 3. **Funding.** (a) The administrative service unit shall apportion among the  
102.4 health-related licensing boards an amount to be allocated to each health-related licensing  
102.5 board. The amount apportioned to each board shall equal each board's share of the annual  
102.6 operating costs for the unit and shall be deposited into the state government special  
102.7 revenue fund.

102.8 (b) The administrative services unit may receive and expend reimbursements for  
102.9 services performed for other agencies.

102.10 Sec. 34. **EFFECTIVE DATE.**

102.11 Sections 8 to 12 are effective upon implementation of the coordinated licensure  
102.12 information system defined in Minnesota Statutes, section 148.2855, but no sooner than  
102.13 July 1, 2012.

## 102.14 **ARTICLE 5**

### 102.15 **HEALTH CARE**

102.16 Section 1. **[1.06] FREEDOM OF CHOICE IN HEALTH CARE ACT.**

102.17 Subdivision 1. **Citation.** This section shall be known as and may be cited as the  
102.18 "Freedom of Choice in Health Care Act."

102.19 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have  
102.20 the meaning given them.

102.21 (b) "Health care service" means any service, treatment, or provision of a product for  
102.22 the care of a physical or mental disease, illness, injury, defect, or condition, or to otherwise  
102.23 maintain or improve physical or mental health, subject to all laws and rules regulating  
102.24 health service providers and products within the state of Minnesota.

102.25 (c) "Mode of securing" means to purchase directly or on credit or by trade, or to  
102.26 contract for third-party payment by insurance or other legal means as authorized by the  
102.27 state of Minnesota, or to apply for or accept employer-sponsored or government-sponsored  
102.28 health care benefits under such conditions as may legally be required as a condition of  
102.29 such benefits, or any combination of the same.

102.30 (d) "Penalty" means any civil or criminal fine, tax, salary or wage withholding,  
102.31 surcharge, fee, or any other imposed consequence established by law or rule of a  
102.32 government or its subdivision or agency that is used to punish or discourage the exercise  
102.33 of rights protected under this section.

103.1            Subd. 3. **Statement of public policy.** (a) The power to require or regulate a person's  
103.2 choice in the mode of securing health care services, or to impose a penalty related to that  
103.3 choice, is not found in the Constitution of the United States of America, and is therefore a  
103.4 power reserved to the people pursuant to the Ninth Amendment, and to the several states  
103.5 pursuant to the Tenth Amendment. The state of Minnesota hereby exercises its sovereign  
103.6 power to declare the public policy of the state of Minnesota regarding the right of all  
103.7 persons residing in the state in choosing the mode of securing health care services.

103.8            (b) It is hereby declared that the public policy of the state of Minnesota, consistent  
103.9 with our constitutionally recognized and inalienable rights of liberty, is that every person  
103.10 within the state of Minnesota is and shall be free to choose or decline to choose any mode  
103.11 of securing health care services without penalty or threat of penalty.

103.12            (c) The policy stated under this section shall not be applied to impair any right of  
103.13 contract related to the provision of health care services to any person or group.

103.14            Subd. 4. **Enforcement.** (a) No public official, employee, or agent of the state of  
103.15 Minnesota or any of its political subdivisions shall act to impose, collect, enforce, or  
103.16 effectuate any penalty in the state of Minnesota that violates the public policy set forth  
103.17 in this section.

103.18            (b) The attorney general shall take any action as is provided in this section or section  
103.19 8.31 in the defense or prosecution of rights protected under this section.

103.20            Sec. 2. Minnesota Statutes 2010, section 8.31, subdivision 1, is amended to read:

103.21            **Subdivision 1. Investigate offenses against provisions of certain designated**  
103.22 **sections; assist in enforcement.** (a) The attorney general shall investigate violations of the  
103.23 law of this state respecting unfair, discriminatory, and other unlawful practices in business,  
103.24 commerce, or trade, and specifically, but not exclusively, the Nonprofit Corporation Act  
103.25 (sections 317A.001 to 317A.909), the Act Against Unfair Discrimination and Competition  
103.26 (sections 325D.01 to 325D.07), the Unlawful Trade Practices Act (sections 325D.09 to  
103.27 325D.16), the Antitrust Act (sections 325D.49 to 325D.66), section 325F.67 and other  
103.28 laws against false or fraudulent advertising, the antidiscrimination acts contained in  
103.29 section 325D.67, the act against monopolization of food products (section 325D.68),  
103.30 the act regulating telephone advertising services (section 325E.39), the Prevention of  
103.31 Consumer Fraud Act (sections 325F.68 to 325F.70), and chapter 53A regulating currency  
103.32 exchanges and assist in the enforcement of those laws as in this section provided.

103.33            (b) The attorney general shall seek injunctive and any other appropriate relief as  
103.34 expeditiously as possible to preserve the rights and property of the residents of Minnesota,  
103.35 and to defend as necessary the state of Minnesota, its officials, employees, and agents in

104.1 the event that any law or regulation violating the public policy set forth in the Freedom  
104.2 of Choice in Health Care Act in this section is enacted by any government, subdivision,  
104.3 or agency thereof.

104.4 (c) The attorney general shall seek injunctive and any other appropriate relief  
104.5 as expeditiously as possible in the event that any law or regulation violating the public  
104.6 policy set forth in the Freedom of Choice in Health Care Act in this section is enacted  
104.7 without adequate federal funding to the state to ensure affordable health care coverage  
104.8 is available to the residents of Minnesota.

104.9 Sec. 3. Minnesota Statutes 2010, section 8.31, subdivision 3a, is amended to read:

104.10 Subd. 3a. **Private remedies.** In addition to the remedies otherwise provided by law,  
104.11 any person injured by a violation of any of the laws referred to in subdivision 1 or a  
104.12 violation of the public policy in section 1.06 may bring a civil action and recover damages,  
104.13 together with costs and disbursements, including costs of investigation and reasonable  
104.14 attorney's fees, and receive other equitable relief as determined by the court. The court  
104.15 may, as appropriate, enter a consent judgment or decree without the finding of illegality.  
104.16 In any action brought by the attorney general pursuant to this section, the court may award  
104.17 any of the remedies allowable under this subdivision. An action under this subdivision  
104.18 for any violation of section 1.06 is in the public interest.

104.19 Sec. 4. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:

104.20 Subdivision 1. **Establishment.** The association shall establish the following  
104.21 maximum premiums to be charged for membership in the comprehensive health insurance  
104.22 plan:

104.23 (a) the premium for the number one qualified plan shall range from a minimum of  
104.24 101 percent to a maximum of 125 percent of the weighted average of rates charged by  
104.25 those insurers and health maintenance organizations with individuals enrolled in:

104.26 (1) \$1,000 annual deductible individual plans of insurance in force in Minnesota;

104.27 (2) individual health maintenance organization contracts of coverage with a \$1,000  
104.28 annual deductible which are in force in Minnesota; and

104.29 (3) other plans of coverage similar to plans offered by the association based on  
104.30 generally accepted actuarial principles;

104.31 (b) the premium for the number two qualified plan shall range from a minimum of  
104.32 101 percent to a maximum of 125 percent of the weighted average of rates charged by  
104.33 those insurers and health maintenance organizations with individuals enrolled in:

104.34 (1) \$500 annual deductible individual plans of insurance in force in Minnesota;



105.1 (2) individual health maintenance organization contracts of coverage with a \$500  
105.2 annual deductible which are in force in Minnesota; and

105.3 (3) other plans of coverage similar to plans offered by the association based on  
105.4 generally accepted actuarial principles;

105.5 (c) the premiums for the plans with a \$2,000, \$5,000, or \$10,000 annual deductible  
105.6 shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted  
105.7 average of rates charged by those insurers and health maintenance organizations with  
105.8 individuals enrolled in:

105.9 (1) \$2,000, \$5,000, or \$10,000 annual deductible individual plans, respectively, in  
105.10 force in Minnesota; and

105.11 (2) individual health maintenance organization contracts of coverage with a \$2,000,  
105.12 \$5,000, or \$10,000 annual deductible, respectively, which are in force in Minnesota; or

105.13 (3) other plans of coverage similar to plans offered by the association based on  
105.14 generally accepted actuarial principles;

105.15 (d) the premium for each type of Medicare supplement plan required to be offered  
105.16 by the association pursuant to section 62E.12 shall range from a minimum of 101 percent  
105.17 to a maximum of 125 percent of the weighted average of rates charged by those insurers  
105.18 and health maintenance organizations with individuals enrolled in:

105.19 (1) Medicare supplement plans in force in Minnesota;

105.20 (2) health maintenance organization Medicare supplement contracts of coverage  
105.21 which are in force in Minnesota; and

105.22 (3) other plans of coverage similar to plans offered by the association based on  
105.23 generally accepted actuarial principles; ~~and~~

105.24 (e) the charge for health maintenance organization coverage shall be based on  
105.25 generally accepted actuarial principles; and

105.26 (f) the premium for a high-deductible, basic plan offered under section 62E.121 shall  
105.27 range from a minimum of 101 percent to a maximum of 125 percent of the weighted  
105.28 average of rates charged by those insurers and health maintenance organizations offering  
105.29 comparable plans outside of the Minnesota Comprehensive Health Association.

105.30 The list of insurers and health maintenance organizations whose rates are used to  
105.31 establish the premium for coverage offered by the association pursuant to paragraphs (a)  
105.32 to (d) and (f) shall be established by the commissioner on the basis of information which  
105.33 shall be provided to the association by all insurers and health maintenance organizations  
105.34 annually at the commissioner's request. This information shall include the number of  
105.35 individuals covered by each type of plan or contract specified in paragraphs (a) to (d) and  
105.36 (f) that is sold, issued, and renewed by the insurers and health maintenance organizations,

106.1 including those plans or contracts available only on a renewal basis. The information shall  
106.2 also include the rates charged for each type of plan or contract.

106.3 In establishing premiums pursuant to this section, the association shall utilize  
106.4 generally accepted actuarial principles, provided that the association shall not discriminate  
106.5 in charging premiums based upon sex. In order to compute a weighted average for each  
106.6 type of plan or contract specified under paragraphs (a) to (d) and (f), the association  
106.7 shall, using the information collected pursuant to this subdivision, list insurers and health  
106.8 maintenance organizations in rank order of the total number of individuals covered by  
106.9 each insurer or health maintenance organization. The association shall then compute  
106.10 a weighted average of the rates charged for coverage by all the insurers and health  
106.11 maintenance organizations by:

106.12 (1) multiplying the numbers of individuals covered by each insurer or health  
106.13 maintenance organization by the rates charged for coverage;

106.14 (2) separately summing both the number of individuals covered by all the insurers  
106.15 and health maintenance organizations and all the products computed under clause (1); and

106.16 (3) dividing the total of the products computed under clause (1) by the total number  
106.17 of individuals covered.

106.18 The association may elect to use a sample of information from the insurers and  
106.19 health maintenance organizations for purposes of computing a weighted average. In no  
106.20 case, however, may a sample used by the association to compute a weighted average  
106.21 include information from fewer than the two insurers or health maintenance organizations  
106.22 highest in rank order.

106.23 **Sec. 5. [62E.121] HIGH-DEDUCTIBLE, BASIC PLAN.**

106.24 **Subdivision 1. Required offering.** The Minnesota Comprehensive Health  
106.25 Association shall offer a high-deductible, basic plan that meets the requirements specified  
106.26 in this section. The high-deductible, basic plan is a one-person plan. Any dependents  
106.27 must be covered separately.

106.28 **Subd. 2. Annual deductible; out-of-pocket maximum.** (a) The plan shall provide  
106.29 the following in-network annual deductible options: \$3,000, \$6,000, \$9,000, and \$12,000.  
106.30 The in-network annual out-of-pocket maximum for each annual deductible option shall be  
106.31 \$1,000 greater than the amount of the annual deductible.

106.32 (b) The deductible is subject to an annual increase based on the change in the  
106.33 Consumer Price Index (CPI).

106.34 **Subd. 3. Office visits for nonpreventive care.** The following co-payments shall  
106.35 apply for each of the first three office visits per calendar year for nonpreventive care:

- 107.1 (1) \$30 per visit for the \$3,000 annual deductible option;  
107.2 (2) \$40 per visit for the \$6,000 annual deductible option;  
107.3 (3) \$50 per visit for the \$9,000 annual deductible option; and  
107.4 (4) \$60 per visit for the \$12,000 annual deductible option.

107.5 For the fourth and subsequent visits during the calendar year, 80 percent coverage is  
107.6 provided under all deductible options, after the deductible is met.

107.7 Subd. 4. **Preventive care.** One hundred percent coverage is provided for preventive  
107.8 care, and no co-payment, coinsurance, or deductible requirements apply.

107.9 Subd. 5. **Prescription drugs.** A \$10 co-payment applies to preferred generic drugs.  
107.10 Preferred brand-name drugs require an enrollee payment of 100 percent of the health  
107.11 plan's discounted rate.

107.12 Subd. 6. **Convenience care center visits.** A \$20 co-payment applies for the first  
107.13 three convenience care center visits during a calendar year. For the fourth and subsequent  
107.14 visits during a calendar year, 80 percent coverage is provided after the deductible is met.

107.15 Subd. 7. **Urgent care center visits.** A \$100 co-payment applies for the first urgent  
107.16 care center visit during a calendar year. For the second and subsequent visits during a  
107.17 calendar year, 80 percent coverage is provided after the deductible is met.

107.18 Subd. 8. **Emergency room visits.** A \$200 co-payment applies for the first  
107.19 emergency room visit during a calendar year. For the second and subsequent visits during  
107.20 a calendar year, 80 percent coverage is provided after the deductible is met.

107.21 Subd. 9. **Lab and x-ray; hospital services; ambulance; surgery.** Lab and x-ray  
107.22 services, hospital services, ambulance services, and surgery are covered at 80 percent  
107.23 after the deductible is met.

107.24 Subd. 10. **Eyewear.** The health plan pays up to \$50 per calendar year for eyewear.

107.25 Subd. 11. **Maternity.** Maternity, labor and delivery, and postpartum care are not  
107.26 covered. One hundred percent coverage is provided for prenatal care and no deductible  
107.27 applies.

107.28 Subd. 12. **Other eligible health care services.** Other eligible health care services  
107.29 are covered at 80 percent after the deductible is met.

107.30 Subd. 13. **Option to remove mental health and substance abuse coverage.**  
107.31 Enrollees have the option of removing mental health and substance abuse coverage in  
107.32 exchange for a reduced premium.

107.33 Subd. 14. **Option to upgrade prescription drug coverage.** Enrollees have  
107.34 the option to upgrade prescription drug coverage to include coverage for preferred  
107.35 brand-name drugs with a \$50 co-payment and coverage for nonpreferred drugs with a  
107.36 \$100 co-payment in exchange for an increased premium.

108.1 Subd. 15. **Out-of-network services.** (a) The out-of-network annual deductible is  
108.2 double the in-network annual deductible.

108.3 (b) There is no out-of-pocket maximum for out-of-network services.

108.4 (c) Benefits for out-of-network services are covered at 60 percent after the deductible  
108.5 is met.

108.6 (d) The lifetime maximum benefit for out-of-network services is \$1,000,000.

108.7 Subd. 16. **Services not covered.** Services not covered include: custodial care  
108.8 or rest care; most dental services; cosmetic services; refractive eye surgery; infertility  
108.9 services; and services that are investigational, not medically necessary, or received while  
108.10 on military duty.

108.11 Sec. 6. Minnesota Statutes 2010, section 62E.14, is amended by adding a subdivision  
108.12 to read:

108.13 Subd. 4f. **Waiver of preexisting conditions for persons covered by healthy**  
108.14 **Minnesota contribution program.** A person may enroll in the comprehensive plan with  
108.15 a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for  
108.16 the healthy Minnesota contribution program, and has been denied coverage as described  
108.17 under section 256L.031, subdivision 6.

108.18 Sec. 7. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

108.19 Subd. 9. **Growth limits; federal programs.** The commissioners of health and  
108.20 human services shall establish a rate methodology for Medicare and Medicaid risk-based  
108.21 contracting with health plan companies that is consistent with statewide growth limits.  
108.22 ~~The methodology shall be presented for review by the Minnesota Health Care Commission~~  
108.23 ~~and the Legislative Commission on Health Care Access prior to the submission of a~~  
108.24 ~~waiver request to the Centers for Medicare and Medicaid Services and subsequent~~  
108.25 ~~implementation of the methodology.~~

108.26 Sec. 8. Minnesota Statutes 2010, section 62J.692, subdivision 7, is amended to read:

108.27 Subd. 7. **Transfers from the commissioner of human services.** Of the amount  
108.28 transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4),  
108.29 \$21,714,000 shall be distributed as follows:

108.30 (1) \$2,157,000 shall be distributed by the commissioner to the University of  
108.31 Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

108.32 (2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County  
108.33 Medical Center for clinical medical education;

109.1 (3) \$17,400,000 shall be distributed by the commissioner to the University of  
109.2 Minnesota Board of Regents for purposes of medical education;

109.3 (4) \$1,121,640 shall be distributed by the commissioner to clinical medical education  
109.4 dental innovation grants in accordance with subdivision 7a; and

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

109.9 Sec. 9. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

109.10 Subd. 9. **Review of eligible providers.** The commissioner and the Medical  
109.11 Education and Research Costs Advisory Committee may review provider groups included  
109.12 in the definition of a clinical medical education program to assure that the distribution of  
109.13 the funds continue to be consistent with the purpose of this section. The results of any  
109.14 such reviews must be reported to the ~~Legislative Commission on Health Care Access~~  
109.15 chairs and ranking minority members of the legislative committees with jurisdiction over  
109.16 health care policy and finance.

109.17 Sec. 10. **[62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL**  
109.18 **ERRORS PROHIBITED.**

109.19 A health care provider shall not bill a patient, and shall not be reimbursed, for  
109.20 any operation, treatment, or other care that is provided to reverse, correct, or otherwise  
109.21 minimize the affects of an adverse health care event, as described in section 144.7065,  
109.22 subdivisions 2 to 7, for which that health care provider is responsible.

109.23 Sec. 11. Minnesota Statutes 2010, section 62Q.32, is amended to read:

109.24 **62Q.32 LOCAL OMBUDSPERSON.**

109.25 County board or community health service agencies may establish an office of  
109.26 ombudsperson to provide a system of consumer advocacy for persons receiving health  
109.27 care services through a health plan company. The ombudsperson's functions may include,  
109.28 but are not limited to:

109.29 (a) mediation or advocacy on behalf of a person accessing the complaint and appeal  
109.30 procedures to ensure that necessary medical services are provided by the health plan  
109.31 company; and

109.32 (b) investigation of the quality of services provided to a person and determine the  
109.33 extent to which quality assurance mechanisms are needed or any other system change

110.1 may be needed. ~~The commissioner of health shall make recommendations for funding~~  
110.2 ~~these functions including the amount of funding needed and a plan for distribution. The~~  
110.3 ~~commissioner shall submit these recommendations to the Legislative Commission on~~  
110.4 ~~Health Care Access by January 15, 1996.~~

110.5 Sec. 12. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

110.6 Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer  
110.7 grouping system for providers based on a combined measure that incorporates both  
110.8 provider risk-adjusted cost of care and quality of care, and for specific conditions as  
110.9 determined by the commissioner. In developing this system, the commissioner shall  
110.10 consult and coordinate with health care providers, health plan companies, state agencies,  
110.11 and organizations that work to improve health care quality in Minnesota. For purposes of  
110.12 the final establishment of the peer grouping system, the commissioner shall not contract  
110.13 with any private entity, organization, or consortium of entities that has or will have a direct  
110.14 financial interest in the outcome of the system.

110.15 (b) By no later than October 15, 2010, the commissioner shall disseminate  
110.16 information to providers on their total cost of care, total resource use, total quality of care,  
110.17 and the total care results of the grouping developed under this subdivision in comparison  
110.18 to an appropriate peer group. Any analyses or reports that identify providers may only be  
110.19 published after the provider has been provided the opportunity by the commissioner to  
110.20 review the underlying data and submit comments. Providers may be given any data for  
110.21 which they are the subject of the data. The provider shall have 30 days to review the data  
110.22 for accuracy and initiate an appeal as specified in paragraph (d).

110.23 (c) By no later than January 1, 2011, the commissioner shall disseminate information  
110.24 to providers on their condition-specific cost of care, condition-specific resource use,  
110.25 condition-specific quality of care, and the condition-specific results of the grouping  
110.26 developed under this subdivision in comparison to an appropriate peer group. Any  
110.27 analyses or reports that identify providers may only be published after the provider has  
110.28 been provided the opportunity by the commissioner to review the underlying data and  
110.29 submit comments. Providers may be given any data for which they are the subject of the  
110.30 data. The provider shall have 30 days to review the data for accuracy and initiate an  
110.31 appeal as specified in paragraph (d).

110.32 (d) The commissioner shall establish an appeals process to resolve disputes from  
110.33 providers regarding the accuracy of the data used to develop analyses or reports. When  
110.34 a provider appeals the accuracy of the data used to calculate the peer grouping system  
110.35 results, the provider shall:

111.1 (1) clearly indicate the reason they believe the data used to calculate the peer group  
111.2 system results are not accurate;

111.3 (2) provide evidence and documentation to support the reason that data was not  
111.4 accurate; and

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

111.7 If a provider does not meet the requirements of this paragraph, a provider's appeal shall be  
111.8 considered withdrawn. The commissioner shall not publish results for a specific provider  
111.9 under paragraph (e) or (f) while that provider has an unresolved appeal.

111.10 (e) Beginning January 1, 2011, the commissioner shall, no less than annually,  
111.11 publish information on providers' total cost, total resource use, total quality, and the results  
111.12 of the total care portion of the peer grouping process. The results that are published must  
111.13 be on a risk-adjusted basis.

111.14 (f) Beginning March 30, 2011, the commissioner shall no less than annually publish  
111.15 information on providers' condition-specific cost, condition-specific resource use, and  
111.16 condition-specific quality, and the results of the condition-specific portion of the peer  
111.17 grouping process. The results that are published must be on a risk-adjusted basis.

111.18 (g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing  
111.19 information under paragraph (e) or (f), the commissioner shall ensure the scientific  
111.20 validity and reliability of the results according to the standards described in paragraph (h).  
111.21 If additional time is needed to establish the scientific validity and reliability of the results,  
111.22 the commissioner may delay the dissemination of data to providers under paragraph (b)  
111.23 or (c), or the publication of information under paragraph (e) or (f). If the delay is more  
111.24 than 60 days, the commissioner shall report in writing to the ~~Legislative Commission on~~  
111.25 ~~Health Care Access~~ chairs and ranking minority members of the legislative committees  
111.26 with jurisdiction over health care policy and finance the following information:

111.27 (1) the reason for the delay;

111.28 (2) the actions being taken to resolve the delay and establish the scientific validity  
111.29 and reliability of the results; and

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

111.31 If there is a delay under this paragraph, the commissioner must disseminate the  
111.32 information to providers under paragraph (b) or (c) at least 90 days before publishing  
111.33 results under paragraph (e) or (f).

111.34 (h) The commissioner's assurance of valid and reliable clinic and hospital peer  
111.35 grouping performance results shall include, at a minimum, the following:

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

112.1 (2) establishment of an explicit minimum reliability threshold developed in  
112.2 collaboration with the subjects of the data and the users of the data, at a level not below  
112.3 nationally accepted standards where such standards exist.

112.4 In achieving these thresholds, the commissioner shall not aggregate clinics that are not  
112.5 part of the same system or practice group. The commissioner shall consult with and solicit  
112.6 feedback from representatives of physician clinics and hospitals during the peer grouping  
112.7 data analysis process to obtain input on the methodological options prior to final analysis  
112.8 and on the design, development, and testing of provider reports.

112.9 Sec. 13. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

112.10 Subd. 9. **Uses of information.** (a) ~~By no later than 12 months after the commissioner~~  
112.11 ~~publishes the information in subdivision 3, paragraph (c):~~ For product renewals or for  
112.12 new products that are offered, after 12 months have elapsed from publication by the  
112.13 commissioner of the information in subdivision 3, paragraph (c):

112.14 (1) the commissioner of management and budget shall use the information and  
112.15 methods developed under subdivision 3 to strengthen incentives for members of the state  
112.16 employee group insurance program to use high-quality, low-cost providers;

112.17 (2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer  
112.18 health benefits to their employees must offer plans that differentiate providers on their  
112.19 cost and quality performance and create incentives for members to use better-performing  
112.20 providers;

112.21 (3) all health plan companies shall use the information and methods developed  
112.22 under subdivision 3 to develop products that encourage consumers to use high-quality,  
112.23 low-cost providers; and

112.24 (4) health plan companies that issue health plans in the individual market or the  
112.25 small employer market must offer at least one health plan that uses the information  
112.26 developed under subdivision 3 to establish financial incentives for consumers to choose  
112.27 higher-quality, lower-cost providers through enrollee cost-sharing or selective provider  
112.28 networks.

112.29 (b) By January 1, 2011, the commissioner of health shall report to the governor  
112.30 and the legislature on recommendations to encourage health plan companies to promote  
112.31 widespread adoption of products that encourage the use of high-quality, low-cost providers.  
112.32 The commissioner's recommendations may include tax incentives, public reporting of  
112.33 health plan performance, regulatory incentives or changes, and other strategies.

112.34 Sec. 14. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:



113.1 Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner  
113.2 of health shall submit to the ~~Legislative Commission on Health Care Access~~ chairs and  
113.3 ranking minority members of the legislative committees with jurisdiction over health care  
113.4 policy and finance periodic progress reports on the implementation of this chapter and  
113.5 sections 256B.0751 to 256B.0754.

113.6 Sec. 15. Minnesota Statutes 2010, section 256.01, subdivision 2b, is amended to read:

113.7 Subd. 2b. **Performance payments.** ~~The commissioner shall develop and implement~~  
113.8 ~~a pay-for-performance system to provide performance payments to eligible medical~~  
113.9 ~~groups and clinics that demonstrate optimum care in serving individuals with chronic~~  
113.10 ~~diseases who are enrolled in health care programs administered by the commissioner under~~  
113.11 ~~chapters 256B, 256D, and 256L.~~ The commissioner may receive any federal matching  
113.12 money that is made available through the medical assistance program for managed care  
113.13 oversight contracted through vendors, including consumer surveys, studies, and external  
113.14 quality reviews as required by the federal Balanced Budget Act of 1997, Code of Federal  
113.15 Regulations, title 42, part 438-managed care, subpart E-external quality review. Any  
113.16 federal money received for managed care oversight is appropriated to the commissioner  
113.17 for this purpose. The commissioner may expend the federal money received in either  
113.18 year of the biennium.

113.19 Sec. 16. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision  
113.20 to read:

113.21 Subd. 33. **Contingency contract fees.** (a) When the commissioner enters into  
113.22 a contingency-based contract for the purpose of recovering medical assistance or  
113.23 MinnesotaCare funds, the commissioner may retain that portion of the recovered funds  
113.24 equal to the amount of the contingency fee.

113.25 (b) Amounts attributed to new recoveries under this subdivision are appropriated  
113.26 to the commissioner to the extent they fulfill the payment terms of the contract with the  
113.27 vendor and shall be deposited into an account in a fund other than the general fund for  
113.28 purposes of fulfilling the terms of the vendor contract.

113.29 Sec. 17. Minnesota Statutes 2010, section 256.969, subdivision 2b, is amended to read:

113.30 Subd. 2b. **Operating payment rates.** In determining operating payment rates for  
113.31 admissions occurring on or after the rate year beginning January 1, 1991, and every two  
113.32 years after, or more frequently as determined by the commissioner, the commissioner  
113.33 shall obtain operating data from an updated base year and establish operating payment

114.1 rates per admission for each hospital based on the cost-finding methods and allowable  
114.2 costs of the Medicare program in effect during the base year. Rates under the general  
114.3 assistance medical care, medical assistance, and MinnesotaCare programs shall not be  
114.4 rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months  
114.5 of the rebased period beginning January 1, 2009. For the first 24 months of the rebased  
114.6 period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota  
114.7 long-term hospital shall be rebased effective January 1, 2011, based on its most recent  
114.8 Medicare cost report ending on or before September 1, 2008, with the provisions under  
114.9 subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent  
114.10 rate setting periods in which the base years are updated, a Minnesota long-term hospital's  
114.11 base year shall remain within the same period as other hospitals. ~~Effective January 1,~~  
114.12 ~~2013, rates shall be rebased at full value~~ Rates must not be rebased to more current data  
114.13 for the first six months of the rebased period beginning January 1, 2013. The base year  
114.14 operating payment rate per admission is standardized by the case mix index and adjusted  
114.15 by the hospital cost index, relative values, and disproportionate population adjustment.  
114.16 The cost and charge data used to establish operating rates shall only reflect inpatient  
114.17 services covered by medical assistance and shall not include property cost information  
114.18 and costs recognized in outlier payments.

114.19 Sec. 18. Minnesota Statutes 2010, section 256B.04, subdivision 18, is amended to read:

114.20 Subd. 18. **Applications for medical assistance.** (a) The state agency may  
114.21 take applications for medical assistance and conduct eligibility determinations for  
114.22 MinnesotaCare enrollees.

114.23 (b) The commissioner of human services shall modify the Minnesota health care  
114.24 programs application form to add a question asking applicants whether they have ever  
114.25 served in the United States military.

114.26 **EFFECTIVE DATE.** This section is effective August 1, 2011.

114.27 Sec. 19. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

114.28 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for  
114.29 medical assistance, a person must not individually own more than \$3,000 in assets, or if a  
114.30 member of a household with two family members, husband and wife, or parent and child,  
114.31 the household must not own more than \$6,000 in assets, plus \$200 for each additional  
114.32 legal dependent. In addition to these maximum amounts, an eligible individual or family  
114.33 may accrue interest on these amounts, but they must be reduced to the maximum at the  
114.34 time of an eligibility redetermination. The accumulation of the clothing and personal

115.1 needs allowance according to section 256B.35 must also be reduced to the maximum at  
115.2 the time of the eligibility redetermination. The value of assets that are not considered in  
115.3 determining eligibility for medical assistance is the value of those assets excluded under  
115.4 the supplemental security income program for aged, blind, and disabled persons, with  
115.5 the following exceptions:

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

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

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

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

115.15 (5) effective upon federal approval, for a person who no longer qualifies as an  
115.16 employed person with a disability due to loss of earnings, assets allowed while eligible  
115.17 for medical assistance under section 256B.057, subdivision 9, are not considered for 12  
115.18 months, beginning with the first month of ineligibility as an employed person with a  
115.19 disability, to the extent that the person's total assets remain within the allowed limits of  
115.20 section 256B.057, subdivision 9, paragraph (c).

115.21 ~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision~~  
115.22 ~~15.~~

115.23 **EFFECTIVE DATE.** This section is effective October 1, 2011.

115.24 Sec. 20. Minnesota Statutes 2010, section 256B.056, subdivision 4, is amended to read:

115.25 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under  
115.26 section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of  
115.27 the federal poverty guidelines. Effective January 1, 2000, and each successive January,  
115.28 recipients of supplemental security income may have an income up to the supplemental  
115.29 security income standard in effect on that date.

115.30 (b) To be eligible for medical assistance, families and children may have an income  
115.31 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,  
115.32 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,  
115.33 1996, shall be increased by three percent.

115.34 (c) Effective July 1, 2002, to be eligible for medical assistance, families and children  
115.35 may have an income up to 100 percent of the federal poverty guidelines for the family size.

116.1 ~~(d) To be eligible for medical assistance under section 256B.055, subdivision 15, a~~  
116.2 ~~person may have an income up to 75 percent of federal poverty guidelines for the family~~  
116.3 ~~size.~~

116.4 ~~(e)~~ (d) In computing income to determine eligibility of persons under paragraphs  
116.5 (a) to ~~(d)~~ (c) who are not residents of long-term care facilities, the commissioner shall  
116.6 disregard increases in income as required by Public Law Numbers 94-566, section 503;  
116.7 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration  
116.8 unusual medical expense payments are considered income to the recipient.

116.9 **EFFECTIVE DATE.** This section is effective October 1, 2011.

116.10 Sec. 21. Minnesota Statutes 2010, section 256B.06, subdivision 4, is amended to read:

116.11 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited  
116.12 to citizens of the United States, qualified noncitizens as defined in this subdivision, and  
116.13 other persons residing lawfully in the United States. Citizens or nationals of the United  
116.14 States must cooperate in obtaining satisfactory documentary evidence of citizenship or  
116.15 nationality according to the requirements of the federal Deficit Reduction Act of 2005,  
116.16 Public Law 109-171.

116.17 (b) "Qualified noncitizen" means a person who meets one of the following  
116.18 immigration criteria:

116.19 (1) admitted for lawful permanent residence according to United States Code, title 8;

116.20 (2) admitted to the United States as a refugee according to United States Code,  
116.21 title 8, section 1157;

116.22 (3) granted asylum according to United States Code, title 8, section 1158;

116.23 (4) granted withholding of deportation according to United States Code, title 8,  
116.24 section 1253(h);

116.25 (5) paroled for a period of at least one year according to United States Code, title 8,  
116.26 section 1182(d)(5);

116.27 (6) granted conditional entrant status according to United States Code, title 8,  
116.28 section 1153(a)(7);

116.29 (7) determined to be a battered noncitizen by the United States Attorney General  
116.30 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,  
116.31 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

116.32 (8) is a child of a noncitizen determined to be a battered noncitizen by the United  
116.33 States Attorney General according to the Illegal Immigration Reform and Immigrant  
116.34 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,  
116.35 Public Law 104-200; or

117.1 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public  
117.2 Law 96-422, the Refugee Education Assistance Act of 1980.

117.3 (c) All qualified noncitizens who were residing in the United States before August  
117.4 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for  
117.5 medical assistance with federal financial participation.

117.6 ~~(d) All qualified noncitizens who entered the United States on or after August 22,~~  
117.7 ~~1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for~~  
117.8 ~~medical assistance with federal financial participation through November 30, 1996.~~

117.9 Beginning December 1, 1996, qualified noncitizens who entered the United States  
117.10 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this  
117.11 chapter are eligible for medical assistance with federal participation for five years if they  
117.12 meet one of the following criteria:

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

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

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

117.18 (iv) veterans of the United States armed forces with an honorable discharge for  
117.19 a reason other than noncitizen status, their spouses and unmarried minor dependent  
117.20 children; or

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

117.23 ~~Beginning December 1, 1996, qualified noncitizens who do not meet one of the~~  
117.24 ~~criteria in items (i) to (v) are eligible for medical assistance without federal financial~~  
117.25 ~~participation as described in paragraph (j).~~

117.26 ~~Notwithstanding paragraph (j),~~ Beginning July 1, 2010, children and pregnant  
117.27 women who are noncitizens described in paragraph (b) or ~~(c)~~ who are lawfully in the  
117.28 United States as defined in Code of Federal Regulations, title 8, section 103.12, and who  
117.29 otherwise meet eligibility requirements of this chapter, are eligible for medical assistance  
117.30 with federal financial participation as provided by the federal Children's Health Insurance  
117.31 Program Reauthorization Act of 2009, Public Law 111-3.

117.32 ~~(c) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who~~  
117.33 ~~are lawfully present in the United States, as defined in Code of Federal Regulations, title~~  
117.34 ~~8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are~~  
117.35 ~~eligible for medical assistance under clauses (1) to (3). These individuals must cooperate~~  
117.36 ~~with the United States Citizenship and Immigration Services to pursue any applicable~~

118.1 ~~immigration status, including citizenship, that would qualify them for medical assistance~~  
118.2 ~~with federal financial participation.~~

118.3 ~~(1) Persons who were medical assistance recipients on August 22, 1996, are eligible~~  
118.4 ~~for medical assistance with federal financial participation through December 31, 1996.~~

118.5 ~~(2) Beginning January 1, 1997, persons described in clause (1) are eligible for~~  
118.6 ~~medical assistance without federal financial participation as described in paragraph (j).~~

118.7 ~~(3) Beginning December 1, 1996, persons residing in the United States prior to~~  
118.8 ~~August 22, 1996, who were not receiving medical assistance and persons who arrived on~~  
118.9 ~~or after August 22, 1996, are eligible for medical assistance without federal financial~~  
118.10 ~~participation as described in paragraph (j).~~

118.11 ~~(f)~~ (e) Nonimmigrants who otherwise meet the eligibility requirements of this  
118.12 chapter are eligible for the benefits as provided in paragraphs ~~(g)~~ (f) to ~~(i)~~ (h). For purposes  
118.13 of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United  
118.14 States Code, title 8, section 1101(a)(15).

118.15 ~~(g)~~ (f) Payment shall also be made for care and services that are furnished to  
118.16 noncitizens, regardless of immigration status, who otherwise meet the eligibility  
118.17 requirements of this chapter, if such care and services are necessary for the treatment of an  
118.18 emergency medical condition, ~~except for organ transplants and related care and services~~  
118.19 ~~and routine prenatal care.~~

118.20 ~~(h)~~ (g) For purposes of this subdivision, the term "emergency medical condition"  
118.21 means a medical condition that meets the requirements of United States Code, title 42,  
118.22 section 1396b(v).

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

118.25 (i) services delivered in an emergency room or by an ambulance service licensed  
118.26 under chapter 144E that are directly related to the treatment of an emergency medical  
118.27 condition;

118.28 (ii) services delivered in an inpatient hospital setting following admission from an  
118.29 emergency room or clinic for an acute emergency condition; and

118.30 (iii) follow-up services that are directly related to the original service provided  
118.31 to treat the emergency medical condition and are covered by the global payment made  
118.32 to the provider.

118.33 (2) Services for the treatment of emergency medical conditions do not include:

118.34 (i) services delivered in an emergency room or inpatient setting to treat a  
118.35 nonemergency condition;

118.36 (ii) organ transplants and related care;

- 119.1 (iii) services for routine prenatal care;
- 119.2 (iv) continuing care, including long-term care, nursing facility services, home health
- 119.3 care, adult day care, day training, or supportive living services;
- 119.4 (v) elective surgery;
- 119.5 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
- 119.6 part of an emergency room visit;
- 119.7 (vii) preventative health care and family planning services;
- 119.8 (viii) dialysis;
- 119.9 (ix) chemotherapy or therapeutic radiation services;
- 119.10 (x) rehabilitation services;
- 119.11 (xi) physical, occupational, or speech therapy;
- 119.12 (xii) transportation services;
- 119.13 (xiii) case management;
- 119.14 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 119.15 (xv) dental services;
- 119.16 (xvi) hospice care;
- 119.17 (xvii) audiology services and hearing aids;
- 119.18 (xviii) podiatry services;
- 119.19 (xix) chiropractic services;
- 119.20 (xx) immunizations;
- 119.21 (xxi) vision services and eyeglasses;
- 119.22 (xxii) waiver services;
- 119.23 (xxiii) individualized education programs; or
- 119.24 (xxiv) chemical dependency treatment.

119.25 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,  
119.26 nonimmigrants, or lawfully present ~~as designated in paragraph (c) and who~~ in the United  
119.27 States as defined in Code of Federal Regulations, title 8, section 103.12, are not covered by  
119.28 a group health plan or health insurance coverage according to Code of Federal Regulations,  
119.29 title 42, section 457.310, and who otherwise meet the eligibility requirements of this  
119.30 chapter, are eligible for medical assistance through the period of pregnancy, including  
119.31 labor and delivery, and 60 days postpartum, to the extent federal funds are available under  
119.32 title XXI of the Social Security Act, and the state children's health insurance program.

119.33 ~~(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens~~  
119.34 ~~lawfully residing in the United States as described in paragraph (c), who are ineligible~~  
119.35 ~~for medical assistance with federal financial participation and who otherwise meet the~~  
119.36 ~~eligibility requirements of chapter 256B and of this paragraph, are eligible for medical~~

120.1 ~~assistance without federal financial participation. Qualified noncitizens as described~~  
120.2 ~~in paragraph (d) are only eligible for medical assistance without federal financial~~  
120.3 ~~participation for five years from their date of entry into the United States.~~

120.4 ~~(k)~~ (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation  
120.5 services from a nonprofit center established to serve victims of torture and are otherwise  
120.6 ineligible for medical assistance under this chapter are eligible for medical assistance  
120.7 without federal financial participation. These individuals are eligible only for the period  
120.8 during which they are receiving services from the center. Individuals eligible under this  
120.9 paragraph shall not be required to participate in prepaid medical assistance.

120.10 Sec. 22. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
120.11 subdivision to read:

120.12 Subd. 3q. Evidence-based childbirth program. (a) The commissioner shall  
120.13 implement a program to reduce the number of elective inductions of labor prior to 39  
120.14 weeks' gestation. In this subdivision, the term "elective induction of labor" means the  
120.15 use of artificial means to stimulate labor in a woman without the presence of a medical  
120.16 condition affecting the woman or the child that makes the onset of labor a medical  
120.17 necessity. The program must promote the implementation of policies within hospitals  
120.18 providing services to recipients of medical assistance or MinnesotaCare that prohibit the  
120.19 use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by  
120.20 the attending providers.

120.21 (b) For all births covered by medical assistance or MinnesotaCare on or after  
120.22 January 1, 2012, a payment for professional services associated with the delivery of a  
120.23 child in a hospital must not be made unless the provider has submitted information about  
120.24 the nature of the labor and delivery including any induction of labor that was performed  
120.25 in conjunction with that specific birth. The information must be on a form prescribed by  
120.26 the commissioner.

120.27 (c) The requirements in paragraph (b) must not apply to deliveries performed  
120.28 at a hospital that has policies and processes in place that have been approved by the  
120.29 commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process  
120.30 for review of hospital induction policies must be established by the commissioner and  
120.31 review of policies must occur at the discretion of the commissioner. The commissioner's  
120.32 decision to approve or rescind approval must include verification and review of items  
120.33 including, but not limited to:

120.34 (1) policies that prohibit use of elective inductions for gestation less than 39 weeks;



121.1 (2) policies that encourage providers to document and communicate with patients a  
121.2 final expected date of delivery by 20 weeks' gestation that includes data from ultrasound  
121.3 measurements as applicable;

121.4 (3) policies that encourage patient education regarding elective inductions, and  
121.5 requires documentation of the processes used to educate patients;

121.6 (4) ongoing quality improvement review as determined by the commissioner; and

121.7 (5) any data that has been collected by the commissioner.

121.8 (d) All hospitals must report annually to the commissioner induction information  
121.9 for all births that were covered by medical assistance or MinnesotaCare in a format and  
121.10 manner to be established by the commissioner.

121.11 (e) The commissioner at any time may choose not to implement or may discontinue  
121.12 any or all aspects of the program if the commissioner is able to determine that hospitals  
121.13 representing at least 90 percent of births covered by medical assistance or MinnesotaCare  
121.14 have approved policies in place.

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

121.16 Sec. 23. Minnesota Statutes 2010, section 256B.0625, subdivision 8, is amended to  
121.17 read:

121.18 Subd. 8. **Physical therapy.** (a) Medical assistance covers physical therapy and  
121.19 related services, ~~including specialized maintenance therapy.~~ Specialized maintenance  
121.20 therapy is covered for recipients age 20 and under.

121.21 (b) Authorization by the commissioner is required to provide medically necessary  
121.22 services to a recipient beyond any of the following onetime service thresholds, or a lower  
121.23 threshold where one has been established by the commissioner for a specified service: (1)  
121.24 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and  
121.25 (3) three evaluations or reevaluations. Services provided by a physical therapy assistant  
121.26 shall be reimbursed at the same rate as services performed by a physical therapist when  
121.27 the services of the physical therapy assistant are provided under the direction of a physical  
121.28 therapist who is on the premises. Services provided by a physical therapy assistant that  
121.29 are provided under the direction of a physical therapist who is not on the premises shall  
121.30 be reimbursed at 65 percent of the physical therapist rate.

121.31 **EFFECTIVE DATE.** This section is effective July 1, 2011, for services provided  
121.32 on a fee-for-service basis, and January 1, 2012, for services provided by a managed care  
121.33 plan or county-based purchasing plan.

122.1 Sec. 24. Minnesota Statutes 2010, section 256B.0625, subdivision 8a, is amended to  
122.2 read:

122.3 Subd. 8a. **Occupational therapy.** (a) Medical assistance covers occupational  
122.4 therapy and related services, ~~including specialized maintenance therapy.~~ Specialized  
122.5 maintenance therapy is covered for recipients age 20 and under.

122.6 (b) Authorization by the commissioner is required to provide medically necessary  
122.7 services to a recipient beyond any of the following onetime service thresholds, or a lower  
122.8 threshold where one has been established by the commissioner for a specified service:

122.9 (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or  
122.10 reevaluations. Services provided by an occupational therapy assistant shall be reimbursed  
122.11 at the same rate as services performed by an occupational therapist when the services of  
122.12 the occupational therapy assistant are provided under the direction of the occupational  
122.13 therapist who is on the premises. Services provided by an occupational therapy assistant  
122.14 that are provided under the direction of an occupational therapist who is not on the  
122.15 premises shall be reimbursed at 65 percent of the occupational therapist rate.

122.16 **EFFECTIVE DATE.** This section is effective July 1, 2011, for services provided  
122.17 on a fee-for-service basis, and January 1, 2012, for services provided by a managed care  
122.18 plan or county-based purchasing plan.

122.19 Sec. 25. Minnesota Statutes 2010, section 256B.0625, subdivision 8b, is amended to  
122.20 read:

122.21 Subd. 8b. **Speech-language pathology and audiology services.** (a) Medical  
122.22 assistance covers speech-language pathology and related services, ~~including specialized~~  
122.23 ~~maintenance therapy.~~ Specialized maintenance therapy is covered for recipients age  
122.24 20 and under.

122.25 (b) Authorization by the commissioner is required to provide medically necessary  
122.26 speech-language pathology services to a recipient beyond any of the following  
122.27 onetime service thresholds, or a lower threshold where one has been established by the  
122.28 commissioner for a specified service: (1) 50 treatment sessions with any combination of  
122.29 approved CPT codes; and (2) one evaluation.

122.30 (c) Medical assistance covers audiology services and related services. Services  
122.31 provided by a person who has been issued a temporary registration under section  
122.32 148.5161 shall be reimbursed at the same rate as services performed by a speech-language  
122.33 pathologist or audiologist as long as the requirements of section 148.5161, subdivision  
122.34 3, are met.

123.1 **EFFECTIVE DATE.** This section is effective July 1, 2011, for services provided  
123.2 on a fee-for-service basis, and January 1, 2012, for services provided by a managed care  
123.3 plan or county-based purchasing plan.

123.4 Sec. 26. Minnesota Statutes 2010, section 256B.0625, subdivision 8c, is amended to  
123.5 read:

123.6 Subd. 8c. **Care management; rehabilitation services.** (a) Effective July 1, 1999,  
123.7 onetime thresholds shall replace annual thresholds for provision of rehabilitation services  
123.8 described in subdivisions 8, 8a, and 8b. The onetime thresholds will be the same in  
123.9 amount and description as the thresholds prescribed by the Department of Human Services  
123.10 health care programs provider manual for calendar year 1997, except they will not be  
123.11 renewed annually, and they will include sensory skills and cognitive training skills.

123.12 (b) A care management approach for authorization of rehabilitation services beyond  
123.13 the threshold described in subdivisions 8, 8a, and 8b shall be instituted in conjunction  
123.14 with the onetime thresholds. The care management approach shall require the provider  
123.15 and the department rehabilitation reviewer to work together directly through written  
123.16 communication, or telephone communication when appropriate, to establish a medically  
123.17 necessary care management plan. Authorization for rehabilitation services shall include  
123.18 approval for up to 12 months of services at a time without additional documentation from  
123.19 the provider during the extended period, when the rehabilitation services are medically  
123.20 necessary due to an ongoing health condition.

123.21 (c) The commissioner shall implement an expedited five-day turnaround time to  
123.22 review authorization requests for recipients who need emergency rehabilitation services  
123.23 and who have exhausted their onetime threshold limit for those services.

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

123.25 Sec. 27. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to  
123.26 read:

123.27 Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to  
123.28 one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater  
123.29 number of visits is obtained.

123.30 Sec. 28. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
123.31 subdivision to read:

123.32 Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined  
123.33 in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by

124.1 another Minnesota licensed practitioner for whom acupuncture is within the practitioner's  
124.2 scope of practice and who has specific acupuncture training or credentialing.

124.3 Sec. 29. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to  
124.4 read:

124.5 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment  
124.6 shall be the lower of the actual acquisition costs of the drugs ~~plus a fixed dispensing fee;~~  
124.7 or the maximum allowable cost set by the federal government or by the commissioner  
124.8 plus the fixed dispensing fee; or the usual and customary price charged to the public. The  
124.9 amount of payment basis must be reduced to reflect all discount amounts applied to the  
124.10 charge by any provider/insurer agreement or contract for submitted charges to medical  
124.11 assistance programs. The net submitted charge may not be greater than the patient liability  
124.12 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee  
124.13 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per  
124.14 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral  
124.15 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral  
124.16 nutritional products dispensed in quantities greater than one liter. Actual acquisition cost  
124.17 includes quantity and other special discounts except time and cash discounts. ~~Effective~~  
124.18 ~~July 1, 2009,~~ The actual acquisition cost of a drug shall be estimated by the commissioner;  
124.19 ~~at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic~~  
124.20 ~~factor drugs shall be estimated at the average wholesale price minus 30 percent. wholesale~~  
124.21 acquisition cost plus four percent for independently owned pharmacies located in a  
124.22 designated rural area within Minnesota, and at wholesale acquisition cost plus two percent  
124.23 for all other pharmacies. A pharmacy is "independently owned" if it is one of four or  
124.24 fewer pharmacies under the same ownership nationally. A "designated rural area" means  
124.25 an area defined as a small rural area or isolated rural area according to the four-category  
124.26 classification of the Rural Urban Commuting Area system developed for the United States  
124.27 Health Resources and Services Administration. Wholesale acquisition cost is defined as  
124.28 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers  
124.29 in the United States, not including prompt pay or other discounts, rebates, or reductions  
124.30 in price, for the most recent month for which information is available, as reported in  
124.31 wholesale price guides or other publications of drug or biological pricing data. The  
124.32 maximum allowable cost of a multisource drug may be set by the commissioner and it  
124.33 shall be comparable to, but no higher than, the maximum amount paid by other third-party  
124.34 payors in this state who have maximum allowable cost programs. Establishment of the

125.1 amount of payment for drugs shall not be subject to the requirements of the Administrative  
125.2 Procedure Act.

125.3 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid  
125.4 to pharmacists for legend drug prescriptions dispensed to residents of long-term care  
125.5 facilities when a unit dose blister card system, approved by the department, is used. Under  
125.6 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.  
125.7 The National Drug Code (NDC) from the drug container used to fill the blister card must  
125.8 be identified on the claim to the department. The unit dose blister card containing the  
125.9 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,  
125.10 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider  
125.11 will be required to credit the department for the actual acquisition cost of all unused  
125.12 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the  
125.13 manufacturer's unopened package. The commissioner may permit the drug clozapine to be  
125.14 dispensed in a quantity that is less than a 30-day supply.

125.15 (c) Whenever a maximum allowable cost has been set for a multisource drug,  
125.16 payment shall be ~~on the basis of~~ the lower of the usual and customary price charged  
125.17 to the public or the maximum allowable cost established by the commissioner unless  
125.18 prior authorization for the brand name product has been granted according to the criteria  
125.19 established by the Drug Formulary Committee as required by subdivision 13f, paragraph  
125.20 (a), and the prescriber has indicated "dispense as written" on the prescription in a manner  
125.21 consistent with section 151.21, subdivision 2.

125.22 (d) The basis for determining the amount of payment for drugs administered in an  
125.23 outpatient setting shall be the lower of the usual and customary cost submitted by the  
125.24 provider or ~~the amount established for Medicare by the~~ 106 percent of the average sales  
125.25 price as determined by the United States Department of Health and Human Services  
125.26 pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales  
125.27 price is unavailable, the amount of payment must be lower of the usual and customary cost  
125.28 submitted by the provider or the wholesale acquisition cost.

125.29 (e) The commissioner may negotiate lower reimbursement rates for specialty  
125.30 pharmacy products than the rates specified in paragraph (a). The commissioner may  
125.31 require individuals enrolled in the health care programs administered by the department  
125.32 to obtain specialty pharmacy products from providers with whom the commissioner has  
125.33 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those  
125.34 used by a small number of recipients or recipients with complex and chronic diseases  
125.35 that require expensive and challenging drug regimens. Examples of these conditions  
125.36 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis

126.1 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms  
126.2 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,  
126.3 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies  
126.4 that require complex care. The commissioner shall consult with the formulary committee  
126.5 to develop a list of specialty pharmacy products subject to this paragraph. In consulting  
126.6 with the formulary committee in developing this list, the commissioner shall take into  
126.7 consideration the population served by specialty pharmacy products, the current delivery  
126.8 system and standard of care in the state, and access to care issues. The commissioner shall  
126.9 have the discretion to adjust the reimbursement rate to prevent access to care issues.

126.10 (f) Home infusion therapy services provided by home infusion therapy pharmacies  
126.11 must be paid at rates according to subdivision 8d.

126.12 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal  
126.13 approval, whichever is later.

126.14 Sec. 30. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to  
126.15 read:

126.16 Subd. 13h. **Medication therapy management services.** (a) Medical assistance  
126.17 and general assistance medical care cover medication therapy management services for  
126.18 a recipient taking ~~four~~ three or more prescriptions to treat or prevent ~~two~~ one or more  
126.19 chronic medical conditions, ~~or~~ or a recipient with a drug therapy problem that is identified  
126.20 by the commissioner or identified by a pharmacist and approved by the commissioner; or  
126.21 prior authorized by the commissioner that has resulted or is likely to result in significant  
126.22 nondrug program costs. The commissioner may cover medical therapy management  
126.23 services under MinnesotaCare if the commissioner determines this is cost-effective. For  
126.24 purposes of this subdivision, "medication therapy management" means the provision  
126.25 of the following pharmaceutical care services by a licensed pharmacist to optimize the  
126.26 therapeutic outcomes of the patient's medications:

126.27 (1) performing or obtaining necessary assessments of the patient's health status;

126.28 (2) formulating a medication treatment plan;

126.29 (3) monitoring and evaluating the patient's response to therapy, including safety  
126.30 and effectiveness;

126.31 (4) performing a comprehensive medication review to identify, resolve, and prevent  
126.32 medication-related problems, including adverse drug events;

126.33 (5) documenting the care delivered and communicating essential information to  
126.34 the patient's other primary care providers;

- 127.1 (6) providing verbal education and training designed to enhance patient  
127.2 understanding and appropriate use of the patient's medications;
- 127.3 (7) providing information, support services, and resources designed to enhance  
127.4 patient adherence with the patient's therapeutic regimens; and
- 127.5 (8) coordinating and integrating medication therapy management services within the  
127.6 broader health care management services being provided to the patient.

127.7 Nothing in this subdivision shall be construed to expand or modify the scope of practice of  
127.8 the pharmacist as defined in section 151.01, subdivision 27.

127.9 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist  
127.10 must meet the following requirements:

127.11 (1) have a valid license issued under chapter 151;

127.12 (2) have graduated from an accredited college of pharmacy on or after May 1996, or  
127.13 completed a structured and comprehensive education program approved by the Board of  
127.14 Pharmacy and the American Council of Pharmaceutical Education for the provision and  
127.15 documentation of pharmaceutical care management services that has both clinical and  
127.16 didactic elements;

127.17 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or  
127.18 have developed a structured patient care process that is offered in a private or semiprivate  
127.19 patient care area that is separate from the commercial business that also occurs in the  
127.20 setting, or in home settings, ~~excluding~~ including long-term care ~~and~~ settings, group homes,  
127.21 ~~if the service is ordered by the provider-directed care coordination team~~ and facilities  
127.22 providing assisted living services, but excluding skilled nursing facilities; and

127.23 (4) make use of an electronic patient record system that meets state standards.

127.24 (c) For purposes of reimbursement for medication therapy management services,  
127.25 the commissioner may enroll individual pharmacists as medical assistance and general  
127.26 assistance medical care providers. The commissioner may also establish contact  
127.27 requirements between the pharmacist and recipient, including limiting the number of  
127.28 reimbursable consultations per recipient.

127.29 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing  
127.30 within a reasonable geographic distance of the patient, a pharmacist who meets the  
127.31 requirements may provide the services via two-way interactive video. Reimbursement  
127.32 shall be at the same rates and under the same conditions that would otherwise apply to  
127.33 the services provided. To qualify for reimbursement under this paragraph, the pharmacist  
127.34 providing the services must meet the requirements of paragraph (b), and must be located  
127.35 within an ambulatory care setting approved by the commissioner. The patient must also

128.1 be located within an ambulatory care setting approved by the commissioner. Services  
128.2 provided under this paragraph may not be transmitted into the patient's residence.

128.3 (e) The commissioner shall establish a pilot project for an intensive medication  
128.4 therapy management program for patients identified by the commissioner with multiple  
128.5 chronic conditions and a high number of medications who are at high risk of preventable  
128.6 hospitalizations, emergency room use, medication complications, and suboptimal  
128.7 treatment outcomes due to medication-related problems. For purposes of the pilot  
128.8 project, medication therapy management services may be provided in a patient's home  
128.9 or community setting, in addition to other authorized settings. The commissioner may  
128.10 waive existing payment policies and establish special payment rates for the pilot project.  
128.11 The pilot project must be designed to produce a net savings to the state compared to the  
128.12 estimated costs that would otherwise be incurred for similar patients without the program.  
128.13 The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

128.15 Sec. 31. Minnesota Statutes 2010, section 256B.0625, subdivision 17, is amended to  
128.16 read:

128.17 Subd. 17. **Transportation costs.** (a) Medical assistance covers medical  
128.18 transportation costs incurred solely for obtaining emergency medical care or transportation  
128.19 costs incurred by eligible persons in obtaining emergency or nonemergency medical  
128.20 care when paid directly to an ambulance company, common carrier, or other recognized  
128.21 providers of transportation services. Medical transportation must be provided by:

128.22 (1) an ambulance, as defined in section 144E.001, subdivision 2;

128.23 (2) special transportation; or

128.24 (3) common carrier including, but not limited to, bus, taxicab, other commercial  
128.25 carrier, or private automobile.

128.26 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,  
128.27 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that  
128.28 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial  
128.29 transportation, or private automobile.

128.30 The commissioner may use an order by the recipient's attending physician to certify that  
128.31 the recipient requires special transportation services. Special transportation providers shall  
128.32 perform driver-assisted services for eligible individuals. Driver-assisted service includes  
128.33 passenger pickup at and return to the individual's residence or place of business, assistance  
128.34 with admittance of the individual to the medical facility, and assistance in passenger  
128.35 securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation



129.1 providers must obtain written documentation from the health care service provider who  
129.2 is serving the recipient being transported, identifying the time that the recipient arrived.  
129.3 Special transportation providers may not bill for separate base rates for the continuation of  
129.4 a trip beyond the original destination. Special transportation providers must take recipients  
129.5 to the nearest appropriate health care provider, using the most direct route. The minimum  
129.6 medical assistance reimbursement rates for special transportation services are:

129.7 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to  
129.8 eligible persons who need a wheelchair-accessible van;

129.9 (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services to  
129.10 eligible persons who do not need a wheelchair-accessible van; and

129.11 (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for  
129.12 special transportation services to eligible persons who need a stretcher-accessible vehicle;

129.13 (2) the base rates for special transportation services in areas defined under RUCA  
129.14 to be super rural shall be equal to the reimbursement rate established in clause (1) plus  
129.15 11.3 percent; and

129.16 (3) for special transportation services in areas defined under RUCA to be rural  
129.17 or super rural areas:

129.18 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125  
129.19 percent of the respective mileage rate in clause (1); and

129.20 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to  
129.21 112.5 percent of the respective mileage rate in clause (1).

129.22 (c) For purposes of reimbursement rates for special transportation services under  
129.23 paragraph (b), the zip code of the recipient's place of residence shall determine whether  
129.24 the urban, rural, or super rural reimbursement rate applies.

129.25 (d) For purposes of this subdivision, "rural urban commuting area" or "RUCA"  
129.26 means a census-tract based classification system under which a geographical area is  
129.27 determined to be urban, rural, or super rural.

129.28 (e) Effective for services provided on or after July 1, 2011, nonemergency  
129.29 transportation rates, including special transportation, taxi, and other commercial carriers,  
129.30 are reduced 4.5 percent. Payments made to managed care plans and county-based  
129.31 purchasing plans must be reduced for services provided on or after January 1, 2012,  
129.32 to reflect this reduction.

129.33 Sec. 32. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to  
129.34 read:

130.1 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers  
130.2 ambulance services. Providers shall bill ambulance services according to Medicare  
130.3 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective  
130.4 for services rendered on or after July 1, 2001, medical assistance payments for ambulance  
130.5 services shall be paid at the Medicare reimbursement rate or at the medical assistance  
130.6 payment rate in effect on July 1, 2000, whichever is greater.

130.7 (b) Effective for services provided on or after July 1, 2011, ambulance services  
130.8 payment rates are reduced 4.5 percent. Payments made to managed care plans and  
130.9 county-based purchasing plans must be reduced for services provided on or after January  
130.10 1, 2012, to reflect this reduction.

130.11 Sec. 33. Minnesota Statutes 2010, section 256B.0625, subdivision 18, is amended to  
130.12 read:

130.13 Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the  
130.14 state agency, medical assistance covers ~~costs of~~ the most appropriate and cost-effective  
130.15 form of transportation incurred by any ambulatory eligible person for obtaining  
130.16 nonemergency medical care.

130.17 Sec. 34. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
130.18 subdivision to read:

130.19 Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise  
130.20 allowed under this subdivision or required under federal or state regulations, the  
130.21 commissioner must not consider a request for authorization of a service when the recipient  
130.22 has coverage from a third-party payer unless the provider requesting authorization has  
130.23 made a good faith effort to receive payment or authorization from the third-party payer.  
130.24 A good faith effort is established by supplying with the authorization request to the  
130.25 commissioner the following:

130.26 (1) a determination of payment for the service from the third-party payer, a  
130.27 determination of authorization for the service from the third-party payer, or a verification  
130.28 of noncoverage of the service by the third-party payer; and

130.29 (2) the information or records required by the department to document the reason for  
130.30 the determination or to validate noncoverage from the third-party payer.

130.31 (b) A provider requesting authorization for services covered by Medicare is not  
130.32 required to bill Medicare before requesting authorization from the commissioner if the  
130.33 provider has reason to believe that a service covered by Medicare is not eligible for  
130.34 payment. The provider must document that, because of recent claim experiences with

131.1 Medicare or because of written communication from Medicare, coverage is not available  
131.2 for the service.

131.3 (c) Authorization is not required if a third-party payer has made payment that is  
131.4 equal to or greater than 60 percent of the maximum payment amount for the service  
131.5 allowed under medical assistance.

131.6 Sec. 35. Minnesota Statutes 2010, section 256B.0625, subdivision 31a, is amended to  
131.7 read:

131.8 Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical  
131.9 assistance covers augmentative and alternative communication systems consisting of  
131.10 electronic or nonelectronic devices and the related components necessary to enable a  
131.11 person with severe expressive communication limitations to produce or transmit messages  
131.12 or symbols in a manner that compensates for that disability.

131.13 ~~(b) Until the volume of systems purchased increases to allow a discount price, the~~  
131.14 ~~commissioner shall reimburse augmentative and alternative communication manufacturers~~  
131.15 ~~and vendors at the manufacturer's suggested retail price for augmentative and alternative~~  
131.16 ~~communication systems and related components. The commissioner shall separately~~  
131.17 ~~reimburse providers for purchasing and integrating individual communication systems~~  
131.18 ~~which are unavailable as a package from an augmentative and alternative communication~~  
131.19 ~~vendor. Augmentative and alternative communication systems must be paid the lower~~  
131.20 of the:

131.21 (1) submitted charge; or

131.22 (2)(i) manufacturer's suggested retail price minus 20 percent for providers that are  
131.23 manufacturers of augmentative and alternative communication systems; or

131.24 (ii) manufacturer's invoice charge plus 20 percent for providers that are not  
131.25 manufacturers of augmentative and alternative communication systems.

131.26 (c) Reimbursement rates established by this purchasing program are not subject to  
131.27 Minnesota Rules, part 9505.0445, item S or T.

131.28 Sec. 36. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
131.29 subdivision to read:

131.30 Subd. 55. **Payment for noncovered services.** (a) Except when specifically  
131.31 prohibited by the commissioner or federal law, a provider may seek payment from the  
131.32 recipient for services not eligible for payment under the medical assistance program when  
131.33 the provider, prior to delivering the service, reviews and considers all other available  
131.34 covered alternatives with the recipient and obtains a signed acknowledgment from the

132.1 recipient of the potential of the recipient's liability. The signed acknowledgment must be  
132.2 in a form approved by the commissioner.

132.3 (b) Conditions under which a provider must not request payment from the recipient  
132.4 include, but are not limited to:

132.5 (1) a service that requires prior authorization, unless authorization has been denied  
132.6 as not medically necessary and all other therapeutic alternatives have been reviewed;

132.7 (2) a service for which payment has been denied for reasons relating to billing  
132.8 requirements;

132.9 (3) standard shipping or delivery and setup of medical equipment or medical  
132.10 supplies;

132.11 (4) services that are included in the recipient's long term care per diem;

132.12 (5) the recipient is enrolled in the Restricted Recipient Program and the provider is  
132.13 one of a provider type designated for the recipient's health care services; and

132.14 (6) the noncovered service is a prescriptive drug identified by the commissioner as  
132.15 having the potential for abuse and overuse, except where payment by the recipient is  
132.16 specifically approved by the commissioner on the date of service based upon compelling  
132.17 evidence supplied by the prescribing provider that establishes medical necessity for that  
132.18 particular drug.

132.19 (c) The payment requested from recipients for noncovered services under this  
132.20 subdivision must not exceed the provider's usual and customary charge for the actual  
132.21 service received by the recipient. A recipient must not be billed for the difference between  
132.22 what medical assistance paid for the service or would pay for a less costly alternative  
132.23 service.

132.24 Sec. 37. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
132.25 subdivision to read:

132.26 Subd. 56. **Medical service coordination.** (a) Medical assistance covers in-reach  
132.27 community-based service coordination that is performed in a hospital emergency  
132.28 department as an eligible procedure under a state healthcare program or private insurance  
132.29 for a frequent user. A frequent user is defined as an individual who has frequented the  
132.30 hospital emergency department for services three or more times in the previous four  
132.31 consecutive months. In-reach community-based service coordination includes navigating  
132.32 services to address a client's mental health, chemical health, social, economic, and housing  
132.33 needs, or any other activity targeted at reducing the incidence of emergency room and  
132.34 other nonmedically necessary health care utilization.

133.1 (b) Reimbursement must be made in 15-minute increments under current Medicaid  
133.2 mental health social work reimbursement methodology and allowed for up to 60 days  
133.3 posthospital discharge based upon the specific identified emergency department visit or  
133.4 inpatient admitting event. A frequent user who is participating in care coordination within  
133.5 a health care home framework is ineligible for reimbursement under this subdivision.  
133.6 Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in  
133.7 social work, public health, corrections, or a related field. The commissioner shall submit  
133.8 any necessary application for waivers to the Centers for Medicare and Medicaid Services  
133.9 to implement this subdivision.

133.10 (c) For the purposes of this subdivision, "in-reach community-based service  
133.11 coordination" means the practice of a community-based worker with training, knowledge,  
133.12 skills, and ability to access a continuum of services, including housing, transportation,  
133.13 chemical and mental health treatment, employment, and peer support services, by working  
133.14 with an organization's staff to transition an individual back into the individual's living  
133.15 environment. In-reach community-based service coordination includes working with the  
133.16 individual during their discharge and for up to a defined amount of time in the individual's  
133.17 living environment, reducing the individual's need for readmittance.

133.18 Sec. 38. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
133.19 subdivision to read:

133.20 Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services  
133.21 provided on or after January 1, 2012, medical assistance payment for an enrollee's cost  
133.22 sharing associated with Medicare Part B is limited to an amount up to the medical  
133.23 assistance total allowed, when the medical assistance rate exceeds the amount paid by  
133.24 Medicare.

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

133.26 Sec. 39. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
133.27 subdivision to read:

133.28 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**  
133.29 Medical assistance covers early and periodic screening, diagnosis, and treatment services  
133.30 (EPSDT). The payment amount for a complete EPSDT screening shall not exceed the rate  
133.31 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

133.32 Sec. 40. Minnesota Statutes 2010, section 256B.0625, is amended by adding a  
133.33 subdivision to read:

134.1 Subd. 59. Services provided by advanced dental therapists and dental  
134.2 therapists. Medical assistance covers services provided by advanced dental therapists  
134.3 and dental therapists when provided within the scope of practice identified in sections  
134.4 150A.105 and 150A.106.

134.5 Sec. 41. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to  
134.6 read:

134.7 Subdivision 1. ~~Co-payments~~ Cost-sharing. (a) Except as provided in subdivision  
134.8 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing  
134.9 for all recipients, effective for services provided on or after ~~October 1, 2003, and before~~  
134.10 ~~January 1, 2009~~ July 1, 2011:

134.11 (1) \$3 per nonpreventive visit, except as provided in paragraph (c). For purposes  
134.12 of this subdivision, a visit means an episode of service which is required because of  
134.13 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an  
134.14 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse  
134.15 midwife, advanced practice nurse, audiologist, optician, or optometrist;

134.16 (2) \$3 for eyeglasses;

134.17 (3) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room, except  
134.18 that this co-payment shall be increased to \$20 upon federal approval; and

134.19 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,  
134.20 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments  
134.21 shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

134.24 ~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall~~  
134.25 ~~include the following co-payments for all recipients, effective for services provided on~~  
134.26 ~~or after January 1, 2009:~~

134.27 ~~(1) \$3.50 for nonemergency visits to a hospital-based emergency room;~~

134.28 ~~(2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,~~  
134.29 ~~subject to a \$7 per month maximum for prescription drug co-payments. No co-payments~~  
134.30 ~~shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

134.31 ~~(3)~~ (6) for individuals identified by the commissioner with income at or below 100  
134.32 percent of the federal poverty guidelines, total monthly ~~co-payments~~ cost-sharing must  
134.33 not exceed five percent of family income. For purposes of this paragraph, family income  
134.34 is the total earned and unearned income of the individual and the individual's spouse, if

135.1 the spouse is enrolled in medical assistance and also subject to the five percent limit on  
135.2 ~~co-payments~~ cost-sharing.

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

135.5 (c) Effective January 1, 2012, or upon federal approval, whichever is later, the  
135.6 following co-payments for nonpreventive visits shall apply to providers included in  
135.7 provider peer grouping:

135.8 (1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of  
135.9 care per medical assistance enrollee is at the 60th percentile or lower for providers of  
135.10 the same type;

135.11 (2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care  
135.12 per medical assistance enrollee is greater than the 60th percentile but does not exceed the  
135.13 80th percentile for providers of the same type; and

135.14 (3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of  
135.15 care per medical assistance enrollee is greater than the 80th percentile for providers of  
135.16 the same type.

135.17 Each managed care and county-based purchasing plan shall calculate the average,  
135.18 risk-adjusted, total annual cost of care for providers under this paragraph using a  
135.19 methodology approved by the commissioner. The commissioner shall develop a  
135.20 methodology for calculating the average, risk-adjusted, total annual cost of care for  
135.21 fee-for-service providers.

135.22 (d) The commissioner shall seek any federal waivers and approvals necessary to  
135.23 increase the co-payment for nonemergency visits to a hospital-based emergency room  
135.24 under paragraph (a), clause (3), and to implement paragraph (c).

135.25 Sec. 42. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to  
135.26 read:

135.27 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following  
135.28 exceptions:

135.29 (1) children under the age of 21;

135.30 (2) pregnant women for services that relate to the pregnancy or any other medical  
135.31 condition that may complicate the pregnancy;

135.32 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or  
135.33 intermediate care facility for the developmentally disabled;

135.34 (4) recipients receiving hospice care;

135.35 (5) 100 percent federally funded services provided by an Indian health service;

- 136.1 (6) emergency services;  
136.2 (7) family planning services;  
136.3 (8) services that are paid by Medicare, resulting in the medical assistance program  
136.4 paying for the coinsurance and deductible; and  
136.5 (9) co-payments that exceed one per day per provider for nonpreventive visits,  
136.6 eyeglasses, and nonemergency visits to a hospital-based emergency room.

136.7 Sec. 43. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to  
136.8 read:

136.9 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall  
136.10 be reduced by the amount of the co-payment or deductible, except that reimbursements  
136.11 shall not be reduced:

136.12 (1) once a recipient has reached the \$12 per month maximum ~~or the \$7 per month~~  
136.13 ~~maximum effective January 1, 2009~~, for prescription drug co-payments; or

136.14 (2) for a recipient identified by the commissioner under 100 percent of the federal  
136.15 poverty guidelines who has met their monthly five percent ~~co-payment~~ cost-sharing limit.

136.16 (b) The provider collects the co-payment or deductible from the recipient. Providers  
136.17 may not deny services to recipients who are unable to pay the co-payment or deductible.

136.18 (c) Medical assistance reimbursement to fee-for-service providers and payments to  
136.19 managed care plans shall not be increased as a result of the removal of co-payments or  
136.20 deductibles effective on or after January 1, 2009.

136.21 Sec. 44. Minnesota Statutes 2010, section 256B.0644, is amended to read:

136.22 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**  
136.23 **PROGRAMS.**

136.24 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a  
136.25 health maintenance organization, as defined in chapter 62D, must participate as a provider  
136.26 or contractor in the medical assistance program, general assistance medical care program,  
136.27 and MinnesotaCare as a condition of participating as a provider in health insurance plans  
136.28 and programs or contractor for state employees established under section 43A.18, the  
136.29 public employees insurance program under section 43A.316, for health insurance plans  
136.30 offered to local statutory or home rule charter city, county, and school district employees,  
136.31 the workers' compensation system under section 176.135, and insurance plans provided  
136.32 through the Minnesota Comprehensive Health Association under sections 62E.01 to  
136.33 62E.19. The limitations on insurance plans offered to local government employees shall



137.1 not be applicable in geographic areas where provider participation is limited by managed  
137.2 care contracts with the Department of Human Services.

137.3 (b) For providers other than health maintenance organizations, participation in the  
137.4 medical assistance program means that:

137.5 (1) the provider accepts new medical assistance, general assistance medical care,  
137.6 and MinnesotaCare patients;

137.7 (2) for providers other than dental service providers, at least 20 percent of the  
137.8 provider's patients are covered by medical assistance, general assistance medical care,  
137.9 and MinnesotaCare as their primary source of coverage; or

137.10 (3) for dental service providers, at least ten percent of the provider's patients are  
137.11 covered by medical assistance, general assistance medical care, and MinnesotaCare as  
137.12 their primary source of coverage, or the provider accepts new medical assistance and  
137.13 MinnesotaCare patients who are children with special health care needs. For purposes  
137.14 of this section, "children with special health care needs" means children up to age 18  
137.15 who: (i) require health and related services beyond that required by children generally;  
137.16 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional  
137.17 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;  
137.18 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other  
137.19 neurological diseases; visual impairment or deafness; Down syndrome and other genetic  
137.20 disorders; autism; fetal alcohol syndrome; and other conditions designated by the  
137.21 commissioner after consultation with representatives of pediatric dental providers and  
137.22 consumers.

137.23 (c) Patients seen on a volunteer basis by the provider at a location other than  
137.24 the provider's usual place of practice may be considered in meeting the participation  
137.25 requirement in this section. The commissioner shall establish participation requirements  
137.26 for health maintenance organizations. The commissioner shall provide lists of participating  
137.27 medical assistance providers on a quarterly basis to the commissioner of management and  
137.28 budget, the commissioner of labor and industry, and the commissioner of commerce. Each  
137.29 of the commissioners shall develop and implement procedures to exclude as participating  
137.30 providers in the program or programs under their jurisdiction those providers who do  
137.31 not participate in the medical assistance program. The commissioner of management  
137.32 and budget shall implement this section through contracts with participating health and  
137.33 dental carriers.

137.34 (d) For purposes of paragraphs (a) and (b), participation in the general assistance  
137.35 medical care program applies only to pharmacy providers.

138.1 (e) A provider described in section 256B.76, subdivision 5, may limit the eligibility  
138.2 of new medical assistance, general assistance medical care, and MinnesotaCare patients  
138.3 for specific categories of rehabilitative services, if medical assistance, general assistance  
138.4 medical care, and MinnesotaCare patients served by the provider in the aggregate exceed  
138.5 30 percent of the provider's overall patient population.

138.6 Sec. 45. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to  
138.7 read:

138.8 Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this  
138.9 section shall preclude the continued development of existing medical or health care  
138.10 home projects currently operating or under development by the commissioner of human  
138.11 services or preclude the commissioner from establishing alternative models and payment  
138.12 mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs  
138.13 under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term  
138.14 care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and  
138.15 medical assistance, are in the waiting period for Medicare, or who have other primary  
138.16 coverage.

138.17 (b) The commissioner of health shall waive health care home certification  
138.18 requirements if an applicant demonstrates that compliance with a certification requirement  
138.19 will create a major financial hardship or is not feasible, and the applicant establishes an  
138.20 alternative way to accomplish the objectives of the certification requirement.

138.21 Sec. 46. Minnesota Statutes 2010, section 256B.0751, is amended by adding a  
138.22 subdivision to read:

138.23 Subd. 8. **Coordination with local services.** The health care home and the county  
138.24 shall coordinate care and services provided to patients enrolled with a health care home  
138.25 who have complex medical needs or a disability, and who need and are eligible for  
138.26 additional local services administered by counties, including but not limited to waived  
138.27 services, mental health services, social services, public health services, transportation, and  
138.28 housing. The coordination of care and services must be as provided in the plan established  
138.29 by the patient and health care home.

138.30 Sec. 47. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

138.31 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section  
138.32 and section 256L.12 shall be entered into or renewed on a calendar year basis beginning  
138.33 January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to

139.1 renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December  
139.2 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may  
139.3 issue separate contracts with requirements specific to services to medical assistance  
139.4 recipients age 65 and older.

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

139.10 (c) Effective for services rendered on or after January 1, 2003, the commissioner  
139.11 shall withhold five percent of managed care plan payments under this section and  
139.12 county-based purchasing plan payments under section 256B.692 for the prepaid medical  
139.13 assistance program pending completion of performance targets. Each performance target  
139.14 must be quantifiable, objective, measurable, and reasonably attainable, except in the case  
139.15 of a performance target based on a federal or state law or rule. Criteria for assessment  
139.16 of each performance target must be outlined in writing prior to the contract effective  
139.17 date. The managed care plan must demonstrate, to the commissioner's satisfaction,  
139.18 that the data submitted regarding attainment of the performance target is accurate. The  
139.19 commissioner shall periodically change the administrative measures used as performance  
139.20 targets in order to improve plan performance across a broader range of administrative  
139.21 services. The performance targets must include measurement of plan efforts to contain  
139.22 spending on health care services and administrative activities. The commissioner may  
139.23 adopt plan-specific performance targets that take into account factors affecting only one  
139.24 plan, including characteristics of the plan's enrollee population. The withheld funds  
139.25 must be returned no sooner than July of the following year if performance targets in the  
139.26 contract are achieved. The commissioner may exclude special demonstration projects  
139.27 under subdivision 23.

139.28 (d) Effective for services rendered on or after January 1, 2009, through December  
139.29 31, 2009, the commissioner shall withhold three percent of managed care plan payments  
139.30 under this section and county-based purchasing plan payments under section 256B.692  
139.31 for the prepaid medical assistance program. The withheld funds must be returned no  
139.32 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
139.33 exclude special demonstration projects under subdivision 23.

139.34 (e) Effective for services provided on or after January 1, 2010, the commissioner  
139.35 shall require that managed care plans use the assessment and authorization processes,  
139.36 forms, timelines, standards, documentation, and data reporting requirements, protocols,

140.1 billing processes, and policies consistent with medical assistance fee-for-service or the  
140.2 Department of Human Services contract requirements consistent with medical assistance  
140.3 fee-for-service or the Department of Human Services contract requirements for all  
140.4 personal care assistance services under section 256B.0659.

140.5 (f) Effective for services rendered on or after January 1, 2010, through December  
140.6 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments  
140.7 under this section and county-based purchasing plan payments under section 256B.692  
140.8 for the prepaid medical assistance program. The withheld funds must be returned no  
140.9 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
140.10 exclude special demonstration projects under subdivision 23.

140.11 (g) Effective for services rendered on or after January 1, 2011, the commissioner  
140.12 shall include as part of the performance targets described in paragraph (c) a reduction in  
140.13 the health plan's emergency room utilization rate for state health care program enrollees  
140.14 by a measurable rate of five percent from the plan's utilization rate for state health care  
140.15 program enrollees for the previous calendar year.

140.16 The withheld funds must be returned no sooner than July 1 and no later than July 31  
140.17 of the following calendar year if the managed care plan demonstrates to the satisfaction of  
140.18 the commissioner that a reduction in the utilization rate was achieved.

140.19 The withhold described in this paragraph shall continue for each consecutive  
140.20 contract period until the plan's emergency room utilization rate for state health care  
140.21 program enrollees is reduced by 25 percent of the plan's emergency room utilization  
140.22 rate for state health care program enrollees for calendar year 2009. Hospitals shall  
140.23 cooperate with the health plans in meeting this performance target and shall accept  
140.24 payment withholds that may be returned to the hospitals if the performance target is  
140.25 achieved. The commissioner shall structure the withhold so that the commissioner returns  
140.26 a portion of the withheld funds in amounts commensurate with achieved reductions in  
140.27 utilization less than the targeted amount. The withhold in this paragraph does not apply to  
140.28 county-based purchasing plans.

140.29 (h) Effective for services rendered on or after January 1, 2012, the commissioner  
140.30 shall include as part of the performance targets described in paragraph (c) a reduction in  
140.31 the plan's hospitalization rates or subsequent hospitalizations within 30 days of a previous  
140.32 hospitalization of a patient regardless of the reason for the hospitalization for state health  
140.33 care program enrollees by a measurable rate of five percent from the plan's utilization rate  
140.34 for state health care program enrollees for the previous calendar year.

140.35 The withheld funds must be returned no sooner than July 1 and no later than July 31  
140.36 of the following calendar year if the managed care plan or county-based purchasing plan

141.1 demonstrates to the satisfaction of the commissioner that a reduction in the hospitalization  
141.2 rate was achieved.

141.3 The withhold described in this paragraph must continue for each consecutive  
141.4 contract period until the plan's subsequent hospitalization rate for state health care  
141.5 program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate  
141.6 for state health care program enrollees for calendar year 2010. Hospitals shall cooperate  
141.7 with the plans in meeting this performance target and shall accept payment withholds that  
141.8 must be returned to the hospitals if the performance target is achieved. The commissioner  
141.9 shall structure the withhold so that the commissioner returns a portion of the withheld  
141.10 funds in amounts commensurate with achieved reductions in utilization less than the  
141.11 targeted amount.

141.12 ~~(h)~~ (i) Effective for services rendered on or after January 1, 2011, through December  
141.13 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments  
141.14 under this section and county-based purchasing plan payments under section 256B.692  
141.15 for the prepaid medical assistance program. The withheld funds must be returned no  
141.16 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
141.17 exclude special demonstration projects under subdivision 23.

141.18 ~~(i)~~ (j) Effective for services rendered on or after January 1, 2012, through December  
141.19 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments  
141.20 under this section and county-based purchasing plan payments under section 256B.692  
141.21 for the prepaid medical assistance program. The withheld funds must be returned no  
141.22 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
141.23 exclude special demonstration projects under subdivision 23.

141.24 ~~(j)~~ (k) Effective for services rendered on or after January 1, 2013, through December  
141.25 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments  
141.26 under this section and county-based purchasing plan payments under section 256B.692  
141.27 for the prepaid medical assistance program. The withheld funds must be returned no  
141.28 sooner than July 1 and no later than July 31 of the following year. The commissioner may  
141.29 exclude special demonstration projects under subdivision 23.

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

142.1           ~~(m)~~ (m) A managed care plan or a county-based purchasing plan under section  
142.2 256B.692 may include as admitted assets under section 62D.044 any amount withheld  
142.3 under this section that is reasonably expected to be returned.

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

142.7           ~~(o)~~ (o) The return of the withhold under paragraphs (d), (f), and (h) to (k) is not  
142.8 subject to the requirements of paragraph (c).

142.9           Sec. 48. Minnesota Statutes 2010, section 256B.69, subdivision 5c, is amended to read:

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

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

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

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

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

142.32           (b) This subdivision shall be effective upon approval of a federal waiver which  
142.33 allows federal financial participation in the medical education and research fund. ~~Effective~~  
142.34 ~~July 1, 2009, and thereafter, The transfers required by~~ amount specified under paragraph  
142.35 (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009.

143.1 Any excess shall first reduce the amounts ~~otherwise required to be transferred~~ specified  
143.2 under paragraph (a), clauses (2) to (4). Any excess following this reduction shall  
143.3 proportionally reduce the ~~transfers~~ amount specified under paragraph (a), clause (1).

143.4 (c) Beginning July 1, ~~2009~~ 2011, of the ~~amounts~~ amount in paragraph (a), the  
143.5 commissioner shall transfer \$21,714,000 each fiscal year to the medical education and  
143.6 research fund. ~~The balance of the transfers under paragraph (a) shall be transferred to the~~  
143.7 ~~medical education and research fund no earlier than July 1 of the following fiscal year.~~

143.8 (d) Beginning July 1, 2011, of the amount in paragraph (a), following the transfer  
143.9 under paragraph (c), the commissioner shall transfer to the medical education research  
143.10 fund \$4,024,000 in fiscal year 2012 and \$4,626,000 in fiscal year 2013 and thereafter.

143.11 Sec. 49. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

143.12 Subd. 28. **Medicare special needs plans; medical assistance basic health care.**

143.13 (a) The commissioner may contract with qualified Medicare-approved special needs  
143.14 plans to provide medical assistance basic health care services to persons with disabilities,  
143.15 including those with developmental disabilities. Basic health care services include:

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

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

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

143.28 ~~Unless a person is otherwise required to enroll in managed care, enrollment in these~~  
143.29 ~~plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic~~  
143.30 ~~enrollment with an option to opt out is not voluntary enrollment.~~

143.31 (b) Beginning January 1, 2007, the commissioner may contract with qualified  
143.32 Medicare special needs plans to provide basic health care services under medical  
143.33 assistance to persons who are dually eligible for both Medicare and Medicaid and those  
143.34 Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare.  
143.35 The commissioner shall consult with the stakeholder group under paragraph (d) in

144.1 developing program specifications for these services. The commissioner shall report to  
144.2 the chairs of the house of representatives and senate committees with jurisdiction over  
144.3 health and human services policy and finance by February 1, 2007, on implementation  
144.4 of these programs and the need for increased funding for the ombudsman for managed  
144.5 care and other consumer assistance and protections needed due to enrollment in managed  
144.6 care of persons with disabilities. Payment for Medicaid services provided under this  
144.7 subdivision for the months of May and June will be made no earlier than July 1 of the  
144.8 same calendar year.

144.9 (c) Notwithstanding subdivision 4, beginning January 1, 2008 2012, the  
144.10 commissioner may expand contracting under this subdivision to all shall enroll persons  
144.11 with disabilities not otherwise required to enroll in managed care under this section,  
144.12 unless the individual chooses to opt out of enrollment. The commissioner shall establish  
144.13 enrollment and opt out procedures consistent with applicable enrollment procedures under  
144.14 this subdivision.

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

- 144.20 (1) implementation efforts;  
144.21 (2) consumer protections; and  
144.22 (3) program specifications such as quality assurance measures, data collection and  
144.23 reporting, and evaluation of costs, quality, and results.

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

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



145.1 Sec. 50. Minnesota Statutes 2010, section 256B.69, is amended by adding a  
145.2 subdivision to read:

145.3 Subd. 30. **Provider payment rates.** (a) Each managed care and county-based plan  
145.4 shall, by October 1, 2011, array all providers within each provider type, employed by or  
145.5 under contract with the plan, by their average total annual cost of care for serving medical  
145.6 assistance and MinnesotaCare enrollees for the most recent reporting year for which data  
145.7 is available, risk-adjusted for enrollee demographics and health status.

145.8 (b) Beginning January 1, 2012, and each contract year thereafter, each managed  
145.9 care and county-based purchasing plan shall implement a progressive payment withhold  
145.10 methodology for each provider type, under which the withhold for a provider increases  
145.11 proportionally as the provider's risk-adjusted total annual cost increases, relative to other  
145.12 providers of the same type. For purposes of this paragraph, the risk-adjusted total annual  
145.13 cost of care is the dollar amount calculated under paragraph (a).

145.14 (c) At the end of each contract year, each plan shall array all providers within each  
145.15 provider type by their average total annual cost of care for serving medical assistance and  
145.16 MinnesotaCare enrollees for that contract year, risk-adjusted for enrollee demographics  
145.17 and health status. For each provider whose risk-adjusted total annual cost of care is at or  
145.18 below the 70th percentile of providers of the same type or specialty, the plan shall return  
145.19 the full amount of any withhold. For each provider whose risk-adjusted total annual cost  
145.20 of care is above the 70th percentile, the plan shall return only the portion of the withhold  
145.21 sufficient to bring the provider's payment rate to the average for providers within the  
145.22 provider type whose risk-adjusted total annual cost of care is at the 70th percentile. Each  
145.23 plan shall reduce provider payments only as allowed under paragraph (f).

145.24 (d) Each managed care and county-based purchasing plan must establish an appeals  
145.25 process to allow providers to appeal determinations of risk-adjusted total annual cost of  
145.26 care. Each plan's appeals process must be approved by the commissioner.

145.27 (e) The commissioner shall require each plan to submit to the commissioner, in  
145.28 the form and manner specified by the commissioner, all provider payment data and  
145.29 information on the withhold methodology that the commissioner determines is necessary  
145.30 to verify compliance with this subdivision.

145.31 (f) The commissioner, for the contract year beginning January 1, 2012, shall reduce  
145.32 plan capitation rates by ten percent from the rates that would otherwise apply, absent  
145.33 application of this subdivision. The reduced rate shall be the historical base rate for  
145.34 negotiating capitation rates for future contract years. The commissioner may recommend  
145.35 additional reductions in capitation rates for future contract years to the legislature, if the  
145.36 commissioner determines this is necessary to ensure that health care providers under

146.1 contract with managed care and county-based purchasing plans practice in an efficient  
146.2 manner. Effective for services rendered on or after January 1, 2012, managed care plans  
146.3 and county-based purchasing plans contracted with the state to administer the health  
146.4 care programs provided under sections 256B.69, 256B.692, and 256L.12, may reduce  
146.5 payments made to providers employed or under contract with the plan. However, a  
146.6 managed care or county-based purchasing plan is prohibited from: (1) reducing payments  
146.7 made to providers whose risk-adjusted total annual cost of care is at or below the 70th  
146.8 percentile of providers of the same type or specialty, or at or below the 80th percentile  
146.9 for provider types or specialties currently subject to plan care management requirements  
146.10 that in the aggregate are more extensive than those that apply to other provider types or  
146.11 specialties, or for which a majority of services are currently subject to prior authorization  
146.12 by the plan and (2) reducing payments to hospitals described under the Social Security  
146.13 Act, title 18, section 1886, subsection (d), paragraph (l), and subparagraph (B), clause (iii).

146.14 (g) The commissioner of human services, in consultation with the commissioner of  
146.15 health, shall develop and provide to managed care and county-based purchasing plans, by  
146.16 September 1, 2011, standard criteria and definitions necessary for consistent calculation  
146.17 of the total annual risk-adjusted cost of care across plans. The commissioner may use  
146.18 encounter data to implement this subdivision, and may provide encounter data or analyses  
146.19 to plans.

146.20 (h) For purposes of this subdivision, "provider" means a vendor of medical care  
146.21 as defined in section 256B.02, subdivision 7, for which sufficient encounter data on  
146.22 utilization and costs is available to implement this subdivision.

146.23 (i) A managed care or county-based purchasing plan must use the methodology  
146.24 described in paragraphs (a) to (e), unless the plan develops an alternative model consistent  
146.25 with the purpose of this subdivision.

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

146.27 Sec. 51. Minnesota Statutes 2010, section 256B.69, is amended by adding a  
146.28 subdivision to read:

146.29 Subd. 32. **Health education.** The commissioner shall require managed care and  
146.30 county-based purchasing plans, as a condition of contract, to provide health education,  
146.31 wellness training, and information about the availability and benefits of preventive  
146.32 services to all medical assistance and MinnesotaCare enrollees, beginning January 1,  
146.33 2012. Plan initiatives developed or implemented to comply with this requirement must be  
146.34 approved by the commissioner.

147.1 Sec. 52. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

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

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

147.12 (1) nonprofit community clinics that:

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

147.14 (ii) have tax exempt status in accordance with the Internal Revenue Code, section  
147.15 501(c)(3);

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

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

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

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

147.24 (vii) have free care available as needed;

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

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

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

147.31 (5) a dental clinic ~~associated with an oral health or dental education program~~ owned  
147.32 and operated by the University of Minnesota or ~~an institution within~~ the Minnesota State  
147.33 Colleges and Universities system.

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

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

148.3 (d) Notwithstanding paragraph (a), critical access payments must not be made for  
148.4 dental services provided from April 1, 2010, through June 30, 2010.

148.5 (e) Notwithstanding section 256B.04, subdivision 2, the commissioner of human  
148.6 services shall not adopt rules governing this section or section 256L.11, subdivision 7.

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

148.8 Sec. 53. **[256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE**  
148.9 **DEMONSTRATION PROJECT.**

148.10 Subdivision 1. **Establishment and implementation.** The commissioner of  
148.11 human services, in consultation with the commissioner of health, shall contract  
148.12 with a Minnesota-based academic and research institution specializing in providing  
148.13 complementary and alternative medicine education and clinical services to establish and  
148.14 implement a five-year demonstration project in conjunction with federally qualified health  
148.15 centers and federally qualified health center look-alikes as defined in section 145.9269, to  
148.16 improve the quality and cost-effectiveness of care provided under medical assistance to  
148.17 enrollees with neck and back problems. The demonstration project must maximize the use  
148.18 of complementary and alternative medicine-oriented primary care providers, including but  
148.19 not limited to physicians and chiropractors. The demonstration project must be designed  
148.20 to significantly improve physical and mental health for enrollees who present with  
148.21 neck and back problems while decreasing medical treatment costs. The commissioner,  
148.22 in consultation with the commissioner of health, shall deliver services through the  
148.23 demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

148.24 Subd. 2. **RFP and project criteria.** The commissioner, in consultation with the  
148.25 commissioner of health, shall develop and issue a request for proposal (RFP) for the  
148.26 demonstration project. The RFP must require the academic and research institution  
148.27 selected to demonstrate a proven track record over at least five years of conducting  
148.28 high-quality, federally funded clinical research. The RFP shall specify the state costs  
148.29 directly related to the requirements of this section and shall require that the selected  
148.30 institution pay those costs to the state. The institution and the federally qualified health  
148.31 centers and federally qualified health center look-alikes shall also:

148.32 (1) provide patient education, provider education, and enrollment training  
148.33 components on health and lifestyle issues in order to promote enrollee responsibility for  
148.34 health care decisions, enhance productivity, prepare enrollees to reenter the workforce,  
148.35 and reduce future health care expenditures;

149.1 (2) use high-quality and cost-effective integrated disease management that includes  
149.2 the best practices of traditional and complementary and alternative medicine;

149.3 (3) incorporate holistic medical care, appropriate nutrition, exercise, medications,  
149.4 and conflict resolution techniques;

149.5 (4) include a provider education component that makes use of professional  
149.6 organizations representing chiropractors, nurses, and other primary care providers  
149.7 and provides appropriate educational materials and activities in order to improve the  
149.8 integration of traditional medical care with licensed chiropractic services and other  
149.9 alternative health care services and achieve program enrollment objectives; and

149.10 (5) provide to the commissioner the information and data necessary for the  
149.11 commissioner to prepare the annual reports required under subdivision 6.

149.12 Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the  
149.13 commissioner from current enrollees in the prepaid medical assistance program who  
149.14 have, or are determined to be at significant risk of developing, neck and back problems.  
149.15 Participation in the demonstration project shall be voluntary. The commissioner shall  
149.16 seek to enroll, over the term of the demonstration project, ten percent of current and  
149.17 future medical assistance enrollees who have, or are determined to be at significant risk  
149.18 of developing, neck and back problems.

149.19 Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and  
149.20 approvals necessary to implement the demonstration project.

149.21 Subd. 5. **Project costs.** The commissioner shall require the academic and research  
149.22 institution selected, federally qualified health centers, and federally qualified health center  
149.23 look-alikes to fund all costs of the demonstration project. Amounts received under  
149.24 subdivision 2 are appropriated to the commissioner for the purposes of this section.

149.25 Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner  
149.26 of health, beginning December 15, 2011, and each December 15 thereafter through  
149.27 December 15, 2015, shall report annually to the legislature on the functional and mental  
149.28 improvements of the populations served by the demonstration project, patient satisfaction,  
149.29 and the cost-effectiveness of the program. The reports must also include data on hospital  
149.30 admissions, days in hospital, rates of outpatient surgery and other services, and drug  
149.31 utilization. The report, due December 15, 2015, must include recommendations on  
149.32 whether the demonstration project should be continued and expanded.

149.33 Sec. 54. **[256B.841] MINNESOTA CHOICE WAIVER APPLICATION AND**  
149.34 **PROCESS.**

149.35 Subdivision 1. **Intent.** It is the intent of the legislature that medical assistance be:

150.1 (1) a sustainable, cost-effective, person-centered, and opportunity-driven program  
150.2 utilizing competitive and value-based purchasing to maximize available service options;  
150.3 and

150.4 (2) a results-oriented system of coordinated care that focuses on independence  
150.5 and choice, promotes accountability and transparency, encourages and rewards healthy  
150.6 outcomes and responsible choices, and promotes efficiency.

150.7 Subd. 2. **Waiver application.** (a) By September 1, 2011, the commissioner of  
150.8 human services shall apply for a waiver and any necessary state plan amendments from  
150.9 the secretary of the United States Department of Health and Human Services, including,  
150.10 but not limited to, a waiver of the appropriate sections of title XIX of the federal Social  
150.11 Security Act, United States Code, title 42, section 1396 et seq., or other provisions of  
150.12 federal law that provide program flexibility and under which Minnesota will operate  
150.13 all facets of the state's medical assistance program. For purposes of this section, and  
150.14 256B.842, and 256B.843, this waiver shall be known as the Minnesota Consumer Health  
150.15 Opportunities and Innovative Care Excellence (CHOICE) waiver.

150.16 (b) The commissioner of human services shall provide the legislative committees  
150.17 with jurisdiction over health and human services finance and policy with the CHOICE  
150.18 waiver application and financial and other related materials, at least ten days prior to  
150.19 submitting the application and materials to the federal Centers for Medicare and Medicaid  
150.20 Services.

150.21 (c) If the state's CHOICE waiver application is approved, the commissioner of  
150.22 human services shall:

150.23 (1) notify the chairs of the legislative committees with jurisdiction over health and  
150.24 human services finance and policy and allow the legislative committees with jurisdiction  
150.25 over health and human services finance and policy to review the terms of the CHOICE  
150.26 waiver; and

150.27 (2) not implement the CHOICE waiver until ten legislative days have passed  
150.28 following notification of the chairs.

150.29 Subd. 3. **Rulemaking; legislative proposals.** Upon acceptance of the terms of the  
150.30 CHOICE waiver, the commissioner of human services shall:

150.31 (1) adopt rules to implement the CHOICE waiver; and

150.32 (2) propose any legislative changes necessary to implement the terms of the  
150.33 CHOICE waiver.

150.34 Subd. 4. **Joint commission on waiver implementation.** (a) After acceptance of the  
150.35 terms of the CHOICE waiver, the governor shall establish a joint commission on CHOICE  
150.36 waiver implementation. The commission shall consist of eight members; four of whom

151.1 shall be members of the senate, not more than three from the same political party, to be  
151.2 appointed by the Subcommittee on Committees of the senate Committee on Rules and  
151.3 Administration, and four of whom shall be members of the house of representatives, not  
151.4 more than three from the same political party, to be appointed by the speaker of the house.

151.5 (b) The commission shall:

151.6 (1) oversee implementation of the CHOICE waiver;

151.7 (2) confer as necessary with state agency commissioners;

151.8 (3) make recommendations on services covered under the medical assistance  
151.9 program;

151.10 (4) monitor and make recommendations on quality and access to care under the  
151.11 CHOICE waiver; and

151.12 (5) make recommendations for the efficient and cost-effective administration of the  
151.13 medical assistance program under the terms of the CHOICE waiver.

151.14 Sec. 55. **[256B.842] PRINCIPLES AND GOALS FOR MEDICAL ASSISTANCE**  
151.15 **REFORM.**

151.16 Subdivision 1. **Goals for reform.** In developing the CHOICE waiver application  
151.17 and implementing the CHOICE waiver, the commissioner of human services shall ensure  
151.18 that the reformed medical assistance program is a person-centered, financially sustainable,  
151.19 and cost-effective program.

151.20 Subd. 2. **Reformed medical assistance criteria.** The reformed medical assistance  
151.21 program established through the CHOICE waiver must:

151.22 (1) empower consumers to make informed and cost-effective choices about their  
151.23 health and offer consumers rewards for healthy decisions;

151.24 (2) ensure adequate access to needed services;

151.25 (3) enable consumers to receive individualized health care that is outcome-oriented  
151.26 and focused on prevention, disease management, recovery, and maintaining independence;

151.27 (4) promote competition between health care providers to ensure best value  
151.28 purchasing, leverage resources, and to create opportunities for improving service quality  
151.29 and performance;

151.30 (5) redesign purchasing and payment methods and encourage and reward  
151.31 high-quality and cost-effective care by incorporating and expanding upon current payment  
151.32 reform and quality of care initiatives including, but not limited to, those initiatives  
151.33 authorized under chapter 62U; and

152.1 (6) continually improve technology to take advantage of recent innovations and  
152.2 advances that help decision makers, consumers, and providers make informed and  
152.3 cost-effective decisions regarding health care.

152.4 Subd. 3. **Annual report.** The commissioner of human services shall annually  
152.5 submit a report to the governor and the legislature, beginning December 1, 2012, and each  
152.6 December 1 thereafter, describing the status of the administration and implementation  
152.7 of the CHOICE waiver.

152.8 **Sec. 56. [256B.843] CHOICE WAIVER APPLICATION REQUIREMENTS.**

152.9 Subdivision 1. **Requirements for CHOICE waiver request.** The commissioner  
152.10 shall seek federal approval to:

152.11 (1) enter into a five-year agreement with the United States Department of Health and  
152.12 Human Services and Centers for Medicaid and Medicare Services (CMS) under section  
152.13 1115a to waive, as part of the CHOICE waiver, provisions of title XIX of the federal  
152.14 Social Security Act, United States Code, title 42, section 1396 et seq., requiring:

152.15 (i) statewideness to allow for the provision of different services in different areas or  
152.16 regions of the state;

152.17 (ii) comparability of services to allow for the provision of different services to  
152.18 members of the same or different coverage groups;

152.19 (iii) no prohibitions restricting the amount, duration, and scope of services included  
152.20 in the medical assistance state plan;

152.21 (iv) no prohibitions limiting freedom of choice of providers; and

152.22 (v) retroactive payment for medical assistance, at the state's discretion;

152.23 (2) waive the applicable provisions of title XIX of the federal Social Security Act,  
152.24 United States Code, title 42, section 1396 et seq., in order to:

152.25 (i) expand cost sharing requirements above the five percent of income threshold for  
152.26 beneficiaries in certain populations;

152.27 (ii) establish health savings or power accounts that encourage and reward  
152.28 beneficiaries who reach certain prevention and wellness targets; and

152.29 (iii) implement a tiered set of parameters to use as the basis for determining  
152.30 long-term service care and setting needs;

152.31 (3) modify income and resource rules in a manner consistent with the goals of the  
152.32 reformed program;

152.33 (4) provide enrollees with a choice of appropriate private sector health coverage  
152.34 options, with full federal financial participation;



153.1 (5) treat payments made toward the cost of care as a monthly premium for  
153.2 beneficiaries receiving home and community-based services when applicable;

153.3 (6) provide health coverage and services to individuals over the age of 65 that are  
153.4 limited in scope and are available only in the home and community-based setting;

153.5 (7) consolidate all home and community-based services currently provided under  
153.6 title XIX of the federal Social Security Act, United States Code, title 42, section 1915(c),  
153.7 into a single program of home and community-based services that include options for  
153.8 consumer direction and shared living;

153.9 (8) expand disease management, care coordination, and wellness programs for all  
153.10 medical assistance recipients; and

153.11 (9) empower and encourage able-bodied medical assistance recipients to work,  
153.12 whenever possible.

153.13 Subd. 2. **Agency coordination.** The commissioner shall establish an intraagency  
153.14 assessment and coordination unit to ensure that decision making and program planning for  
153.15 recipients who may need long-term care, residential placement, and community support  
153.16 services are coordinated. The assessment and coordination unit shall determine level of  
153.17 care, develop service plans and a service budget, make referrals to appropriate settings,  
153.18 provide education and choice counseling to consumers and providers, track utilization,  
153.19 and monitor outcomes.

153.20 Sec. 57. Minnesota Statutes 2010, section 256D.03, subdivision 3, is amended to read:

153.21 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning ~~April 1,~~  
153.22 ~~2010~~ October 1, 2011, the general assistance medical care program shall be administered  
153.23 according to section 256D.031, unless otherwise stated, except for outpatient prescription  
153.24 drug coverage, which shall continue to be administered under this section and funded  
153.25 under section 256D.031, subdivision 9, ~~beginning June 1, 2010.~~

153.26 (b) Outpatient prescription drug coverage under general assistance medical care is  
153.27 limited to prescription drugs that:

153.28 (1) are covered under the medical assistance program as described in section  
153.29 256B.0625, subdivisions 13 and 13d; and

153.30 (2) are provided by manufacturers that have fully executed general assistance  
153.31 medical care rebate agreements with the commissioner and comply with the agreements.

153.32 Outpatient prescription drug coverage under general assistance medical care must conform  
153.33 to coverage under the medical assistance program according to section 256B.0625,  
153.34 subdivisions 13 to 13h.

154.1 (c) Outpatient prescription drug coverage does not include drugs administered in a  
154.2 clinic or other outpatient setting.

154.3 ~~(d) For the period beginning April 1, 2010, to May 31, 2010, general assistance~~  
154.4 ~~medical care covers the services listed in subdivision 4.~~

154.5 **EFFECTIVE DATE.** This section is effective October 1, 2011.

154.6 Sec. 58. Minnesota Statutes 2010, section 256D.031, subdivision 1, is amended to read:

154.7 Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general  
154.8 assistance medical care may be paid for any individual who is not eligible for medical  
154.9 assistance under chapter 256B, including eligibility for medical assistance based on a  
154.10 spenddown of excess income according to section 256B.056, subdivision 5, and who:

154.11 (1) is receiving assistance under section 256D.05, except for families with children  
154.12 who are eligible under the Minnesota family investment program (MFIP), or who is  
154.13 having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

154.14 ~~(2) is a resident of Minnesota and has gross countable income not in excess of 75~~  
154.15 ~~percent of federal poverty guidelines for the family size, using a six-month budget period,~~  
154.16 ~~and whose equity in assets is not in excess of \$1,000 per assistance unit.~~

154.17 (2) is a resident of Minnesota and has gross countable income that is equal to or less  
154.18 than 125 percent of the federal poverty guidelines for the family size, using a six-month  
154.19 budget period, and who meets the asset limit specified in section 256L.17, subdivision 2.

154.20 Exempt assets, the reduction of excess assets, and the waiver of excess assets must  
154.21 conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d,  
154.22 except that the maximum amount of undistributed funds in a trust that could be distributed  
154.23 to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's  
154.24 discretion under the terms of the trust, must be applied toward the asset maximum.

154.25 (b) The commissioner shall adjust the income standards under this section each July  
154.26 1 by the annual update of the federal poverty guidelines following publication by the  
154.27 United States Department of Health and Human Services.

154.28 Sec. 59. Minnesota Statutes 2010, section 256D.031, subdivision 6, is amended to read:

154.29 Subd. 6. **Coordinated care delivery systems.** (a) Effective ~~June 1, 2010~~ October  
154.30 1, 2011, the commissioner shall contract with hospitals or groups of hospitals, or  
154.31 county-based purchasing plans, that qualify under paragraph (b) and agree to deliver  
154.32 services according to this subdivision. Contracting hospitals or plans shall develop  
154.33 and implement a coordinated care delivery system to provide health care services to  
154.34 individuals who are eligible for general assistance medical care under this section and who

155.1 either choose to receive services through the coordinated care delivery system or who are  
 155.2 enrolled by the commissioner under paragraph (c). The health care services provided by  
 155.3 the system must include: (1) the services described in subdivision 4 with the exception  
 155.4 of outpatient prescription drug coverage but shall include drugs administered in a clinic  
 155.5 or other outpatient setting; or (2) a set of comprehensive and medically necessary health  
 155.6 services that the recipients might reasonably require to be maintained in good health and  
 155.7 that has been approved by the commissioner, including at a minimum, but not limited  
 155.8 to, emergency care, medical transportation services, inpatient hospital and physician  
 155.9 care, outpatient health services, preventive health services, mental health services,  
 155.10 and prescription drugs administered in a clinic or other outpatient setting. Outpatient  
 155.11 prescription drug coverage is covered on a fee-for-service basis in accordance with section  
 155.12 256D.03, subdivision 3, and funded under subdivision 9. A hospital or plan establishing a  
 155.13 coordinated care delivery system under this subdivision must ensure that the requirements  
 155.14 of this subdivision are met.

155.15 (b) A hospital or group of hospitals, or a county-based purchasing plan established  
 155.16 under section 256B.692, may contract with the commissioner to develop and implement a  
 155.17 coordinated care delivery system ~~as follows: if the hospital or group of hospitals or plan~~  
 155.18 agrees to satisfy the requirements of this subdivision.

155.19 ~~(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during~~  
 155.20 ~~calendar year 2008, it received fee-for-service payments for services to general assistance~~  
 155.21 ~~medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater~~  
 155.22 ~~than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to~~  
 155.23 ~~provide geographic access or to ensure that at least 80 percent of enrollees have access to~~  
 155.24 ~~a coordinated care delivery system; and~~

155.25 ~~(2) effective December 1, 2010, a Minnesota hospital not qualified under clause~~  
 155.26 ~~(1) may contract with the commissioner under this subdivision if it agrees to satisfy the~~  
 155.27 ~~requirements of this subdivision.~~

155.28 Participation by hospitals or plans shall become effective quarterly on ~~June 1, September~~  
 155.29 ~~1, December 1, or March 1~~ October 1, January 1, April 1, or July 1. Hospital or plan  
 155.30 participation is effective for a period of 12 months and may be renewed for successive  
 155.31 12-month periods.

155.32 (c) Applicants and recipients may enroll in any available coordinated care delivery  
 155.33 system statewide. If more than one coordinated care delivery system is available, the  
 155.34 applicant or recipient shall be allowed to choose among the systems. The commissioner  
 155.35 may assign an applicant or recipient to a coordinated care delivery system if no choice  
 155.36 is made by the applicant or recipient. The commissioner shall consider a recipient's zip

156.1 code, city of residence, county of residence, or distance from a participating coordinated  
 156.2 care delivery system when determining default assignment. An applicant or recipient  
 156.3 may decline enrollment in a coordinated care delivery system but services excluding  
 156.4 outpatient prescription drug coverage are only available through a coordinated care  
 156.5 delivery system. Upon enrollment into a coordinated care delivery system, the recipient  
 156.6 must agree to receive all nonemergency services through the coordinated care delivery  
 156.7 system. Enrollment in a coordinated care delivery system is for six months and may be  
 156.8 renewed for additional six-month periods, except that initial enrollment is for six months  
 156.9 or until the end of a recipient's period of general assistance medical care eligibility,  
 156.10 whichever occurs first. ~~A recipient who continues to meet the eligibility requirements of~~  
 156.11 ~~this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a~~  
 156.12 ~~coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants~~  
 156.13 ~~and recipients not enrolled in a coordinated care delivery system may seek services from~~  
 156.14 ~~a hospital eligible for reimbursement under the temporary uncompensated care pool~~  
 156.15 ~~established under subdivision 8. After February 28, 2011, services are available only~~  
 156.16 ~~through a coordinated care delivery system.~~

156.17 (d) The hospital or plan may contract and coordinate with providers and clinics  
 156.18 for the delivery of services and shall contract with essential community providers as  
 156.19 defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the  
 156.20 extent practicable. When contracting with providers and clinics, the hospital or plan  
 156.21 shall give preference to providers and clinics certified as health care homes under section  
 156.22 256B.0751. The hospital or plan must contract with federally qualified health centers or  
 156.23 federally qualified health center look-alikes, as defined in section 145.9269, subdivision 1,  
 156.24 and essential community providers as defined in section 62Q.19, that agree to accept the  
 156.25 terms, conditions, and payment rates offered by the hospital or plan to similarly situated  
 156.26 providers, except that reimbursement to federally qualified health centers and federally  
 156.27 qualified health center look-alikes must comply with federal law. If a provider or clinic or  
 156.28 health center contracts with a hospital or plan to provide services through the coordinated  
 156.29 care delivery system, the provider may not refuse to provide services to any recipient  
 156.30 enrolled in the system, and payment for services shall be negotiated with the hospital or  
 156.31 plan and paid by the hospital or plan from the system's allocation under subdivision 7.

156.32 (e) A coordinated care delivery system must:

156.33 (1) provide the covered services required under paragraph (a) to recipients enrolled  
 156.34 in the coordinated care delivery system, and comply with the requirements of subdivision  
 156.35 4, paragraphs (b) to (g);

156.36 (2) establish a process to monitor enrollment and ensure the quality of care provided;

157.1 (3) in cooperation with counties, coordinate the delivery of health care services with  
157.2 existing homeless prevention, supportive housing, and rent subsidy programs and funding  
157.3 administered by the Minnesota Housing Finance Agency under chapter 462A; and

157.4 (4) adopt innovative and cost-effective methods of care delivery and coordination,  
157.5 which may include the use of allied health professionals, telemedicine, patient educators,  
157.6 care coordinators, and community health workers.

157.7 (f) The hospital or plan may require a recipient to designate a primary care provider  
157.8 or a primary care clinic. The hospital or plan may limit the delivery of services to a  
157.9 network of providers who have contracted with the hospital or plan to deliver services in  
157.10 accordance with this subdivision, and require a recipient to seek services only within this  
157.11 network. The hospital or plan may also require a referral to a provider before the service  
157.12 is eligible for payment. A coordinated care delivery system is not required to provide  
157.13 payment to a provider who is not employed by or under contract with the system for  
157.14 services provided to a recipient enrolled in the system, except in cases of an emergency.  
157.15 For purposes of this section, emergency services are defined in accordance with Code of  
157.16 Federal Regulations, title 42, section 438.114 (a).

157.17 (g) A recipient enrolled in a coordinated care delivery system has the right to appeal  
157.18 to the commissioner according to section 256.045.

157.19 (h) The state shall not be liable for the payment of any cost or obligation incurred  
157.20 by the coordinated care delivery system.

157.21 (i) The hospital or plan must provide the commissioner with data necessary for  
157.22 assessing enrollment, quality of care, cost, and utilization of services. Each hospital or  
157.23 plan must provide, on a quarterly basis on a form prescribed by the commissioner for each  
157.24 recipient served by the coordinated care delivery system, the services provided, the cost of  
157.25 services provided, and the actual payment amount for the services provided and any other  
157.26 information the commissioner deems necessary to claim federal Medicaid match. The  
157.27 commissioner must provide this data to the legislature on a quarterly basis.

157.28 (j) ~~Effective June 1, 2010,~~ The provisions of section 256.9695, subdivision 2,  
157.29 paragraph (b), do not apply to general assistance medical care provided under this section.

157.30 (k) Notwithstanding any other provision in this section to the contrary, ~~for~~  
157.31 ~~participation beginning September 1, 2010,~~ the commissioner ~~shall offer the same contract~~  
157.32 ~~terms related to~~ shall negotiate an enrollment threshold formula and financial liability  
157.33 ~~protections to~~ with a hospital or group of hospitals or plan qualified under this subdivision  
157.34 to develop and implement a coordinated care delivery system ~~as those contained in the~~  
157.35 ~~coordinated care delivery system contracts effective June 1, 2010.~~

158.1 ~~(1) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are~~  
158.2 ~~implemented effective July 1, 2010, this subdivision must not be implemented.~~

158.3 **EFFECTIVE DATE.** This section is effective October 1, 2011.

158.4 Sec. 60. Minnesota Statutes 2010, section 256D.031, subdivision 7, is amended to read:

158.5 Subd. 7. **Payments; rate setting for the hospital coordinated care delivery**  
158.6 **system.** (a) Effective for general assistance medical care services, with the exception  
158.7 of outpatient prescription drug coverage, ~~provided on or after June 1, 2010,~~ through a  
158.8 coordinated care delivery system, the commissioner shall allocate the annual appropriation  
158.9 for the coordinated care delivery system to hospitals or plans participating under  
158.10 subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after  
158.11 ~~June 1, 2010~~ October 1, 2011. The payment shall be allocated among all hospitals or  
158.12 plans qualified to participate on the allocation date ~~as follows:~~ based upon the enrollment  
158.13 thresholds negotiated with the commissioner.

158.14 ~~(1) each hospital or group of hospitals shall be allocated an initial amount based on~~  
158.15 ~~the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for~~  
158.16 ~~general assistance medical care services to all participating hospitals;~~

158.17 ~~(2) the initial allocations to Hennepin County Medical Center; Regions Hospital;~~  
158.18 ~~Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview;~~  
158.19 ~~shall be increased to 110 percent of the value determined in clause (1);~~

158.20 ~~(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata~~  
158.21 ~~amount in order to keep the allocations within the limit of available appropriations; and~~

158.22 ~~(4) the amounts determined under clauses (1) to (3) shall be allocated to participating~~  
158.23 ~~hospitals.~~

158.24 The commissioner may prospectively reallocate payments to participating hospitals  
158.25 or plans on a biannual basis to ensure that final allocations reflect actual coordinated  
158.26 care delivery system enrollment. ~~The 2008 base year shall be updated by one calendar~~  
158.27 ~~year each June 1, beginning June 1, 2011.~~

158.28 ~~(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the~~  
158.29 ~~commissioner shall make one-third of the quarterly payment in June and the remaining~~  
158.30 ~~two-thirds of the quarterly payment in July to each participating hospital or group of~~  
158.31 ~~hospitals.~~

158.32 ~~(c)~~ (b) In order to be reimbursed under this section, nonhospital providers of health  
158.33 care services shall contract with one or more hospitals or plans described in paragraph (a)  
158.34 to provide services to general assistance medical care recipients through the coordinated  
158.35 care delivery system established by the hospital or plan. The hospital or plan shall

159.1 reimburse bills submitted by nonhospital providers participating under this paragraph at a  
159.2 rate negotiated between the hospital or plan and the nonhospital provider.

159.3 ~~(d)~~ (c) The commissioner shall apply for federal matching funds under section  
159.4 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

159.5 ~~(e)~~ (d) Outpatient prescription drug coverage is provided in accordance with section  
159.6 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

159.7 **EFFECTIVE DATE.** This section is effective October 1, 2011.

159.8 Sec. 61. Minnesota Statutes 2010, section 256D.031, subdivision 9, is amended to read:

159.9 Subd. 9. **Prescription drug pool.** (a) The commissioner shall establish an outpatient  
159.10 prescription drug pool, effective ~~June 1, 2010~~ October 1, 2011. Money in the pool must  
159.11 be used to reimburse pharmacies and other pharmacy service providers as defined in  
159.12 Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed  
159.13 to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates  
159.14 established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage  
159.15 is subject to the availability of funds in the pool. If the commissioner forecasts that  
159.16 expenditures under this subdivision will exceed the appropriation for this purpose, the  
159.17 commissioner may bring recommendations to the Legislative Advisory Commission on  
159.18 methods to resolve the shortfall.

159.19 (b) Effective ~~June 1, 2010~~ January 1, 2012, coordinated care delivery systems  
159.20 established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an  
159.21 assessment equal to 20 percent of payments for the prescribed drugs for recipients of  
159.22 services through that coordinated care delivery system, as calculated by the commissioner  
159.23 based on the most recent available data.

159.24 Sec. 62. Minnesota Statutes 2010, section 256D.031, subdivision 10, is amended to  
159.25 read:

159.26 Subd. 10. **Assistance for veterans.** Hospitals and plans participating in the  
159.27 coordinated care delivery system under subdivision 6 shall consult with counties, county  
159.28 veterans service officers, and the Veterans Administration to identify other programs for  
159.29 which general assistance medical care recipients enrolled in their system are qualified.

159.30 Sec. 63. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:

159.31 Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross  
159.32 family income" for nonfarm self-employed means income calculated for the ~~12-month~~  
159.33 six-month period of eligibility using as a baseline the adjusted gross income reported

160.1 on the applicant's federal income tax form for the previous year and adding back in  
160.2 depreciation, and carryover net operating loss amounts that apply to the business in which  
160.3 the family is currently engaged.

160.4 (b) "Gross individual or gross family income" for farm self-employed means  
160.5 income calculated for the ~~12-month~~ six-month period of eligibility using as the baseline  
160.6 the adjusted gross income reported on the applicant's federal income tax form for the  
160.7 previous year.

160.8 (c) "Gross individual or gross family income" means the total income for all family  
160.9 members, calculated for the ~~12-month~~ six-month period of eligibility.

160.10 Sec. 64. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

160.11 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for  
160.12 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of  
160.13 each state revenue and expenditure forecast, the commissioner must make an assessment  
160.14 of the expected expenditures for the covered services for the remainder of the current  
160.15 biennium and for the following biennium. The estimated expenditure, including the  
160.16 reserve, shall be compared to an estimate of the revenues that will be available in the health  
160.17 care access fund. Based on this comparison, and after consulting with the chairs of the  
160.18 house of representatives Ways and Means Committee and the senate Finance Committee,  
160.19 ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as  
160.20 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures  
160.21 remain within the limits of available revenues for the remainder of the current biennium  
160.22 and for the following biennium. The commissioner shall not hire additional staff using  
160.23 appropriations from the health care access fund until the commissioner of management  
160.24 and budget makes a determination that the adjustments implemented under paragraph (b)  
160.25 are sufficient to allow MinnesotaCare expenditures to remain within the limits of available  
160.26 revenues for the remainder of the current biennium and for the following biennium.

160.27 (b) The adjustments the commissioner shall use must be implemented in this order:  
160.28 first, stop enrollment of single adults and households without children; second, upon 45  
160.29 days' notice, stop coverage of single adults and households without children already  
160.30 enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium  
160.31 subsidy amounts by ten percent for families with gross annual income above 200 percent  
160.32 of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium  
160.33 subsidy amounts by ten percent for families with gross annual income at or below 200  
160.34 percent; and fifth, require applicants to be uninsured for at least six months prior to  
160.35 eligibility in the MinnesotaCare program. If these measures are insufficient to limit the



161.1 expenditures to the estimated amount of revenue, the commissioner shall further limit  
161.2 enrollment or decrease premium subsidies.

161.3 Sec. 65. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

161.4 Subd. 5. ~~Co-payments and coinsurance~~ Cost-sharing. (a) Except as provided in  
161.5 paragraphs (b) ~~and~~, (c), ~~and~~ (h), the MinnesotaCare benefit plan shall include the following  
161.6 ~~co-payments and coinsurance~~ cost-sharing requirements for all enrollees:

161.7 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,  
161.8 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual;

161.9 (2) \$3 per prescription for adult enrollees;

161.10 (3) \$25 for eyeglasses for adult enrollees;

161.11 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an  
161.12 episode of service which is required because of a recipient's symptoms, diagnosis, or  
161.13 established illness, and which is delivered in an ambulatory setting by a physician or  
161.14 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,  
161.15 audiologist, optician, or optometrist; ~~and~~

161.16 (5) \$6 for nonemergency visits to a hospital-based emergency room for services  
161.17 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

161.18 (6) a family deductible equal to the maximum amount allowed under Code of  
161.19 Federal Regulations, title 42, part 447.54.

161.20 (b) Paragraph (a), clause (1), ~~does~~ and paragraph (e) do not apply to parents and  
161.21 relative caretakers of children under the age of 21.

161.22 (c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

161.23 (d) Paragraph (a), clause (4), does not apply to mental health services.

161.24 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal  
161.25 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,  
161.26 and who are not pregnant shall be financially responsible for the coinsurance amount, if  
161.27 applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

161.28 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,  
161.29 or changes from one prepaid health plan to another during a calendar year, any charges  
161.30 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket  
161.31 expenses incurred by the enrollee for inpatient services, that were submitted or incurred  
161.32 prior to enrollment, or prior to the change in health plans, shall be disregarded.

161.33 (g) MinnesotaCare reimbursements to fee-for-service providers and payments to  
161.34 managed care plans or county-based purchasing plans shall not be increased as a result of  
161.35 the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

162.1 (h) Effective January 1, 2012, the following co-payments for nonpreventive visits  
162.2 shall apply to enrollees who are adults without children eligible under section 256L.04,  
162.3 subdivision 7:

162.4 (1) \$3 for visits to providers whose average, risk-adjusted, total annual cost of care  
162.5 per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same  
162.6 type;

162.7 (2) \$6 for visits to providers whose average, risk-adjusted, total annual cost of care  
162.8 per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the  
162.9 80th percentile for providers of the same type; and

162.10 (3) \$10 for visits to providers whose average, risk-adjusted, total annual cost of  
162.11 care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the  
162.12 same type.

162.13 Each managed care and county-based purchasing plan shall calculate the average,  
162.14 risk-adjusted, total annual cost of care for providers under this paragraph using a  
162.15 methodology that has been approved by the commissioner.

162.16 Sec. 66. **[256L.031] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

162.17 Subdivision 1. **Defined contributions to enrollees.** (a) Beginning January 1, 2012,  
162.18 the commissioner shall provide each MinnesotaCare enrollee eligible under section  
162.19 256L.04, subdivision 7, with family income greater than 125 percent of the federal poverty  
162.20 guidelines with a monthly defined contribution to purchase health coverage under a health  
162.21 plan as defined in section 62A.011, subdivision 3.

162.22 (b) Beginning January 1, 2012, the commissioner shall provide each MinnesotaCare  
162.23 adult enrollee eligible under section 256L.04, subdivision 1, with family income greater  
162.24 than 133 percent of the federal poverty guidelines with a monthly defined contribution to  
162.25 purchase health coverage under a health plan as defined in section 62A.011, subdivision 3,  
162.26 offered by a health plan company as defined in section 62Q.01, subdivision 4.

162.27 (c) Enrollees eligible under paragraph (a) or (b) shall not be charged premiums  
162.28 under section 256L.15 and are exempt from the managed care enrollment requirement  
162.29 of section 256L.12.

162.30 (d) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees  
162.31 eligible under paragraph (a) or (b) unless otherwise provided in this section. Covered  
162.32 services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights  
162.33 and complaint procedures, and the effective date of coverage for enrollees eligible under  
162.34 paragraph (a) shall be as provided under the terms of the health plan purchased by the  
162.35 enrollee.

163.1 (e) Unless otherwise provided in this section, all MinnesotaCare requirements  
163.2 related to eligibility, income and asset methodology, income reporting, and program  
163.3 administration, continue to apply to enrollees obtaining coverage under this section.

163.4 Subd. 2. Use of defined contribution; health plan requirements. (a) An enrollee  
163.5 may use up to the monthly defined contribution to pay premiums for coverage under a  
163.6 health plan as defined in section 62A.011, subdivision 3.

163.7 (b) An enrollee must select a health plan within three calendar months of approval of  
163.8 MinnesotaCare eligibility. If a health plan is not selected and purchased within this time  
163.9 period, the enrollee must reapply and must meet all eligibility criteria.

163.10 (c) A health plan purchased under this section must:

163.11 (1) provide coverage for mental health and chemical dependency treatment services;  
163.12 and

163.13 (2) comply with the coverage limitations specified in section 256L.03, subdivision  
163.14 1, the second paragraph.

163.15 Subd. 3. Determination of defined contribution amount. (a) The commissioner  
163.16 shall determine the defined contribution sliding scale using the base contribution specified  
163.17 in paragraph (b) for the specified age ranges. The commissioner shall use a sliding scale  
163.18 for defined contributions that provides:

163.19 (1) persons with the lowest eligible household income with a defined contribution  
163.20 of 110 percent of the base contribution;

163.21 (2) persons with household incomes equal to 175 percent of the federal poverty  
163.22 guidelines with a defined contribution of 100 percent of the base contribution;

163.23 (3) persons with household incomes equal to or greater than 250 percent of  
163.24 the federal poverty guidelines with a defined contribution of 80 percent of the base  
163.25 contribution; and

163.26 (4) persons with household incomes in evenly spaced increments between the  
163.27 percentages of the federal poverty guideline or income level specified in clauses (1) to (3)  
163.28 with a base contribution that is a percentage interpolated from the defined contribution  
163.29 percentages specified in clauses (1) to (3).

163.30	<u>Under 19</u>	<u>\$105</u>
163.31	<u>19-29</u>	<u>\$125</u>
163.32	<u>30-34</u>	<u>\$135</u>
163.33	<u>35-39</u>	<u>\$140</u>
163.34	<u>40-44</u>	<u>\$175</u>
163.35	<u>45-49</u>	<u>\$215</u>
163.36	<u>50-54</u>	<u>\$295</u>

164.1 55-59 \$345  
164.2 60+ \$360

164.3 (b) The commissioner shall multiply the defined contribution amounts developed  
164.4 under paragraph (a) by 1.20 for enrollees who are denied coverage under an individual  
164.5 health plan by a health plan company and who purchase coverage through the Minnesota  
164.6 Comprehensive Health Association.

164.7 Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer  
164.8 the defined contributions. The commissioner shall:

164.9 (1) calculate and process defined contributions for enrollees; and

164.10 (2) pay the defined contribution amount to health plan companies or the Minnesota  
164.11 Comprehensive Health Association, as applicable, for enrollee health plan coverage.

164.12 (b) Nonpayment of a health plan premium shall result in disenrollment from  
164.13 MinnesotaCare effective the first day of the calendar month following the calendar month  
164.14 for which the premium was due. Persons disenrolled for nonpayment or who voluntarily  
164.15 terminate coverage may not reenroll until four calendar months have elapsed.

164.16 Subd. 5. **Assistance to enrollees.** The commissioner of human services, in  
164.17 consultation with the commissioner of commerce, shall develop an efficient and  
164.18 cost-effective method of referring eligible applicants to professional insurance agent  
164.19 associations.

164.20 Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning  
164.21 January 1, 2012, MinnesotaCare enrollees who are denied coverage in the individual  
164.22 health market by a health plan company in accordance with section 62A.65 are eligible  
164.23 for coverage through a health plan offered by the Minnesota Comprehensive Health  
164.24 Association and may enroll in MCHA in accordance with section 62E.14. Any difference  
164.25 between the revenue and covered losses to the MCHA related to implementation of this  
164.26 section shall be paid to the MCHA from the health care access fund.

164.27 Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers and  
164.28 approvals necessary to implement coverage under this section for MinnesotaCare enrollees  
164.29 eligible under subdivision 1. The commissioner shall seek the continuation of federal  
164.30 financial participation for the adult enrollees eligible under section 256L.04, subdivision 1.

164.31 Sec. 67. Minnesota Statutes 2010, section 256L.04, subdivision 1, is amended to read:

164.32 Subdivision 1. **Families with children.** (a) Families with children with family  
164.33 income equal to or less than 275 percent of the federal poverty guidelines for the  
164.34 applicable family size shall be eligible for MinnesotaCare according to this section. All

165.1 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers  
165.2 to enrollment under section 256L.07, shall apply unless otherwise specified.

165.3 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,  
165.4 if the children are eligible. Children may be enrolled separately without enrollment by  
165.5 parents. However, if one parent in the household enrolls, both parents must enroll, unless  
165.6 other insurance is available. If one child from a family is enrolled, all children must  
165.7 be enrolled, unless other insurance is available. If one spouse in a household enrolls,  
165.8 the other spouse in the household must also enroll, unless other insurance is available.  
165.9 Families cannot choose to enroll only certain uninsured members.

165.10 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies  
165.11 to the MinnesotaCare program. These persons are no longer counted in the parental  
165.12 household and may apply as a separate household.

165.13 (d) ~~Beginning July 1, 2010, or upon federal approval, whichever is later,~~ Parents are  
165.14 not eligible for MinnesotaCare if their gross income exceeds ~~\$57,500~~ \$50,000.

165.15 ~~(e) Children formerly enrolled in medical assistance and automatically deemed~~  
165.16 ~~eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt~~  
165.17 ~~from the requirements of this section until renewal.~~

165.18 (f) [Reserved.]

165.19 Sec. 68. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

165.20 Subd. 7. **Single adults and households with no children.** (a) The definition of  
165.21 eligible persons, through September 30, 2011, includes all individuals and households  
165.22 with no children who have gross family incomes that are equal to or less than ~~200~~ 250  
165.23 percent of the federal poverty guidelines.

165.24 (b) Effective ~~July 1, 2009~~ October 1, 2011, the definition of eligible persons includes  
165.25 all individuals and households with no children who have gross family incomes that are  
165.26 greater than 125 percent of the federal poverty guidelines and equal to or less than 250  
165.27 percent of the federal poverty guidelines.

165.28 **EFFECTIVE DATE.** This section is effective October 1, 2011.

165.29 Sec. 69. Minnesota Statutes 2010, section 256L.04, subdivision 10, is amended to read:

165.30 Subd. 10. **Citizenship requirements.** Eligibility for MinnesotaCare is limited to  
165.31 citizens or nationals of the United States, qualified noncitizens, ~~and other persons residing~~  
165.32 ~~lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs~~  
165.33 ~~(a) to (c) and (j)~~ who are eligible for medical assistance with federal participation  
165.34 according to United States Code, title 8, section 1612. Undocumented noncitizens and

166.1 nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a  
166.2 nonimmigrant is an individual in one or more of the classes listed in United States Code,  
166.3 title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides  
166.4 in the United States without the approval or acquiescence of the United States Citizenship  
166.5 and Immigration Services. Families with children who are citizens or nationals of  
166.6 the United States must cooperate in obtaining satisfactory documentary evidence of  
166.7 citizenship or nationality according to the requirements of the federal Deficit Reduction  
166.8 Act of 2005, Public Law 109-171.

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

166.10 Sec. 70. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

166.11 Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall  
166.12 use electronic verification as the primary method of income verification. If there is a  
166.13 discrepancy between reported income and electronically verified income, an individual  
166.14 may be required to submit additional verification. In addition, the commissioner shall  
166.15 perform random audits to verify reported income and eligibility. The commissioner  
166.16 may execute data sharing arrangements with the Department of Revenue and any other  
166.17 governmental agency in order to perform income verification related to eligibility and  
166.18 premium payment under the MinnesotaCare program.

166.19 (b) In determining eligibility for MinnesotaCare, the commissioner shall require  
166.20 applicants and enrollees seeking renewal of eligibility to verify both earned and unearned  
166.21 income. The commissioner shall also require applicants and enrollees , and their spouses  
166.22 or parents, who are age 21 and over and employed 20 or more hours per week by any one  
166.23 employer, to verify that they do not have access to employer-subsidized coverage as  
166.24 described in section 256L.07, subdivision 2. Data collected is nonpublic data as defined  
166.25 in section 13.02, subdivision 9.

166.26 Sec. 71. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

166.27 Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, ~~2007~~ 2011, an enrollee's  
166.28 eligibility must be renewed every ~~12~~ six months. ~~The 12-month period begins in the~~  
166.29 ~~month after the month the application is approved.~~

166.30 (b) Each new period of eligibility must take into account any changes in  
166.31 circumstances that impact eligibility and premium amount. An enrollee must provide all  
166.32 the information needed to redetermine eligibility by the first day of the month that ends  
166.33 the eligibility period. If there is no change in circumstances, the enrollee may renew  
166.34 eligibility at designated locations that include community clinics and health care providers'

167.1 offices. The designated sites shall forward the renewal forms to the commissioner. The  
167.2 commissioner may establish criteria and timelines for sites to forward applications to the  
167.3 commissioner or county agencies. The premium for the new period of eligibility must be  
167.4 received as provided in section 256L.06 in order for eligibility to continue.

167.5 (c) An enrollee who fails to submit renewal forms and related documentation  
167.6 necessary for verification of continued eligibility in a timely manner shall remain eligible  
167.7 for one additional month beyond the end of the current eligibility period before being  
167.8 disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the  
167.9 additional month.

167.10 Sec. 72. Minnesota Statutes 2010, section 256L.05, is amended by adding a subdivision  
167.11 to read:

167.12 Subd. 6. Referral of veterans. The commissioner shall ensure that all applicants  
167.13 for MinnesotaCare who identify themselves as veterans are referred to a county veterans  
167.14 service officer for assistance in applying to the United States Department of Veterans  
167.15 Affairs for any veterans benefits for which they may be eligible.

167.16 Sec. 73. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

167.17 Subdivision 1. **General requirements.** (a) Children enrolled in the original  
167.18 children's health plan as of September 30, 1992, children who enrolled in the  
167.19 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,  
167.20 article 4, section 17, and children who have family gross incomes that are equal to or  
167.21 less than 150 percent of the federal poverty guidelines are eligible without meeting  
167.22 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as  
167.23 long as they maintain continuous coverage in the MinnesotaCare program or medical  
167.24 assistance. Children who apply for MinnesotaCare on or after the implementation date  
167.25 of the employer-subsidized health coverage program as described in Laws 1998, chapter  
167.26 407, article 5, section 45, who have family gross incomes that are equal to or less than 150  
167.27 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to  
167.28 be eligible for MinnesotaCare.

167.29 (b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose  
167.30 income increases above ~~275 percent of the federal poverty guidelines~~ the limits described  
167.31 in section 256L.04, subdivision 1, are no longer eligible for the program and shall be  
167.32 disenrolled by the commissioner. ~~Beginning January 1, 2008,~~

167.33 (c) Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7,  
167.34 whose income increases above 200 percent of the federal poverty guidelines or 250

168.1 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for  
168.2 the program and shall be disenrolled by the commissioner.

168.3 (d) For persons disenrolled under this subdivision, MinnesotaCare coverage  
168.4 terminates the last day of the calendar month following the month in which the  
168.5 commissioner determines that the income of a family or individual exceeds program  
168.6 income limits.

168.7 ~~(b)~~ (e) Notwithstanding paragraph ~~(a)~~ (b), children may remain enrolled in  
168.8 MinnesotaCare if ten percent of their gross individual or gross family income as defined  
168.9 in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month  
168.10 policy with a \$500 deductible available through the Minnesota Comprehensive Health  
168.11 Association. Children who are no longer eligible for MinnesotaCare under this clause shall  
168.12 be given a 12-month notice period from the date that ineligibility is determined before  
168.13 disenrollment. The premium for children remaining eligible under this clause shall be the  
168.14 maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

168.15 ~~(e)~~ (f) Notwithstanding paragraphs (a) and ~~(b)~~ (e), parents are not eligible for  
168.16 MinnesotaCare if gross household income exceeds ~~\$57,500 for the 12-month~~ \$25,000 for  
168.17 the six-month period of eligibility.

168.18 Sec. 74. Minnesota Statutes 2010, section 256L.11, subdivision 7, is amended to read:

168.19 Subd. 7. **Critical access dental providers.** Effective for dental services provided to  
168.20 MinnesotaCare enrollees on or after ~~January 1, 2007,~~ July 1, 2011, the commissioner shall  
168.21 increase payment rates to dentists and dental clinics deemed by the commissioner to be  
168.22 critical access providers under section 256B.76, subdivision 4, by ~~50~~ 30 percent above  
168.23 the payment rate that would otherwise be paid to the provider. The commissioner shall  
168.24 pay the prepaid health plans under contract with the commissioner amounts sufficient to  
168.25 reflect this rate increase. The prepaid health plan must pass this rate increase to providers  
168.26 who have been identified by the commissioner as critical access dental providers under  
168.27 section 256B.76, subdivision 4.

168.28 Sec. 75. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

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

168.33 (b) For services rendered on or after January 1, 2004, the commissioner shall  
168.34 withhold five percent of managed care plan payments and county-based purchasing



169.1 plan payments under this section pending completion of performance targets. Each  
169.2 performance target must be quantifiable, objective, measurable, and reasonably attainable,  
169.3 except in the case of a performance target based on a federal or state law or rule. Criteria  
169.4 for assessment of each performance target must be outlined in writing prior to the  
169.5 contract effective date. The managed care plan must demonstrate, to the commissioner's  
169.6 satisfaction, that the data submitted regarding attainment of the performance target is  
169.7 accurate. The commissioner shall periodically change the administrative measures used  
169.8 as performance targets in order to improve plan performance across a broader range of  
169.9 administrative services. The performance targets must include measurement of plan  
169.10 efforts to contain spending on health care services and administrative activities. The  
169.11 commissioner may adopt plan-specific performance targets that take into account factors  
169.12 affecting only one plan, such as characteristics of the plan's enrollee population. The  
169.13 withheld funds must be returned no sooner than July 1 and no later than July 31 of the  
169.14 following calendar year if performance targets in the contract are achieved.

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

169.20 (d) Effective for services rendered on or after January 1, 2011, the commissioner  
169.21 shall include as part of the performance targets described in paragraph (b) a reduction in  
169.22 the plan's emergency room utilization rate for state health care program enrollees by a  
169.23 measurable rate of five percent from the plan's utilization rate for the previous calendar  
169.24 year.

169.25 The withheld funds must be returned no sooner than July 1 and no later than July 31  
169.26 of the following calendar year if the managed care plan demonstrates to the satisfaction of  
169.27 the commissioner that a reduction in the utilization rate was achieved.

169.28 The withhold described in this paragraph shall continue for each consecutive  
169.29 contract period until the plan's emergency room utilization rate for state health care  
169.30 program enrollees is reduced by 25 percent of the plan's emergency room utilization rate  
169.31 for state health care program enrollees for calendar year 2009. Hospitals shall cooperate  
169.32 with the health plans in meeting this performance target and shall accept payment  
169.33 withholds that may be returned to the hospitals if the performance target is achieved. The  
169.34 commissioner shall structure the withhold so that the commissioner returns a portion of  
169.35 the withheld funds in amounts commensurate with achieved reductions in utilization less

170.1 than the targeted amount. The withhold described in this paragraph does not apply to  
170.2 county-based purchasing plans.

170.3 (e) Effective for services provided on or after January 1, 2012, the commissioner  
170.4 shall include as part of the performance targets described in paragraph (b) a reduction in  
170.5 the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous  
170.6 hospitalization of a patient regardless of the reason for the hospitalization for state health  
170.7 care program enrollees by a measurable rate of five percent from the plan's hospitalization  
170.8 rate for the previous calendar year.

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

170.13 The withhold described in this paragraph must continue for each consecutive  
170.14 contract period until the plan's subsequent hospitalization rate for state health care  
170.15 program enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate  
170.16 for state health care program enrollees for calendar year 2010. Hospitals shall cooperate  
170.17 with the plans in meeting this performance target and shall accept payment withholds that  
170.18 must be returned to the hospitals if the performance target is achieved. The commissioner  
170.19 shall structure the withhold so that the commissioner returns a portion of the withheld  
170.20 funds in amounts commensurate with achieved reductions in utilizations less than the  
170.21 targeted amount. The withhold described in this paragraph does not apply to county-based  
170.22 purchasing plans.

170.23 ~~(e)~~ (f) A managed care plan or a county-based purchasing plan under section  
170.24 256B.692 may include as admitted assets under section 62D.044 any amount withheld  
170.25 under this section that is reasonably expected to be returned.

170.26 Sec. 76. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

170.27 Subd. 1a. **Payment options.** The commissioner may offer the following payment  
170.28 options to an enrollee:

- 170.29 (1) payment by check;
- 170.30 (2) payment by credit card;
- 170.31 (3) payment by recurring automatic checking withdrawal;
- 170.32 (4) payment by onetime electronic transfer of funds;
- 170.33 (5) payment by wage withholding with the consent of the employer and the  
170.34 employee; or
- 170.35 (6) payment by using state tax refund payments.

171.1 The commissioner shall include information about the payment options on each  
171.2 premium notice. At application or reapplication, a MinnesotaCare applicant or enrollee  
171.3 may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to  
171.4 collect funds from the applicant's or enrollee's refund for the purposes of meeting all or  
171.5 part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or  
171.6 enrollee may authorize the commissioner to apply for the state working family tax credit  
171.7 on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be  
171.8 subject to the \$10 fee under section 270A.07, subdivision 1.

171.9 Sec. 77. **PLAN TO COORDINATE CARE FOR CHILDREN WITH HIGH-COST**  
171.10 **MENTAL HEALTH CONDITIONS.**

171.11 The commissioner of human services shall develop and submit to the legislature  
171.12 by December 15, 2011, a plan to provide care coordination to medical assistance and  
171.13 MinnesotaCare enrollees who are children with high-cost mental health conditions. For  
171.14 purposes of this section, a child has a "high-cost mental health condition" if mental health  
171.15 and medical expenses over the past year totalled \$100,000 or more. For purposes of this  
171.16 section, "care coordination" means collaboration between an advanced practice nurse and  
171.17 primary care physicians and specialists to manage care; development of mental health  
171.18 management plans for recurrent mental health issues; oversight and coordination of all  
171.19 aspects of care in partnership with families; organization of medical, treatment, and  
171.20 therapy information into a summary of critical information; coordination and appropriate  
171.21 sequencing of evaluations and multiple appointments; information and assistance with  
171.22 accessing resources; and telephone triage for behavior or other problems.

171.23 Sec. 78. **REGULATORY SIMPLIFICATION AND REDUCTION OF**  
171.24 **PROVIDER REPORTING AND DATA SUBMITTAL REQUIREMENTS.**

171.25 Subdivision 1. **Regulatory simplification and report reduction work group.** The  
171.26 commissioner of management and budget shall convene a regulatory simplification and  
171.27 report reduction work group of persons designated by the commissioners of health, human  
171.28 services, and commerce to eliminate redundant, unnecessary, and obsolete state mandated  
171.29 reporting or data submittal requirements for health care providers or group purchasers  
171.30 related to health care costs, quality, utilization, access, or patient encounters or related to  
171.31 provider or group purchaser, monitoring, finances, and regulation. For purposes of this  
171.32 section, the term "health care providers or group purchasers" has the meaning provided  
171.33 in Minnesota Statutes, section 62J.03, subdivisions 6 and 8, except that it also includes  
171.34 nursing homes.

172.1 Subd. 2. Plan development and other duties. (a) The commissioner of  
172.2 management and budget, in consultation with the work group, shall develop a plan for  
172.3 regulatory simplification and report reduction activities of the commissioners of health,  
172.4 human services, and commerce that considers collection and regulation of the following  
172.5 in a coordinated manner:

172.6 (1) encounter data;

172.7 (2) group purchaser provider network data;

172.8 (3) financial reporting;

172.9 (4) reporting and documentation requirements relating to member communications  
172.10 and marketing materials;

172.11 (5) state regulation and oversight of group purchasers;

172.12 (6) requirements and procedures for denial, termination, or reduction of services  
172.13 and member appeals and grievances; and

172.14 (7) state performance improvement projects, requirements, and procedures.

172.15 (b) The commissioners of health, human services, and commerce, following  
172.16 consultation with the work group, shall present to the legislature by January 1, 2012,  
172.17 proposals to implement their recommendations.

172.18 Subd. 3. New reporting and other duties. (a) The commissioner of management  
172.19 and budget, in consultation with the work group and the commissioners of health, human  
172.20 services, and commerce, shall develop criteria to be used by the commissioners in  
172.21 determining whether to establish new reporting and data submittal requirements. These  
172.22 criteria must support the establishment of new reporting and data submittal requirements  
172.23 only:

172.24 (1) if required by a federal agency or state statute;

172.25 (2) if needed for a state regulatory audit or corrective action plan;

172.26 (3) if needed to monitor or protect public health;

172.27 (4) if needed to manage the cost and quality of Minnesota's public health insurance  
172.28 programs; or

172.29 (5) if a review and analysis by the commissioner of the relevant agency has  
172.30 documented the necessity, importance, and administrative cost of the requirement, and  
172.31 has determined that the information sought cannot be efficiently obtained through another  
172.32 state or federal report.

172.33 (b) The commissioners of health, human services, and commerce, following  
172.34 consultation with the work group, may propose to the legislature new provider and group  
172.35 purchaser reporting and data submittal requirements to take effect on or after July 1, 2012.

173.1 These proposals shall include an analysis of the extent to which the requirements meet  
173.2 the criteria developed under paragraph (a).

173.3 **Sec. 79. SPECIALIZED MAINTENANCE THERAPY.**

173.4 The commissioner of human services shall evaluate whether providing medical  
173.5 assistance coverage for specialized maintenance therapy for enrollees with serious and  
173.6 persistent mental illness who are at risk of hospitalization will improve the quality of  
173.7 care and lower medical assistance spending by reducing rates of hospitalization. The  
173.8 commissioner shall present findings and recommendations to the chairs and ranking  
173.9 minority members of the legislative committees with jurisdiction over health and human  
173.10 services finance and policy by December 15, 2011.

173.11 **Sec. 80. BENEFIT SET OPTIONS.**

173.12 The commissioner of human services shall analyze and provide recommendations  
173.13 for state plan amendments that would provide different benefits for different demographic  
173.14 populations under the medical assistance program as permitted under federal law, with the  
173.15 goal of tailoring more cost-effective coverage based on unique needs of the demographic  
173.16 population. The commissioner shall report these recommendations to the chairs and  
173.17 ranking minority members of the senate and house health and human services committees  
173.18 by January 15, 2012.

173.19 **Sec. 81. REDUCING HOSPITALIZATION RATES.**

173.20 The commissioner of human services, by January 15, 2012, shall present  
173.21 recommendations to the legislature to reduce hospitalization rates for state health care  
173.22 program enrollees who are children with high-cost medical conditions.

173.23 **Sec. 82. MEDICAID FRAUD PREVENTION AND DETECTION.**

173.24 Subdivision 1. **Request for proposals.** By October 31, 2011, the commissioner  
173.25 of human services shall issue a request for proposals to prevent and detect Medicaid  
173.26 fraud and mispayment. The request for proposals shall require the vendor to provide  
173.27 data analytics capabilities, including, but not limited to, predictive modeling techniques  
173.28 and other forms of advanced analytics, technical assistance, claims review, and medical  
173.29 record and documentation investigations, to detect and investigate improper payments  
173.30 both before and after payments are made.

174.1 Subd. 2. **Proof of concept phase.** The selected vendor, at no cost to the state, shall  
174.2 be required to apply its analytics and investigations on a subset of data provided by the  
174.3 commissioner to demonstrate the direct recoveries of the solution.

174.4 Subd. 3. **Data confidentiality.** Data provided by the commissioner to the vendor  
174.5 under this section must maintain the confidentiality of the information.

174.6 Subd. 4. **Full implementation phase.** The request for proposal must require the  
174.7 commissioner to implement the recommendations provided by the vendor if the work  
174.8 done under the requirements of subdivision 2 provides recoveries directly related to the  
174.9 investigations to the state. After full implementation, the vendor shall be paid from  
174.10 recoveries directly attributable to the work done by the vendor, according to the terms and  
174.11 performance measures negotiated in the contract.

174.12 Subd. 5. **Selection of vendor.** The commissioner of human services shall select a  
174.13 vendor from the responses to the request for proposal by January 31, 2012.

174.14 Subd. 6. **Progress report.** The commissioner shall provide a report describing the  
174.15 progress made under this section to the governor and the chairs and ranking minority  
174.16 members of the legislative committees with jurisdiction over the Department of Human  
174.17 Services by June 15, 2012. The report shall provide a dynamic scoring analysis of the  
174.18 work described in the report.

174.19 **Sec. 83. WOUND CARE TREATMENT.**

174.20 The commissioner of human services, through the health services policy committee  
174.21 established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall study  
174.22 the effectiveness of new strategies for wound care treatment for medical assistance and  
174.23 MinnesotaCare enrollees with diabetes, including but not limited to the use of new wound  
174.24 care technologies, assessment tools, and reporting programs. The commissioner shall  
174.25 present recommendations by December 15, 2011, to the legislature on whether these  
174.26 new strategies for wound care treatment should be covered under medical assistance  
174.27 and MinnesotaCare.

174.28 **Sec. 84. PROHIBITION OF STATE FUNDS TO IMPLEMENT CERTAIN**  
174.29 **FEDERAL HEALTH CARE REFORMS.**

174.30 State funds must not be expended in the planning or implementation of the Patient  
174.31 Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care  
174.32 and Education Affordability and Reconciliation Act of 2010, Public Law 111-152, and no

175.1 provisions of the act may be implemented, until the constitutionality of the act has been  
175.2 affirmed by the United States Supreme Court.

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

175.4 Sec. 85. **COMMISSIONER'S ACTIONS; REPEAL OF EARLY MEDICAL**  
175.5 **ASSISTANCE EXPANSION.**

175.6 (a) Effective October 1, 2011, the commissioner of human services shall suspend  
175.7 implementation and administration of Minnesota Statutes 2010, sections 256B.055,  
175.8 subdivision 15; 256B.056, subdivision 3, paragraph (b); and 256B.056, subdivision 4,  
175.9 paragraph (d). The commissioner shall refer persons enrolled under these provisions, and  
175.10 applicants for coverage under these provisions, to the general assistance medical care  
175.11 program established under Minnesota Statutes, section 256D.031.

175.12 (b) The commissioner shall seek all federal approvals and waivers necessary  
175.13 to implement Minnesota Statutes, section 256D.031, and to ensure federal financial  
175.14 participation for the population covered under Minnesota Statutes, section 256D.031.

175.15 Sec. 86. **GENERAL ASSISTANCE MEDICAL CARE PROGRAM;**  
175.16 **PROVISIONS REVIVED.**

175.17 Notwithstanding their contingent repeal in Laws 2010, First Special Session chapter  
175.18 1, article 16, section 47, the following statutes are revived and have the force of law  
175.19 effective October 1, 2011:

175.20 (1) Minnesota Statutes 2010, section 256D.03, subdivisions 3, 3a, 6, 7, and 8;

175.21 (2) Minnesota Statutes 2010, section 256D.031, subdivisions 1, 2, 3, 4, 6, 7, 9,  
175.22 and 10; and

175.23 (3) Laws 2010, chapter 200, article 1, section 18.

175.24 Sec. 87. **REPEALER.**

175.25 (a) Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, are repealed.

175.26 (b) Minnesota Statutes 2010, section 256L.07, subdivision 7, **exempting eligibility**  
175.27 **for children formally under medical assistance**, is repealed retroactively from October  
175.28 1, 2008, and federal approval is no longer necessary.

175.29 (c) The amendment in Laws 2009, chapter 79, article 5, section 55, as amended by  
175.30 Laws 2009, chapter 173, article 1, section 36, **(256L.04, subdivision 1, children deemed**  
175.31 **eligible are exempt from eligibility requirements)** is repealed retroactively from January  
175.32 1, 2009, and federal approval is no longer necessary.

176.1 (d) Laws 2009, chapter 79, article 5, section 56, (256L.04, subdivision 1b,  
176.2 exemption from income limit for children) is repealed retroactively from July 1, 2009,  
176.3 and federal approval is no longer necessary.

176.4 (e) Laws 2009, chapter 79, article 5, section 60, (256L.05, subdivision 1c, open  
176.5 enrollment and streamlined application) is repealed retroactively from July 1, 2009,  
176.6 and federal approval is no longer necessary.

176.7 (f) Laws 2009, chapter 79, article 5, section 66, (256L.07, subdivision 8, automatic  
176.8 eligibility certain children) is repealed retroactively from July 1, 2009, and federal  
176.9 approval is no longer necessary.

176.10 (g) The amendment in Laws 2009, chapter 79, article 5, section 57, (256L.04,  
176.11 subdivision 7a, ineligibility for adults with certain income) is repealed retroactively  
176.12 from July 1, 2009, and federal approval is no longer necessary.

176.13 (h) The amendment in Laws 2009, chapter 79, article 5, section 61, (256L.05,  
176.14 subdivision 3, children eligibility following termination from foster care) is repealed  
176.15 retroactively from July 1, 2009, and federal approval is no longer necessary.

176.16 (i) The amendment in Laws 2009, chapter 79, article 5, section 62, (256L.05,  
176.17 subdivision 3a, exemption from cancellation for nonrenewal for children) is repealed  
176.18 retroactively from July 1, 2009, and federal approval is no longer necessary.

176.19 (j) The amendment in Laws 2009, chapter 79, article 5, section 63, (256L.07,  
176.20 subdivision 1, children whose gross family income is greater than 275 percent FPG  
176.21 may remain enrolled) is repealed retroactively from July 1, 2009, and federal approval is  
176.22 no longer necessary.

176.23 (k) The amendment in Laws 2009, chapter 79, article 5, section 64, (256L.07,  
176.24 subdivision 2, exempts children from requirement not to have employer-subsidized  
176.25 coverage) is repealed retroactively from July 1, 2009, and federal approval is no longer  
176.26 necessary.

176.27 (l) The amendment in Laws 2009, chapter 79, article 5, section 65, (256L.07,  
176.28 subdivision 3, requires children with family gross income over 200 percent of FPG  
176.29 to have had no health coverage for four months prior to application) is repealed  
176.30 retroactively from July 1, 2009, and federal approval is no longer necessary.

176.31 (m) The amendment in Laws 2009, chapter 79, article 5, section 68, (256L.15,  
176.32 subdivision 2, children in families with income less than 200 percent FPG pay no  
176.33 premium) is repealed retroactively from July 1, 2009, and federal approval is no longer  
176.34 necessary.

176.35 (n) The amendment in Laws 2009, chapter 79, article 5, section 69, (256L.15,  
176.36 subdivision 3, exempts children with family income below 200 percent FPG from



177.1 sliding fee scale) is repealed retroactively from July 1, 2009, and federal approval is  
177.2 no longer necessary.

177.3 (o) Laws 2009, chapter 79, article 5, section 79, (uncoded federal approval) is  
177.4 repealed the day following final enactment.

177.5 (p) Minnesota Statutes 2010, section 256B.057, subdivision 2c, (extended medical  
177.6 assistance for certain children) is repealed.

177.7 (q) The amendments in Laws 2008, chapter 358, article 3, sections 8; and 9,  
177.8 (renewal rolling month and premium grace month) are repealed.

177.9 Sec. 88. **REPEALER.**

177.10 Minnesota Statutes 2010, sections 256B.055, subdivision 15; and 256B.0756, are  
177.11 repealed effective October 1, 2011.

## 177.12 **ARTICLE 6**

### 177.13 **CONTINUING CARE**

177.14 Section 1. **[15.996] PERFORMANCE-BASED ORGANIZATIONS.**

177.15 Subdivision 1. **Designation.** The governor may designate one or more programs  
177.16 within the Department of Human Services and within up to two other executive branch  
177.17 state agencies whose missions involve people with disabilities as performance-based  
177.18 organizations. The goal of the performance-based organization designation is to provide  
177.19 the best services in the most cost-effective manner to people with disabilities. For a  
177.20 program that is designated as a performance-based organization, the agency providing  
177.21 services or another governmental or private organization under contract with the agency  
177.22 may enter into a performance-based agreement that allows the agency or the entity under  
177.23 contract with the agency more flexibility in its operations in exchange for a greater level of  
177.24 accountability. With any required legislative approval, a performance-based organization  
177.25 agreement may exempt an agency or an outside entity providing services from one or  
177.26 more procedural laws, rules, or policies that otherwise would govern the program.

177.27 Subd. 2. **Performance-based organization agreement.** Designation of a  
177.28 performance-based organization must be implemented through a performance-based  
177.29 organization agreement. A performance-based organization agreement may be between  
177.30 the governor and an agency, if an agency is to provide services under the agreement, or  
177.31 between an agency and an outside entity, if the outside entity is to provide the services. A  
177.32 performance-based organization agreement must:

177.33 (1) describe the programs subject to the agreement;

178.1 (2) specify the procedural laws, rules, or policies that will not apply to the  
178.2 performance-based organization, why waiver or variance from these laws, rules, or  
178.3 policies is necessary to achieve desired outcomes, and a description of alternative means  
178.4 of accomplishing the purposes of those laws, rules, or policies;

178.5 (3) contain procedures for oversight of the performance-based organization,  
178.6 including requirements and procedures for program and financial audits;

178.7 (4) if the performance-based organization involves a nonstate entity, contain  
178.8 provisions governing assumption of liability, and types and amounts of insurance coverage  
178.9 to be obtained;

178.10 (5) specify the duration of the agreement; and

178.11 (6) specify measurable performance-based outcomes for achieving program  
178.12 goals, time periods during which these outcomes will be measured and reported, and  
178.13 consequences for not meeting the performance-based outcomes.

178.14 Subd. 3. **Duration; legislative approval; reporting.** (a) A performance-based  
178.15 organization agreement may be up to three years and may be renewed.

178.16 (b) The chief executive of the state agency whose program is subject to a  
178.17 performance-based organization must report to the chairs and ranking minority members  
178.18 of legislative policy and finance committees with jurisdiction over the program on the  
178.19 proposed content of the performance-based organization, and specifically describing  
178.20 any procedural laws, rules, and policies that will not apply. The legislature must  
178.21 approve a performance-based organization before the state agency may enter into a  
178.22 performance-based agreement.

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

178.24 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor  
178.25 child, including a child determined eligible for medical assistance without consideration of  
178.26 parental income, must contribute to the cost of services used by making monthly payments  
178.27 on a sliding scale based on income, unless the child is married or has been married,  
178.28 parental rights have been terminated, or the child's adoption is subsidized according to  
178.29 section 259.67 or through title IV-E of the Social Security Act. The parental contribution  
178.30 is a partial or full payment for medical services provided for diagnostic, therapeutic,  
178.31 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as  
178.32 defined in United States Code, title 26, section 213, needed by the child with a chronic  
178.33 illness or disability.

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

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

179.7 (2) if the adjusted gross income is equal to or greater than 175 percent of federal  
179.8 poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines,  
179.9 the parental contribution shall be determined using a sliding fee scale established by the  
179.10 commissioner of human services which begins at one percent of adjusted gross income at  
179.11 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted  
179.12 gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal  
179.13 poverty guidelines;

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

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

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

179.26 If the child lives with the parent, the annual adjusted gross income is reduced by  
179.27 \$2,400 prior to calculating the parental contribution. If the child resides in an institution  
179.28 specified in section 256B.35, the parent is responsible for the personal needs allowance  
179.29 specified under that section in addition to the parental contribution determined under this  
179.30 section. The parental contribution is reduced by any amount required to be paid directly to  
179.31 the child pursuant to a court order, but only if actually paid.

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

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

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

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

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

180.27 (h) The contribution under paragraph (b) shall be increased by an additional five  
180.28 percent if the local agency determines that insurance coverage is available but not  
180.29 obtained for the child. For purposes of this section, "available" means the insurance is a  
180.30 benefit of employment for a family member at an annual cost of no more than five percent  
180.31 of the family's annual income. For purposes of this section, "insurance" means health  
180.32 and accident insurance coverage, enrollment in a nonprofit health service plan, health  
180.33 maintenance organization, self-insured plan, or preferred provider organization.

180.34 Parents who have more than one child receiving services shall not be required  
180.35 to pay more than the amount for the child with the highest expenditures. There shall  
180.36 be no resource contribution from the parents. The parent shall not be required to pay

181.1 a contribution in excess of the cost of the services provided to the child, not counting  
181.2 payments made to school districts for education-related services. Notice of an increase in  
181.3 fee payment must be given at least 30 days before the increased fee is due.

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

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

181.7 (2) the insurer denied insurance;

181.8 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted  
181.9 a complaint or appeal, in writing, to the commissioner of health or the commissioner of  
181.10 commerce, or litigated the complaint or appeal; and

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

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

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

181.19 ~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~  
181.20 ~~2013, the parental contribution shall be computed by applying the following contribution~~  
181.21 ~~schedule to the adjusted gross income of the natural or adoptive parents:~~

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

181.25 ~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal~~  
181.26 ~~poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,~~  
181.27 ~~the parental contribution shall be determined using a sliding fee scale established by the~~  
181.28 ~~commissioner of human services which begins at one percent of adjusted gross income~~  
181.29 ~~at 175 percent of federal poverty guidelines and increases to eight percent of adjusted~~  
181.30 ~~gross income for those with adjusted gross income up to 525 percent of federal poverty~~  
181.31 ~~guidelines;~~

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

181.35 ~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal~~  
181.36 ~~poverty guidelines and less than 900 percent of federal poverty guidelines, the parental~~

182.1 ~~contribution shall be determined using a sliding fee scale established by the commissioner~~  
182.2 ~~of human services which begins at 9.5 percent of adjusted gross income at 675 percent of~~  
182.3 ~~federal poverty guidelines and increases to 12 percent of adjusted gross income for those~~  
182.4 ~~with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

182.5 ~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal~~  
182.6 ~~poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross~~  
182.7 ~~income. If the child lives with the parent, the annual adjusted gross income is reduced by~~  
182.8 ~~\$2,400 prior to calculating the parental contribution. If the child resides in an institution~~  
182.9 ~~specified in section 256B.35, the parent is responsible for the personal needs allowance~~  
182.10 ~~specified under that section in addition to the parental contribution determined under this~~  
182.11 ~~section. The parental contribution is reduced by any amount required to be paid directly to~~  
182.12 ~~the child pursuant to a court order, but only if actually paid.~~

182.13 Sec. 3. Minnesota Statutes 2010, section 256.01, subdivision 24, is amended to read:

182.14 Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability  
182.15 Linkage Line, ~~a~~ to serve as Minnesota's neutral access point for statewide consumer  
182.16 disability information, referral, and assistance system for people with disabilities and  
182.17 chronic illnesses that. The Disability Linkage Line shall:

182.18 (1) deliver information and assistance based on national and state standards;

182.19 ~~(1) provides~~ (2) provide information about state and federal eligibility requirements,  
182.20 benefits, and service options;

182.21 (3) provide benefits and options counseling;

182.22 ~~(2) makes~~ (4) make referrals to appropriate support entities;

182.23 ~~(3) delivers information and assistance based on national and state standards;~~

182.24 ~~(4) assists~~ (5) educate people to on their options so they can make well-informed  
182.25 decisions choices; and

182.26 ~~(5) supports~~ (6) help support the timely resolution of service access and benefit  
182.27 issues;

182.28 (7) inform people of their long-term community services and supports;

182.29 (8) provide necessary resources and supports that can lead to employment and  
182.30 increased economic stability of people with disabilities; and

182.31 (9) serve as the technical assistance and help center for the Web-based tool,  
182.32 Minnesota's Disability Benefits 101.org.

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

182.34 Sec. 4. Minnesota Statutes 2010, section 256.01, subdivision 29, is amended to read:

183.1 Subd. 29. **State medical review team.** (a) To ensure the timely processing of  
183.2 determinations of disability by the commissioner's state medical review team under  
183.3 sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, ~~paragraph~~  
183.4 ~~(f)~~, and 256B.055, subdivision 12, the commissioner shall review all medical evidence  
183.5 submitted by county agencies with a referral and seek additional information from  
183.6 providers, applicants, and enrollees to support the determination of disability where  
183.7 necessary. Disability shall be determined according to the rules of title XVI and title  
183.8 XIX of the Social Security Act and pertinent rules and policies of the Social Security  
183.9 Administration.

183.10 (b) Prior to a denial or withdrawal of a requested determination of disability due  
183.11 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is  
183.12 necessary and appropriate to a determination of disability, and (2) assist applicants and  
183.13 enrollees to obtain the evidence, including, but not limited to, medical examinations  
183.14 and electronic medical records.

183.15 (c) The commissioner shall provide the chairs of the legislative committees with  
183.16 jurisdiction over health and human services finance and budget the following information  
183.17 on the activities of the state medical review team by February 1 of each year:

183.18 (1) the number of applications to the state medical review team that were denied,  
183.19 approved, or withdrawn;

183.20 (2) the average length of time from receipt of the application to a decision;

183.21 (3) the number of appeals, appeal results, and the length of time taken from the date  
183.22 the person involved requested an appeal for a written decision to be made on each appeal;

183.23 (4) for applicants, their age, health coverage at the time of application, hospitalization  
183.24 history within three months of application, and whether an application for Social Security  
183.25 or Supplemental Security Income benefits is pending; and

183.26 (5) specific information on the medical certification, licensure, or other credentials  
183.27 of the person or persons performing the medical review determinations and length of  
183.28 time in that position.

183.29 (d) Any appeal made under section 256.045, subdivision 3, of a disability  
183.30 determination made by the state medical review team must be decided according to the  
183.31 timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is  
183.32 not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the  
183.33 appeal must be immediately reviewed by the chief appeals referee.

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

184.1 Sec. 5. Minnesota Statutes 2010, section 256B.04, is amended by adding a subdivision  
184.2 to read:

184.3 Subd. 20. **Money Follows the Person Rebalancing demonstration project.** In  
184.4 accordance with federal law governing Money Follows the Person Rebalancing funds,  
184.5 amounts equal to the value of enhanced federal funding resulting from the operation of the  
184.6 demonstration project grant must be transferred from the medical assistance account in  
184.7 the general fund to an account in the special revenue fund. Funds in the special revenue  
184.8 fund account do not cancel and are appropriated to the commissioner to carry out the  
184.9 goals of the Money Follows the Person Rebalancing demonstration project as required  
184.10 under the approved federal plan for the use of the funds, and may be transferred to the  
184.11 medical assistance account if applicable.

184.12 Sec. 6. Minnesota Statutes 2010, section 256B.05, is amended by adding a subdivision  
184.13 to read:

184.14 Subd. 5. **Obligation of local agency to process medical assistance applications**  
184.15 **within established timelines.** The local agency must act on an application for medical  
184.16 assistance within ten working days of receipt of all information needed to act on the  
184.17 application but no later than required under Minnesota Rules, part 9505.0090, subparts  
184.18 2 and 3.

184.19 Sec. 7. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

184.20 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for  
184.21 medical assistance, a person must not individually own more than \$3,000 in assets, or if a  
184.22 member of a household with two family members, husband and wife, or parent and child,  
184.23 the household must not own more than \$6,000 in assets, plus \$200 for each additional  
184.24 legal dependent. In addition to these maximum amounts, an eligible individual or family  
184.25 may accrue interest on these amounts, but they must be reduced to the maximum at the  
184.26 time of an eligibility redetermination. The accumulation of the clothing and personal  
184.27 needs allowance according to section 256B.35 must also be reduced to the maximum at  
184.28 the time of the eligibility redetermination. The value of assets that are not considered in  
184.29 determining eligibility for medical assistance is the value of those assets excluded under  
184.30 the supplemental security income program for aged, blind, and disabled persons, with  
184.31 the following exceptions:

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

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



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

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

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

185.13 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision  
185.14 15.

185.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

185.16 Sec. 8. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

185.23 (4) pays a premium and other obligations under paragraph (e).

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

185.30 ~~(b)~~ (c) After the month of enrollment, a person enrolled in medical assistance under  
185.31 this subdivision who:

185.32 (1) is temporarily unable to work and without receipt of earned income due to a  
185.33 medical condition, as verified by a physician, ~~may retain eligibility for up to four calendar~~  
185.34 ~~months~~; or

186.1 (2) ~~effective January 1, 2004,~~ loses employment for reasons not attributable to the  
186.2 enrollee, and is without receipt of earned income may retain eligibility for up to four  
186.3 consecutive months after the month of job loss. To receive a four-month extension,  
186.4 enrollees must verify the medical condition or provide notification of job loss. All other  
186.5 eligibility requirements must be met and the enrollee must pay all calculated premium  
186.6 costs for continued eligibility.

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

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

186.10 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,  
186.11 Keogh plans, and pension plans; ~~and~~

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

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

186.14 ~~(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65~~  
186.15 ~~earned income disregard. To be eligible, a person applying for medical assistance under~~  
186.16 ~~this subdivision must have earned income above the disregard level.~~

186.17 ~~(2) Effective January 1, 2004, to be considered earned income, Medicare, Social~~  
186.18 ~~Security, and applicable state and federal income taxes must be withheld. To be eligible,~~  
186.19 ~~a person must document earned income tax withholding.~~

186.20 ~~(e)(1) A person whose earned and unearned income is equal to or greater than 100~~  
186.21 ~~percent of federal poverty guidelines for the applicable family size must pay a premium~~  
186.22 ~~to be eligible for medical assistance under this subdivision. (e) All enrollees must pay a~~  
186.23 ~~premium to be eligible for medical assistance under this subdivision, except as provided~~  
186.24 ~~under section 256.01, subdivision 18b.~~

186.25 (1) An enrollee must pay the greater of a \$65 premium or the premium shall be  
186.26 calculated based on the person's gross earned and unearned income and the applicable  
186.27 family size using a sliding fee scale established by the commissioner, which begins at  
186.28 one percent of income at 100 percent of the federal poverty guidelines and increases  
186.29 to 7.5 percent of income for those with incomes at or above 300 percent of the federal  
186.30 poverty guidelines.

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

186.33 ~~(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for~~  
186.34 ~~medical assistance under this subdivision. An enrollee shall pay the greater of a \$35~~  
186.35 ~~premium or the premium calculated in clause (1).~~

187.1           (3) ~~Effective November 1, 2003,~~ All enrollees who receive unearned income must  
187.2 pay ~~one-half of one~~ five percent of unearned income in addition to the premium amount,  
187.3 except as provided under section 256.01, subdivision 18b.

187.4           ~~(4) Effective November 1, 2003, for enrollees whose income does not exceed 200~~  
187.5 ~~percent of the federal poverty guidelines and who are also enrolled in Medicare, the~~  
187.6 ~~commissioner must reimburse the enrollee for Medicare Part B premiums under section~~  
187.7 ~~256B.0625, subdivision 15, paragraph (a).~~

187.8           ~~(5)~~ (4) Increases in benefits under title II of the Social Security Act shall not be  
187.9 counted as income for purposes of this subdivision until July 1 of each year.

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

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

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

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

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

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

188.5 **EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or  
188.6 older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

188.7 Sec. 9. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to  
188.8 read:

188.9 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant  
188.10 must meet the following requirements:

188.11 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years  
188.12 of age with these additional requirements:

188.13 (i) supervision by a qualified professional every 60 days; and

188.14 (ii) employment by only one personal care assistance provider agency responsible  
188.15 for compliance with current labor laws;

188.16 (2) be employed by a personal care assistance provider agency;

188.17 (3) enroll with the department as a personal care assistant after clearing a background  
188.18 study. Except as provided in subdivision 11a, before a personal care assistant provides  
188.19 services, the personal care assistance provider agency must initiate a background study on  
188.20 the personal care assistant under chapter 245C, and the personal care assistance provider  
188.21 agency must have received a notice from the commissioner that the personal care assistant  
188.22 is:

188.23 (i) not disqualified under section 245C.14; or

188.24 (ii) is disqualified, but the personal care assistant has received a set aside of the  
188.25 disqualification under section 245C.22;

188.26 (4) be able to effectively communicate with the recipient and personal care  
188.27 assistance provider agency;

188.28 (5) be able to provide covered personal care assistance services according to the  
188.29 recipient's personal care assistance care plan, respond appropriately to recipient needs,  
188.30 and report changes in the recipient's condition to the supervising qualified professional  
188.31 or physician;

188.32 (6) not be a consumer of personal care assistance services;

188.33 (7) maintain daily written records including, but not limited to, time sheets under  
188.34 subdivision 12;

189.1 (8) effective January 1, 2010, complete standardized training as determined  
189.2 by the commissioner before completing enrollment. The training must be available  
189.3 in languages other than English and to those who need accommodations due to  
189.4 disabilities. Personal care assistant training must include successful completion of the  
189.5 following training components: basic first aid, vulnerable adult, child maltreatment,  
189.6 OSHA universal precautions, basic roles and responsibilities of personal care assistants  
189.7 including information about assistance with lifting and transfers for recipients, emergency  
189.8 preparedness, orientation to positive behavioral practices, fraud issues, and completion of  
189.9 time sheets. Upon completion of the training components, the personal care assistant must  
189.10 demonstrate the competency to provide assistance to recipients;

189.11 (9) complete training and orientation on the needs of the recipient within the first  
189.12 seven days after the services begin; and

189.13 (10) be limited to providing and being paid for up to 275 hours per month, except  
189.14 that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,  
189.15 2011, of personal care assistance services regardless of the number of recipients being  
189.16 served or the number of personal care assistance provider agencies enrolled with. The  
189.17 number of hours worked per day shall not be disallowed by the department unless in  
189.18 violation of the law.

189.19 (b) A legal guardian may be a personal care assistant if the guardian is not being paid  
189.20 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

189.21 (c) ~~Effective January 1, 2010,~~ Persons who do not qualify as a personal care assistant  
189.22 include parents and stepparents of minors, spouses, paid legal guardians, family foster  
189.23 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or  
189.24 staff of a residential setting. When the personal care assistant is a relative of the recipient,  
189.25 the commissioner shall pay 80 percent of the provider rate. For purposes of this section,  
189.26 relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or  
189.27 older, an adult child, a grandparent, or a grandchild.

189.28 **EFFECTIVE DATE.** This section is effective October 1, 2011.

189.29 Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to  
189.30 read:

189.31 Subd. 28. **Personal care assistance provider agency; required documentation.**

189.32 (a) Required documentation must be completed and kept in the personal care assistance  
189.33 provider agency file or the recipient's home residence. The required documentation  
189.34 consists of:

189.35 (1) employee files, including:

- 190.1 (i) applications for employment;
- 190.2 (ii) background study requests and results;
- 190.3 (iii) orientation records about the agency policies;
- 190.4 (iv) trainings completed with demonstration of competence;
- 190.5 (v) supervisory visits;
- 190.6 (vi) evaluations of employment; and
- 190.7 (vii) signature on fraud statement;
- 190.8 (2) recipient files, including:
- 190.9 (i) demographics;
- 190.10 (ii) emergency contact information and emergency backup plan;
- 190.11 (iii) personal care assistance service plan;
- 190.12 (iv) personal care assistance care plan;
- 190.13 (v) month-to-month service use plan;
- 190.14 (vi) all communication records;
- 190.15 (vii) start of service information, including the written agreement with recipient; and
- 190.16 (viii) date the home care bill of rights was given to the recipient;
- 190.17 (3) agency policy manual, including:
- 190.18 (i) policies for employment and termination;
- 190.19 (ii) grievance policies with resolution of consumer grievances;
- 190.20 (iii) staff and consumer safety;
- 190.21 (iv) staff misconduct; and
- 190.22 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
- 190.23 resolution of consumer grievances;
- 190.24 (4) time sheets for each personal care assistant along with completed activity sheets
- 190.25 for each recipient served; ~~and~~
- 190.26 (5) agency marketing and advertising materials and documentation of marketing
- 190.27 activities and costs; and
- 190.28 (6) for each personal care assistant, whether or not the personal care assistant is
- 190.29 providing care to a relative as defined in subdivision 11.
- 190.30 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do
- 190.31 not consistently comply with the requirements of this subdivision.

190.32 Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to

190.33 read:

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

190.35 (a) "Long-term care consultation services" means:

191.1 (1) assistance in identifying services needed to maintain an individual in the most  
191.2 inclusive environment;

191.3 (2) providing recommendations on cost-effective community services that are  
191.4 available to the individual;

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

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

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

191.11 (6) federally mandated screening to determine the need for an institutional level of  
191.12 care under subdivision 4a;

191.13 (7) determination of home and community-based waiver service eligibility  
191.14 including level of care determination for individuals who need an institutional level of  
191.15 care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility  
191.16 including state plan home care services identified in sections 256B.0625, subdivisions  
191.17 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support  
191.18 plan development with appropriate referrals, including the option for ~~consumer-directed~~  
191.19 community self-directed supports;

191.20 (8) providing recommendations for nursing facility placement when there are no  
191.21 cost-effective community services available; ~~and~~

191.22 (9) assistance to transition people back to community settings after facility  
191.23 admission; and

191.24 (10) providing notice to the individual or legal representative of the annual and  
191.25 monthly average authorized amount for traditional agency services and self-directed  
191.26 services under section 256B.0657 for which the recipient is found eligible.

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

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

191.33 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health  
191.34 plans administering long-term care consultation assessment and support planning services.

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

192.1 Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to  
192.2 read:

192.3 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,  
192.4 services planning, or other assistance intended to support community-based living,  
192.5 including persons who need assessment in order to determine waiver or alternative  
192.6 care program eligibility, must be visited by a long-term care consultation team within  
192.7 ~~15 calendar~~ 20 calendar days after the date on which an assessment was requested or  
192.8 recommended. After January 1, 2011, these requirements also apply to personal care  
192.9 assistance services, private duty nursing, and home health agency services, on timelines  
192.10 established in subdivision 5. Face-to-face assessments must be conducted according  
192.11 to paragraphs (b) to (i).

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

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

192.20 (d) The assessment must be conducted in a face-to-face interview with the person  
192.21 being assessed and the person's legal representative, as required by legally executed  
192.22 documents, and other individuals as requested by the person, who can provide information  
192.23 on the needs, strengths, and preferences of the person necessary to develop a support  
192.24 plan that ensures the person's health and safety, but who is not a provider of service or  
192.25 has any financial interest in the provision of services. For persons who are to be assessed  
192.26 for elderly waiver customized living services under section 256B.0915, and with the  
192.27 permission of the person being assessed or the persons' designated or legal representative,  
192.28 the client's current or proposed provider of services may submit a copy of the provider's  
192.29 nursing assessment or written report outlining their recommendations regarding the  
192.30 client's care needs. The person conducting the assessment will notify the provider of the  
192.31 date by which this information is to be submitted. This information shall be provided to  
192.32 the person conducting the assessment prior to the assessment.

192.33 (e) The person, or the person's legal representative, must be provided with  
192.34 written recommendations for community-based services, including ~~consumer-directed~~  
192.35 self-directed options, or institutional care that include documentation that the most  
192.36 cost-effective alternatives available were offered to the individual. For purposes of



193.1 this requirement, "cost-effective alternatives" means community services and living  
193.2 arrangements that cost the same as or less than institutional care. For persons determined  
193.3 eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the  
193.4 community support plan must also include the estimated annual and monthly average  
193.5 authorized budget amount for those services.

193.6 (f)(1) If the person chooses to use community-based services, the person or the  
193.7 person's legal representative must be provided with a written community support plan,  
193.8 regardless of whether the individual is eligible for Minnesota health care programs. The  
193.9 written community support plan must include:

193.10 (i) a summary of assessed needs as defined in paragraphs (c) and (d);

193.11 (ii) the individual's options and choices to meet identified needs, including all  
193.12 available options for case management services and providers;

193.13 (iii) identification of health and safety risks and how those risks will be addressed,  
193.14 including personal risk management strategies;

193.15 (iv) referral information; and

193.16 (v) informal caregiver supports, if applicable.

193.17 (2) For persons determined eligible for services defined under subdivision 1a,  
193.18 paragraph (a), clauses (7) to (10), the community support plan must also include:

193.19 (i) identification of individual goals;

193.20 (ii) identification of short-term and long-term service outcomes. Short-term service  
193.21 outcomes are defined as achievable within six months;

193.22 (iii) a recommended schedule for case management visits. When achievement of  
193.23 short-term service outcomes may affect the amount of service required, the schedule must  
193.24 be at least every six months and must reflect evaluation and progress toward identified  
193.25 short-term service outcomes; and

193.26 (iv) the estimated annual and monthly budget amount for services.

193.27 (3) In addition, for persons determined eligible for state plan home care under  
193.28 subdivision 1a, paragraph (a), clause (8), the person or person's representative must also  
193.29 receive a copy of the home care service plan developed by a certified assessor.

193.30 (4) A person may request assistance in identifying community supports without  
193.31 participating in a complete assessment. Upon a request for assistance identifying  
193.32 community support, the person must be transferred or referred to the services available  
193.33 under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone  
193.34 assistance and follow up.

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

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

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

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

194.11 (3) information about Minnesota health care programs;

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

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

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

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

194.21 (i) Face-to-face assessment completed as part of eligibility determination for  
194.22 the alternative care, elderly waiver, community alternatives for disabled individuals,  
194.23 community alternative care, and traumatic brain injury waiver programs under sections  
194.24 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more  
194.25 than 60 calendar days after the date of assessment. The effective eligibility start date  
194.26 for these programs can never be prior to the date of assessment. If an assessment was  
194.27 completed more than 60 days before the effective waiver or alternative care program  
194.28 eligibility start date, assessment and support plan information must be updated ~~in a~~  
194.29 ~~face-to-face visit~~ and documented in the department's Medicaid Management Information  
194.30 System (MMIS). The updated assessment may be completed by face-to-face visit, written  
194.31 communication, or telephone as determined by the commissioner to establish statewide  
194.32 consistency. The effective date of program eligibility in this case cannot be prior to the  
194.33 date the updated assessment is completed.

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

195.1 Sec. 13. Minnesota Statutes 2010, section 256B.0913, subdivision 4, is amended to  
195.2 read:

195.3 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

195.4 (a) Funding for services under the alternative care program is available to persons who  
195.5 meet the following criteria:

195.6 (1) the person has been determined by a community assessment under section  
195.7 256B.0911 to be a person who would require the level of care provided in a nursing  
195.8 facility, but for the provision of services under the alternative care program. Effective  
195.9 January 1, 2011, this determination must be made according to the criteria established in  
195.10 section 144.0724, subdivision 11;

195.11 (2) the person is age 65 or older;

195.12 (3) the person would be eligible for medical assistance within 135 days of admission  
195.13 to a nursing facility;

195.14 (4) the person is not ineligible for the payment of long-term care services by the  
195.15 medical assistance program due to an asset transfer penalty under section 256B.0595 or  
195.16 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

195.17 (5) the person needs long-term care services that are not funded through other  
195.18 state or federal funding, or other health insurance or other third-party insurance such as  
195.19 long-term care insurance;

195.20 (6) except for individuals described in clause (7), the monthly cost of the alternative  
195.21 care services funded by the program for this person does not exceed 75 percent of the  
195.22 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit  
195.23 does not prohibit the alternative care client from payment for additional services, but in no  
195.24 case may the cost of additional services purchased under this section exceed the difference  
195.25 between the client's monthly service limit defined under section 256B.0915, subdivision  
195.26 3, and the alternative care program monthly service limit defined in this paragraph. If  
195.27 care-related supplies and equipment or environmental modifications and adaptations are or  
195.28 will be purchased for an alternative care services recipient, the costs may be prorated on a  
195.29 monthly basis for up to 12 consecutive months beginning with the month of purchase.  
195.30 If the monthly cost of a recipient's other alternative care services exceeds the monthly  
195.31 limit established in this paragraph, the annual cost of the alternative care services shall be  
195.32 determined. In this event, the annual cost of alternative care services shall not exceed 12  
195.33 times the monthly limit described in this paragraph;

195.34 (7) for individuals assigned a case mix classification A as described under section  
195.35 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily  
195.36 living, or (ii) ~~only one dependency~~ up to two dependencies in bathing, dressing, grooming,

196.1 ~~or walking, or (iii) a dependency score of less than three if eating is the only dependency~~  
196.2 and eating when the dependency score in eating is three or greater as determined by  
196.3 an assessment performed under section 256B.0911, the monthly cost of alternative  
196.4 care services funded by the program cannot exceed \$600 \$593 per month for all new  
196.5 participants enrolled in the program on or after July 1, 2009 2011. This monthly limit  
196.6 shall be applied to all other participants who meet this criteria at reassessment. This  
196.7 monthly limit shall be increased annually as described in section 256B.0915, subdivision  
196.8 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from  
196.9 payment for additional services, but in no case may the cost of additional services  
196.10 purchased exceed the difference between the client's monthly service limit defined in this  
196.11 clause and the limit described in clause (6) for case mix classification A; and

196.12 (8) the person is making timely payments of the assessed monthly fee.

196.13 A person is ineligible if payment of the fee is over 60 days past due, unless the person  
196.14 agrees to:

196.15 (i) the appointment of a representative payee;

196.16 (ii) automatic payment from a financial account;

196.17 (iii) the establishment of greater family involvement in the financial management of  
196.18 payments; or

196.19 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

196.20 The lead agency may extend the client's eligibility as necessary while making  
196.21 arrangements to facilitate payment of past-due amounts and future premium payments.  
196.22 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be  
196.23 reinstated for a period of 30 days.

196.24 (b) Alternative care funding under this subdivision is not available for a person  
196.25 who is a medical assistance recipient or who would be eligible for medical assistance  
196.26 without a spenddown or waiver obligation. A person whose initial application for medical  
196.27 assistance and the elderly waiver program is being processed may be served under the  
196.28 alternative care program for a period up to 60 days. If the individual is found to be eligible  
196.29 for medical assistance, medical assistance must be billed for services payable under the  
196.30 federally approved elderly waiver plan and delivered from the date the individual was  
196.31 found eligible for the federally approved elderly waiver plan. Notwithstanding this  
196.32 provision, alternative care funds may not be used to pay for any service the cost of which:  
196.33 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;  
196.34 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible  
196.35 to participate in the federally approved elderly waiver program under the special income  
196.36 standard provision.

197.1 (c) Alternative care funding is not available for a person who resides in a licensed  
197.2 nursing home, certified boarding care home, hospital, or intermediate care facility, except  
197.3 for case management services which are provided in support of the discharge planning  
197.4 process for a nursing home resident or certified boarding care home resident to assist with  
197.5 a relocation process to a community-based setting.

197.6 (d) Alternative care funding is not available for a person whose income is greater  
197.7 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal  
197.8 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal  
197.9 year for which alternative care eligibility is determined, who would be eligible for the  
197.10 elderly waiver with a waiver obligation.

197.11 Sec. 14. Minnesota Statutes 2010, section 256B.0915, subdivision 3a, is amended to  
197.12 read:

197.13 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of  
197.14 waived services to an individual elderly waiver client except for individuals described  
197.15 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case  
197.16 mix resident class to which the elderly waiver client would be assigned under Minnesota  
197.17 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance  
197.18 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in  
197.19 which the resident assessment system as described in section 256B.438 for nursing home  
197.20 rate determination is implemented. Effective on the first day of the state fiscal year in  
197.21 which the resident assessment system as described in section 256B.438 for nursing home  
197.22 rate determination is implemented and the first day of each subsequent state fiscal year, the  
197.23 monthly limit for the cost of waived services to an individual elderly waiver client shall  
197.24 be the rate of the case mix resident class to which the waiver client would be assigned  
197.25 under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the  
197.26 previous state fiscal year, adjusted by ~~the greater of any legislatively adopted home and~~  
197.27 ~~community-based services percentage rate increase or the average statewide percentage~~  
197.28 ~~increase in nursing facility payment rates~~ adjustment.

197.29 (b) The monthly limit for the cost of waived services to an individual elderly  
197.30 waiver client assigned to a case mix classification A under paragraph (a) with:

197.31 (1) no dependencies in activities of daily living; ~~or~~

197.32 (2) only one dependency up to two dependencies in bathing, dressing, grooming, or  
197.33 walking, or (3) a dependency score of less than three if eating is the only dependency,  
197.34 and eating when the dependency score in eating is three or greater as determined by an  
197.35 assessment performed under section 256B.0911

198.1 shall be ~~the lower of the case mix classification amount for case mix A as determined~~  
 198.2 ~~under paragraph (a) or the case mix classification amount for case mix A~~ \$1,750 per  
 198.3 month effective on ~~October~~ July 1, 2008 2011, per month for all new participants enrolled  
 198.4 in the program on or after July 1, ~~2009~~ 2011. This monthly limit shall be applied to all  
 198.5 other participants who meet this criteria at reassessment. This monthly limit shall be  
 198.6 increased annually as described in paragraph (a).

198.7 (c) If extended medical supplies and equipment or environmental modifications are  
 198.8 or will be purchased for an elderly waiver client, the costs may be prorated for up to  
 198.9 12 consecutive months beginning with the month of purchase. If the monthly cost of a  
 198.10 recipient's waived services exceeds the monthly limit established in paragraph (a) or  
 198.11 (b), the annual cost of all waived services shall be determined. In this event, the annual  
 198.12 cost of all waived services shall not exceed 12 times the monthly limit of waived  
 198.13 services as described in paragraph (a) or (b).

198.14 Sec. 15. Minnesota Statutes 2010, section 256B.0915, subdivision 3b, is amended to  
 198.15 read:

198.16 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing**  
 198.17 **facility.** (a) For a person who is a nursing facility resident at the time of requesting a  
 198.18 determination of eligibility for elderly waived services, a monthly conversion budget  
 198.19 limit for the cost of elderly waived services may be requested. The monthly conversion  
 198.20 budget limit for the cost of elderly waiver services shall be the resident class assigned  
 198.21 under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing  
 198.22 facility where the resident currently resides until July 1 of the state fiscal year in which  
 198.23 the resident assessment system as described in section 256B.438 for nursing home rate  
 198.24 determination is implemented. Effective on July 1 of the state fiscal year in which the  
 198.25 resident assessment system as described in section 256B.438 for nursing home rate  
 198.26 determination is implemented, the monthly conversion budget limit for the cost of elderly  
 198.27 waiver services shall be based on the per diem nursing facility rate as determined by the  
 198.28 resident assessment system as described in section 256B.438 for ~~that resident~~ residents  
 198.29 in the nursing facility where the ~~resident~~ elderly waiver applicant currently resides  
 198.30 ~~multiplied~~. The monthly conversion budget limit shall be calculated by multiplying the  
 198.31 per diem by 365 ~~and~~ divided by 12, less and reduced by the recipient's maintenance needs  
 198.32 allowance as described in subdivision 1d. The initially approved monthly conversion rate  
 198.33 may budget limit shall be adjusted by the ~~greater of any subsequent legislatively adopted~~  
 198.34 ~~home and community-based services percentage rate increase or the average statewide~~  
 198.35 ~~percentage increase in nursing facility payment rates~~ annually as described in subdivision

199.1 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from  
199.2 a nursing facility after a minimum 30-day stay and found eligible for waived services  
199.3 on or after July 1, 1997. For conversions from the nursing home to the elderly waiver  
199.4 with consumer directed community support services, ~~the conversion rate limit is equal to~~  
199.5 ~~the nursing facility rate~~ per diem used to calculate the monthly conversion budget limit  
199.6 must be reduced by a percentage equal to the percentage difference between the consumer  
199.7 directed services budget limit that would be assigned according to the federally approved  
199.8 waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

199.9 (b) The following costs must be included in determining the total monthly costs  
199.10 for the waiver client:

199.11 (1) cost of all waived services, including ~~extended medical~~ specialized supplies  
199.12 and equipment and environmental ~~modifications and~~ accessibility adaptations; and

199.13 (2) cost of skilled nursing, home health aide, and personal care services reimbursable  
199.14 by medical assistance.

199.15 Sec. 16. Minnesota Statutes 2010, section 256B.0915, subdivision 3e, is amended to  
199.16 read:

199.17 Subd. 3e. **Customized living service rate.** (a) Payment for customized living  
199.18 services shall be a monthly rate authorized by the lead agency within the parameters  
199.19 established by the commissioner. The payment agreement must delineate the amount of  
199.20 each component service included in the recipient's customized living service plan. The  
199.21 lead agency shall ensure that there is a documented need within the parameters established  
199.22 by the commissioner for all component customized living services authorized.

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

199.27 (c) Component service rates must not exceed payment rates for comparable elderly  
199.28 waiver or medical assistance services and must reflect economies of scale. Customized  
199.29 living services must not include rent or raw food costs.

199.30 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the  
199.31 individualized monthly authorized payment for the customized living service plan shall  
199.32 not exceed 50 percent of the greater of either the statewide or any of the geographic  
199.33 groups' weighted average monthly nursing facility rate of the case mix resident class  
199.34 to which the elderly waiver eligible client would be assigned under Minnesota Rules,  
199.35 parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described

200.1 in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the  
200.2 resident assessment system as described in section 256B.438 for nursing home rate  
200.3 determination is implemented. Effective on July 1 of the state fiscal year in which  
200.4 the resident assessment system as described in section 256B.438 for nursing home  
200.5 rate determination is implemented and July 1 of each subsequent state fiscal year, the  
200.6 individualized monthly authorized payment for the services described in this clause shall  
200.7 not exceed the limit which was in effect on June 30 of the previous state fiscal year  
200.8 updated annually based on legislatively adopted changes to all service rate maximums for  
200.9 home and community-based service providers.

200.10 (e) Effective July 1, 2011, the individualized monthly payment for the customized  
200.11 living service plan for individuals described in subdivision 3a, paragraph (b), must be the  
200.12 monthly authorized payment limit for customized living for individuals classified as case  
200.13 mix A, reduced by 25 percent. This rate limit must be applied to all new participants  
200.14 enrolled in the program on or after July 1, 2011, who meet the criteria described in  
200.15 subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who  
200.16 meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

200.17 ~~(e)~~ (f) Customized living services are delivered by a provider licensed by the  
200.18 Department of Health as a class A or class F home care provider and provided in a  
200.19 building that is registered as a housing with services establishment under chapter 144D.  
200.20 Licensed home care providers are subject to section 256B.0651, subdivision 14.

200.21 (g) A provider may not bill or otherwise charge an elderly waiver participant or their  
200.22 family for additional units of any allowable component service beyond those available  
200.23 under the service rate limits described in paragraph (d), nor for additional units of any  
200.24 allowable component service beyond those approved in the service plan by the lead agency.

200.25 Sec. 17. Minnesota Statutes 2010, section 256B.0915, subdivision 3h, is amended to  
200.26 read:

200.27 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The  
200.28 payment rate for 24-hour customized living services is a monthly rate authorized by the  
200.29 lead agency within the parameters established by the commissioner of human services.  
200.30 The payment agreement must delineate the amount of each component service included in  
200.31 each recipient's customized living service plan. The lead agency shall ensure that there is a  
200.32 documented need within the parameters established by the commissioner for all component  
200.33 customized living services authorized. The lead agency shall not authorize 24-hour  
200.34 customized living services unless there is a documented need for 24-hour supervision.



201.1 (b) For purposes of this section, "24-hour supervision" means that the recipient  
201.2 requires assistance due to needs related to one or more of the following:

201.3 (1) intermittent assistance with toileting, positioning, or transferring;

201.4 (2) cognitive or behavioral issues;

201.5 (3) a medical condition that requires clinical monitoring; or

201.6 (4) for all new participants enrolled in the program on or after ~~January~~ July 1, 2011,  
201.7 and all other participants at their first reassessment after ~~January~~ July 1, 2011, dependency  
201.8 in at least ~~two~~ three of the following activities of daily living as determined by assessment  
201.9 under section 256B.0911: bathing; dressing; grooming; walking; or eating when the  
201.10 dependency score in eating is three or greater; and needs medication management and at  
201.11 least 50 hours of service per month. The lead agency shall ensure that the frequency and  
201.12 mode of supervision of the recipient and the qualifications of staff providing supervision  
201.13 are described and meet the needs of the recipient.

201.14 (c) The payment rate for 24-hour customized living services must be based on the  
201.15 amount of component services to be provided utilizing component rates established by the  
201.16 commissioner. Counties and tribes will use tools issued by the commissioner to develop  
201.17 and document customized living plans and authorize rates.

201.18 (d) Component service rates must not exceed payment rates for comparable elderly  
201.19 waiver or medical assistance services and must reflect economies of scale.

201.20 (e) The individually authorized 24-hour customized living payments, in combination  
201.21 with the payment for other elderly waiver services, including case management, must not  
201.22 exceed the recipient's community budget cap specified in subdivision 3a. Customized  
201.23 living services must not include rent or raw food costs.

201.24 (f) The individually authorized 24-hour customized living payment rates shall not  
201.25 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized  
201.26 living services in effect and in the Medicaid management information systems on March  
201.27 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050  
201.28 to 9549.0059, to which elderly waiver service clients are assigned. When there are  
201.29 fewer than 50 authorizations in effect in the case mix resident class, the commissioner  
201.30 shall multiply the calculated service payment rate maximum for the A classification by  
201.31 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to  
201.32 9549.0059, to determine the applicable payment rate maximum. Service payment rate  
201.33 maximums shall be updated annually based on legislatively adopted changes to all service  
201.34 rates for home and community-based service providers.

201.35 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner  
201.36 may establish alternative payment rate systems for 24-hour customized living services in

202.1 housing with services establishments which are freestanding buildings with a capacity of  
202.2 16 or fewer, by applying a single hourly rate for covered component services provided  
202.3 in either:

202.4 (1) licensed corporate adult foster homes; or

202.5 (2) specialized dementia care units which meet the requirements of section 144D.065

202.6 and in which:

202.7 (i) each resident is offered the option of having their own apartment; or

202.8 (ii) the units are licensed as board and lodge establishments with maximum capacity  
202.9 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,  
202.10 subparts 1, 2, 3, and 4, item A.

202.11 (h) A provider may not bill or otherwise charge an elderly waiver participant or their  
202.12 family for additional units of any allowable component service beyond those available  
202.13 under the service rate limits described in paragraph (e), nor for additional units of any  
202.14 allowable component service beyond those approved in the service plan by the lead agency.

202.15 Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to  
202.16 read:

202.17 Subd. 10. **Waiver payment rates; managed care organizations.** The  
202.18 commissioner shall adjust the elderly waiver capitation payment rates for managed care  
202.19 organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum  
202.20 service rate limits for customized living services and 24-hour customized living services  
202.21 under subdivisions 3e and 3h ~~for the contract period beginning October 1, 2009~~. Medical  
202.22 assistance rates paid to customized living providers by managed care organizations under  
202.23 this section shall not exceed the maximum service rate limits and component rates as  
202.24 determined by the commissioner under subdivisions 3e and 3h.

202.25 Sec. 19. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to  
202.26 read:

202.27 Subd. 6a. **Statewide availability of ~~consumer-directed community self-directed~~**  
202.28 **support services.** (a) The commissioner shall submit to the federal Health Care Financing  
202.29 Administration by August 1, 2001, an amendment to the home and community-based  
202.30 waiver ~~for persons with developmental disabilities~~ under section 256B.092 and by April 1,  
202.31 2005, for waivers under sections 256B.0915 and 256B.49, to make ~~consumer-directed~~  
202.32 ~~community self-directed~~ support services available in every county of the state by January  
202.33 1, 2002.

203.1 (b) Until the waiver amendment for self-directed community supports is effective, if  
203.2 a county declines to meet the requirements for provision of ~~consumer-directed community~~  
203.3 self-directed supports, the commissioner shall contract with another county, a group of  
203.4 counties, or a private agency to plan for and administer ~~consumer-directed community~~  
203.5 self-directed supports in that county.

203.6 (c) The state of Minnesota, county agencies, tribal governments, or administrative  
203.7 entities under contract to participate in the implementation and administration of the home  
203.8 and community-based waiver for persons with developmental disabilities, shall not be  
203.9 liable for damages, injuries, or liabilities sustained through the purchase of support by the  
203.10 individual, the individual's family, legal representative, or the authorized representative  
203.11 with funds received through the ~~consumer-directed community~~ self-directed support  
203.12 service under this section. Liabilities include but are not limited to: workers' compensation  
203.13 liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment  
203.14 Tax Act (FUTA).

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

203.16 Sec. 20. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to  
203.17 read:

203.18 Subd. 1b. ~~Individual service~~ **Coordinated services and support plan.** ~~The~~  
203.19 ~~individual service~~ Each recipient of case management services and any legal representative  
203.20 shall be provided a written copy of the coordinated services and support plan ~~must~~, which:

203.21 (1) ~~include~~ is developed within ten working days after the case manager receives the  
203.22 community support plan from the certified assessor under section 256B.0911;

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

203.26 (3) reasonably assures the health, safety, and welfare of the recipient;

203.27 (2) ~~identify~~ (4) identifies the person's preferences for services as stated by the person,  
203.28 the person's legal guardian or conservator, or the parent if the person is a minor;

203.29 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,  
203.30 paragraph (o), of service and support providers;

203.31 (3) ~~identify~~ (6) identifies long- and short-range goals for the person;

203.32 (4) ~~identify~~ (7) identifies specific services and the amount and frequency of the  
203.33 services to be provided to the person based on assessed needs, preferences, ~~and~~ available  
203.34 resources. ~~The individual service plan shall also specify other services the person needs~~  
203.35 that are not available, and other services the person needs that are not available. The

204.1 individual coordinated services and support plan shall also specify service outcomes and  
204.2 the provider's responsibility to monitor the achievement of the service outcomes;

204.3 ~~(5) identify~~ (8) identifies the need for an ~~individual program~~ individual's provider  
204.4 plan to be developed by the provider according to the respective state and federal licensing  
204.5 and certification standards, and additional assessments to be completed or arranged by the  
204.6 provider after service initiation;

204.7 ~~(6) identify~~ (9) identifies provider responsibilities to implement and make  
204.8 recommendations for modification to the ~~individual service~~ coordinated services and  
204.9 support plan;

204.10 ~~(7) include~~ (10) includes notice of the right to have assessments completed and  
204.11 service plans developed within specified time periods, the right to appeal action or  
204.12 inaction, and the right to request a conciliation conference or a hearing, an appeal under  
204.13 section 256.045;

204.14 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian  
204.15 or conservator, or the parent if the person is a minor, and the authorized county  
204.16 representative; and

204.17 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical  
204.18 needs that impact the delivery of services.

204.19 ~~Service planning formats developed for interagency planning such as transition,~~  
204.20 ~~vocational, and individual family service plans may be substituted for service planning~~  
204.21 ~~formats developed by county agencies.~~

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

204.23 Sec. 21. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to  
204.24 read:

204.25 Subd. 1e. **Case management service monitoring, coordination, and evaluation;**  
204.26 **and monitoring of services duties.** (a) If the ~~individual service~~ coordinated services and  
204.27 support plan identifies the need for individual ~~program~~ provider plans for authorized  
204.28 services, the case ~~manager~~ management service provider shall assure that ~~individual~~  
204.29 ~~program~~ the individual provider plans are developed by the providers according to clauses  
204.30 (2) to (5). The providers shall assure that the individual ~~program~~ provider plans:

204.31 (1) are developed according to the respective state and federal licensing and  
204.32 certification requirements;

204.33 (2) are designed to achieve the goals of the individual service plan;

204.34 (3) are consistent with other aspects of the ~~individual service~~ coordinated services  
204.35 and support plan;

205.1 (4) assure the health and safety of the person; and  
205.2 (5) are developed with consistent and coordinated approaches to services and service  
205.3 outcomes among the various service providers.

205.4 (b) The case ~~manager~~ management service provider shall monitor the provision of  
205.5 services:

205.6 (1) to assure that the ~~individual service~~ coordinated services and support plan is  
205.7 being followed according to paragraph (a);

205.8 (2) to identify any changes or modifications that might be needed in the ~~individual~~  
205.9 ~~service~~ coordinated services and support plan, including changes resulting from  
205.10 recommendations of current service providers;

205.11 (3) to determine if the person's legal rights are protected, and if not, notify the  
205.12 person's legal guardian or conservator, or the parent if the person is a minor, protection  
205.13 services, or licensing agencies as appropriate; and

205.14 (4) to determine if the person, the person's legal guardian or conservator, or the  
205.15 parent if the person is a minor, is satisfied with the services provided.

205.16 (c) If the provider fails to develop or carry out the individual ~~program~~ provider plan  
205.17 according to paragraph (a), the case manager shall notify the person's legal guardian or  
205.18 conservator, or the parent if the person is a minor, the provider, the respective licensing  
205.19 and certification agencies, and the county board where the services are being provided. In  
205.20 addition, the case manager shall identify other steps needed to assure the person receives  
205.21 the services identified in the ~~individual service~~ coordinated services and support plan.

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

205.23 Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to  
205.24 read:

205.25 Subd. 1g. **Conditions not requiring development of ~~individual service~~ a**  
205.26 **coordinated services and support plan.** Unless otherwise required by federal law, the  
205.27 county agency is not required to complete ~~an individual service~~ a coordinated services and  
205.28 support plan as defined in subdivision 1b for:

205.29 (1) persons whose families are requesting respite care for their family member who  
205.30 resides with them, or whose families are requesting a family support grant and are not  
205.31 requesting purchase or arrangement of habilitative services; and

205.32 (2) persons with developmental disabilities, living independently without authorized  
205.33 services or receiving funding for services at a rehabilitation facility as defined in section  
205.34 268A.01, subdivision 6, and not in need of or requesting additional services.

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

206.2 Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

206.3 Subd. 3. **Authorization and termination of services.** ~~County agency case managers~~  
206.4 Lead agencies, under rules of the commissioner, shall authorize and terminate services  
206.5 of community and regional treatment center providers according to ~~individual service~~  
206.6 coordinated services and support plans. Services provided to persons with developmental  
206.7 disabilities may only be authorized and terminated ~~by case managers~~ according to (1)  
206.8 rules of the commissioner and (2) the ~~individual service~~ coordinated services and support  
206.9 plan as defined in subdivision 1b. Medical assistance services not needed shall not be  
206.10 authorized by ~~county~~ lead agencies or funded by the commissioner. When purchasing or  
206.11 arranging for unlicensed respite care services for persons with overriding health needs, the  
206.12 county agency shall seek the advice of a health care professional in assessing provider  
206.13 staff training needs and skills necessary to meet the medical needs of the person.

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

206.15 Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

206.16 Subd. 8. ~~Screening team~~ **Additional certified assessor duties.** The ~~screening team~~  
206.17 certified assessor shall:

206.18 (1) review diagnostic data;

206.19 (2) review health, social, and developmental assessment data using a ~~uniform~~  
206.20 ~~screening~~ comprehensive assessment tool specified by the commissioner;

206.21 (3) identify the level of services appropriate to maintain the person in the most  
206.22 normal and least restrictive setting that is consistent with the person's treatment needs;

206.23 (4) identify other noninstitutional public assistance or social service that may prevent  
206.24 or delay long-term residential placement;

206.25 (5) assess whether a person is in need of long-term residential care;

206.26 (6) make recommendations regarding placement services and payment for: (i) social  
206.27 service or public assistance support, or both, to maintain a person in the person's own home  
206.28 or other place of residence; (ii) training and habilitation service, vocational rehabilitation,  
206.29 and employment training activities; (iii) community residential placement services; ~~(iv)~~  
206.30 ~~regional treatment center placement~~; or ~~(v)~~ (iv) a home and community-based service

206.31 alternative to community residential placement or regional treatment center placement;

206.32 (7) evaluate the availability, location, and quality of the services listed in clause  
206.33 (6), including the impact of ~~placement alternatives~~ services and supports options on the

207.1 person's ability to maintain or improve existing patterns of contact and involvement with  
207.2 parents and other family members;

207.3 (8) identify the cost implications of recommendations in clause (6) and provide  
207.4 written notice of the annual and monthly average authorized amount to be spent for  
207.5 services for the recipient;

207.6 (9) make recommendations to a court as may be needed to assist the court in making  
207.7 decisions regarding commitment of persons with developmental disabilities; and

207.8 (10) inform the person and the person's legal guardian or conservator, or the parent if  
207.9 the person is a minor, that appeal may be made to the commissioner pursuant to section  
207.10 256.045.

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

207.12 Sec. 25. **[256B.0961] STATE QUALITY ASSURANCE, QUALITY**  
207.13 **IMPROVEMENT, AND LICENSING SYSTEM.**

207.14 Subdivision 1. Scope. (a) In order to improve the quality of services provided to  
207.15 Minnesotans with disabilities and to meet the requirements of the federally approved  
207.16 home and community-based waivers under section 1915c of the Social Security Act, a  
207.17 State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans  
207.18 receiving disability services is enacted. This system is a partnership between the  
207.19 Department of Human Services and the State Quality Council established under  
207.20 subdivision 3.

207.21 (b) This system is a result of the recommendations from the Department of Human  
207.22 Services' licensing and alternative quality assurance study mandated under Laws 2005,  
207.23 First Special Session chapter 4, article 7, section 57, and presented to the legislature  
207.24 in February 2007.

207.25 (c) The disability services eligible under this section include:

207.26 (1) the home and community-based services waiver programs for persons with  
207.27 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,  
207.28 including traumatic brain injuries and services for those who qualify for nursing facility  
207.29 level of care or hospital facility level of care;

207.30 (2) home care services under section 256B.0651;

207.31 (3) family support grants under section 252.32;

207.32 (4) consumer support grants under section 256.476;

207.33 (5) semi-independent living services under section 252.275; and

207.34 (6) services provided through an intermediate care facility for the developmentally  
207.35 disabled.

208.1 (d) For purposes of this section, the following definitions apply:

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

208.3 (2) "council" means the State Quality Council under subdivision 3;

208.4 (3) "Quality Assurance Commission" means the commission under section  
208.5 256B.0951; and

208.6 (4) "system" means the State Quality Assurance, Quality Improvement and  
208.7 Licensing System under this section.

208.8 Subd. 2. Duties of the commissioner of human services. (a) The commissioner of  
208.9 human services shall establish the State Quality Council under subdivision 3.

208.10 (b) The commissioner shall initially delegate authority to perform licensing  
208.11 functions and activities according to section 245A.16 to a host county in Region 10. The  
208.12 commissioner must not license or reimburse a participating facility, program, or service  
208.13 located in Region 10 if the commissioner has received notification from the host county  
208.14 that the facility, program, or service has failed to qualify for licensure.

208.15 (c) The commissioner may conduct random licensing inspections based on outcomes  
208.16 adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services  
208.17 eligible under this section. The role of the random inspections is to verify that the system  
208.18 protects the safety and well-being of persons served and maintains the availability of  
208.19 high-quality services for persons with disabilities.

208.20 (d) The commissioner shall ensure that the federal home and community-based  
208.21 waiver requirements are met and that incidents that may have jeopardized safety and health  
208.22 or violated services-related assurances, civil and human rights, and other protections  
208.23 designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and  
208.24 acted upon in a timely manner.

208.25 (e) The commissioner shall seek a federal waiver by July 1, 2012 to allow  
208.26 intermediate care facilities for persons with developmental disabilities to participate in  
208.27 this system.

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

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

208.35 (1) disability service recipients and their family members;



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

209.4 (3) disability service providers;

209.5 (4) disability advocacy groups; and

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

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

209.11 (d) The State Quality Council shall:

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

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

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

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

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

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

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

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

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

209.33 (g) The State Quality Council, in partnership with the commissioner, shall establish  
209.34 an ongoing review process for the system. The review shall take into account the  
209.35 comprehensive nature of the system which is designed to evaluate the broad spectrum of

210.1 licensed and unlicensed entities that provide services to persons with disabilities. The  
210.2 review shall address efficiencies and effectiveness of the system.

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

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

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

210.15 Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as  
210.16 selected by the State Quality Council, regional quality councils of key stakeholders,  
210.17 including regional representatives of:

210.18 (1) disability service recipients and their family members;

210.19 (2) disability service providers;

210.20 (3) disability advocacy groups; and

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

210.23 (b) Each regional quality council shall:

210.24 (1) direct and monitor the community-based, person-directed quality assurance  
210.25 system in this section;

210.26 (2) approve a training program for quality assurance team members under clause  
210.27 (13);

210.28 (3) review summary reports from quality assurance team reviews and make  
210.29 recommendations to the State Quality Council regarding program licensure;

210.30 (4) make recommendations to the State Quality Council regarding the system;

210.31 (5) resolve complaints between the quality assurance teams, counties, providers,  
210.32 persons receiving services, their families, and legal representatives;

210.33 (6) analyze and review quality outcomes and critical incident data reporting  
210.34 incidents of life safety concerns immediately to the Department of Human Services  
210.35 licensing division;

211.1 (7) provide information and training programs for persons with disabilities and their  
211.2 families and legal representatives on service options and quality expectations;

211.3 (8) disseminate information and resources developed to other regional quality  
211.4 councils;

211.5 (9) respond to state-level priorities;

211.6 (10) establish regional priorities for quality improvement;

211.7 (11) submit an annual report to the State Quality Council on the status, outcomes,  
211.8 improvement priorities, and activities in the region;

211.9 (12) choose a representative to participate on the State Quality Council and assume  
211.10 other responsibilities consistent with the priorities of the State Quality Council; and

211.11 (13) recruit, train, and assign duties to members of quality assurance teams, taking  
211.12 into account the size of the service provider, the number of services to be reviewed,  
211.13 the skills necessary for the team members to complete the process, and ensure that no  
211.14 team member has a financial, personal, or family relationship with the facility, program,  
211.15 or service being reviewed or with anyone served at the facility, program, or service.

211.16 Quality assurance teams must be comprised of county staff, persons receiving services  
211.17 or the person's families, legal representatives, members of advocacy organizations,  
211.18 providers, and other involved community members. Team members must complete  
211.19 the training program approved by the regional quality council and must demonstrate  
211.20 performance-based competency. Team members may be paid a per diem and reimbursed  
211.21 for expenses related to their participation in the quality assurance process.

211.22 (c) The commissioner shall monitor the safety standards, rights, and procedural  
211.23 protections for the monitoring of psychotropic medications and those identified under  
211.24 sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2)  
211.25 and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause  
211.26 (7); 626.556; and 626.557.

211.27 (d) The regional quality councils may hire staff to perform the duties assigned in  
211.28 this subdivision.

211.29 (e) The regional quality councils may charge fees for their services.

211.30 (f) The quality assurance process undertaken by a regional quality council consists of  
211.31 an evaluation by a quality assurance team of the facility, program, or service. The process  
211.32 must include an evaluation of a random sample of persons served. The sample must be  
211.33 representative of each service provided. The sample size must be at least five percent but  
211.34 not less than two persons served. All persons must be given the opportunity to be included  
211.35 in the quality assurance process in addition to those chosen for the random sample.

212.1 (g) A facility, program, or service may contest a licensing decision of the regional  
212.2 quality council as permitted under chapter 245A.

212.3 Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation  
212.4 with the State Quality Council, shall conduct an annual independent statewide survey  
212.5 of service recipients, randomly selected, to determine the effectiveness and quality  
212.6 of disability services. The survey must be consistent with the system performance  
212.7 expectations of the Centers for Medicare and Medicaid Services (CMS) Quality  
212.8 Framework. The survey must analyze whether desired outcomes for persons with different  
212.9 demographic, diagnostic, health, and functional needs, who are receiving different types  
212.10 of services in different settings and with different costs, have been achieved. Annual  
212.11 statewide and regional reports of the results must be published and used to assist regions,  
212.12 counties, and providers to plan and measure the impact of quality improvement activities.

212.13 Subd. 6. **Mandated reporters.** Members of the State Quality Council under  
212.14 subdivision 3, the regional quality councils under subdivision 4, and quality assurance  
212.15 team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as  
212.16 defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

212.17 **EFFECTIVE DATE.** (a) Subdivisions 1 to 6 are effective July 1, 2011.

212.18 (b) The jurisdictions of the regional quality councils in subdivision 4 must be  
212.19 defined, with implementation dates, by July 1, 2012. During the biennium beginning July  
212.20 1, 2011, the Quality Assurance Commission shall continue to implement the alternative  
212.21 licensing system under this section.

212.22 Sec. 26. Minnesota Statutes 2010, section 256B.431, subdivision 2r, is amended to  
212.23 read:

212.24 Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the  
212.25 commissioner shall limit payment for leave days in a nursing facility to 79 percent of that  
212.26 nursing facility's total payment rate for the involved resident.

212.27 (b) For services rendered on or after July 1, 2003, for facilities reimbursed under this  
212.28 section or section 256B.434, the commissioner shall limit payment for leave days in a  
212.29 nursing facility to 60 percent of that nursing facility's total payment rate for the involved  
212.30 resident.

212.31 (c) For services rendered on or after July 1, 2011, for facilities reimbursed under  
212.32 this chapter, the commissioner shall limit payment for leave days in a nursing facility  
212.33 to 30 percent of that nursing facility's total payment rate for the involved resident, and  
212.34 shall allow this payment only when the occupancy of the nursing facility, inclusive of

213.1 bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules,  
213.2 part 9505.0415.

213.3 Sec. 27. Minnesota Statutes 2010, section 256B.431, subdivision 32, is amended to  
213.4 read:

213.5 Subd. 32. **Payment during first 90 30 days.** (a) ~~For rate years beginning on or after~~  
213.6 ~~July 1, 2001, the total payment rate for a facility reimbursed under this section, section~~  
213.7 ~~256B.434, or any other section for the first 90 paid days after admission shall be:~~

213.8 ~~(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical~~  
213.9 ~~assistance rate for each case mix class;~~

213.10 ~~(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent~~  
213.11 ~~of the facility's medical assistance rate for each case mix class;~~

213.12 ~~(3) beginning with the 91st paid day after admission, the payment rate shall be the~~  
213.13 ~~rate otherwise determined under this section, section 256B.434, or any other section; and~~

213.14 ~~(4) payments under this paragraph apply to admissions occurring on or after July 1,~~  
213.15 ~~2001, and before July 1, 2003, and to resident days occurring before July 30, 2003.~~

213.16 ~~(b)~~ For rate years beginning on or after July 1, 2003 2011, the total payment rate for  
213.17 a facility reimbursed under this section, section 256B.434, or any other section shall be:

213.18 (1) for the first 30 calendar days after admission, the rate shall be 120 percent of  
213.19 the facility's medical assistance rate for each RUG class;

213.20 (2) beginning with the 31st calendar day after admission, the payment rate shall be  
213.21 the rate otherwise determined under this section, section 256B.434, or any other section;

213.22 and

213.23 (3) payments under this paragraph apply to admissions occurring on or after July  
213.24 1, 2003 2011.

213.25 ~~(c) Effective January 1, 2004,~~ (b) The enhanced rates under this subdivision shall not  
213.26 be allowed if a resident has resided during the previous 30 calendar days in:

213.27 (1) the same nursing facility;

213.28 (2) a nursing facility owned or operated by a related party; or

213.29 (3) a nursing facility or part of a facility that closed or was in the process of closing.

213.30 Sec. 28. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

213.31 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which  
213.32 have their payment rates determined under this section rather than section 256B.431, the  
213.33 commissioner shall establish a rate under this subdivision. The nursing facility must enter  
213.34 into a written contract with the commissioner.

214.1 (b) A nursing facility's case mix payment rate for the first rate year of a facility's  
 214.2 contract under this section is the payment rate the facility would have received under  
 214.3 section 256B.431.

214.4 (c) A nursing facility's case mix payment rates for the second and subsequent years  
 214.5 of a facility's contract under this section are the previous rate year's contract payment  
 214.6 rates plus an inflation adjustment and, for facilities reimbursed under this section or  
 214.7 section 256B.431, an adjustment to include the cost of any increase in Health Department  
 214.8 licensing fees for the facility taking effect on or after July 1, 2001. The index for the  
 214.9 inflation adjustment must be based on the change in the Consumer Price Index-All Items  
 214.10 (United States City average) (CPI-U) forecasted by the commissioner of management and  
 214.11 budget's national economic consultant, as forecasted in the fourth quarter of the calendar  
 214.12 year preceding the rate year. The inflation adjustment must be based on the 12-month  
 214.13 period from the midpoint of the previous rate year to the midpoint of the rate year for  
 214.14 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,  
 214.15 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,  
 214.16 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, ~~October 1, 2011, and~~  
 214.17 ~~October 1, 2012~~; this paragraph shall apply only to the property-related payment rate;  
 214.18 ~~except that adjustments to include the cost of any increase in Health Department licensing~~  
 214.19 ~~fees taking effect on or after July 1, 2001, shall be provided.~~ For the rate years beginning  
 214.20 on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall  
 214.21 be suspended. Beginning in 2005, adjustment to the property payment rate under this  
 214.22 section and section 256B.431 shall be effective on October 1. In determining the amount  
 214.23 of the property-related payment rate adjustment under this paragraph, the commissioner  
 214.24 shall determine the proportion of the facility's rates that are property-related based on the  
 214.25 facility's most recent cost report.

214.26 (d) The commissioner shall develop additional incentive-based payments of up to  
 214.27 five percent above a facility's operating payment rate for achieving outcomes specified  
 214.28 in a contract. The commissioner may solicit contract amendments and implement those  
 214.29 which, on a competitive basis, best meet the state's policy objectives. The commissioner  
 214.30 shall limit the amount of any incentive payment and the number of contract amendments  
 214.31 under this paragraph to operate the incentive payments within funds appropriated for this  
 214.32 purpose. The contract amendments may specify various levels of payment for various  
 214.33 levels of performance. Incentive payments to facilities under this paragraph may be in the  
 214.34 form of time-limited rate adjustments or onetime supplemental payments. In establishing  
 214.35 the specified outcomes and related criteria, the commissioner shall consider the following  
 214.36 state policy objectives:

215.1 (1) successful diversion or discharge of residents to the residents' prior home or other  
215.2 community-based alternatives;

215.3 (2) adoption of new technology to improve quality or efficiency;

215.4 (3) improved quality as measured in the Nursing Home Report Card;

215.5 (4) reduced acute care costs; and

215.6 (5) any additional outcomes proposed by a nursing facility that the commissioner  
215.7 finds desirable.

215.8 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that  
215.9 take action to come into compliance with existing or pending requirements of the life  
215.10 safety code provisions or federal regulations governing sprinkler systems must receive  
215.11 reimbursement for the costs associated with compliance if all of the following conditions  
215.12 are met:

215.13 (1) the expenses associated with compliance occurred on or after January 1, 2005,  
215.14 and before December 31, 2008;

215.15 (2) the costs were not otherwise reimbursed under subdivision 4f or section  
215.16 144A.071 or 144A.073; and

215.17 (3) the total allowable costs reported under this paragraph are less than the minimum  
215.18 threshold established under section 256B.431, subdivision 15, paragraph (e), and  
215.19 subdivision 16.

215.20 The commissioner shall use money appropriated for this purpose to provide to qualifying  
215.21 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,  
215.22 2008. Nursing facilities that have spent money or anticipate the need to spend money  
215.23 to satisfy the most recent life safety code requirements by (1) installing a sprinkler  
215.24 system or (2) replacing all or portions of an existing sprinkler system may submit to the  
215.25 commissioner by June 30, 2007, on a form provided by the commissioner the actual  
215.26 costs of a completed project or the estimated costs, based on a project bid, of a planned  
215.27 project. The commissioner shall calculate a rate adjustment equal to the allowable  
215.28 costs of the project divided by the resident days reported for the report year ending  
215.29 September 30, 2006. If the costs from all projects exceed the appropriation for this  
215.30 purpose, the commissioner shall allocate the money appropriated on a pro rata basis  
215.31 to the qualifying facilities by reducing the rate adjustment determined for each facility  
215.32 by an equal percentage. Facilities that used estimated costs when requesting the rate  
215.33 adjustment shall report to the commissioner by January 31, 2009, on the use of this  
215.34 money on a form provided by the commissioner. If the nursing facility fails to provide  
215.35 the report, the commissioner shall recoup the money paid to the facility for this purpose.  
215.36 If the facility reports expenditures allowable under this subdivision that are less than

216.1 the amount received in the facility's annualized rate adjustment, the commissioner shall  
216.2 recoup the difference.

216.3 Sec. 29. Minnesota Statutes 2010, section 256B.437, subdivision 6, is amended to read:

216.4 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human  
216.5 services shall calculate the amount of the planned closure rate adjustment available under  
216.6 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

216.7 (1) the amount available is the net reduction of nursing facility beds multiplied  
216.8 by \$2,080;

216.9 (2) the total number of beds in the nursing facility or facilities receiving the planned  
216.10 closure rate adjustment must be identified;

216.11 (3) capacity days are determined by multiplying the number determined under  
216.12 clause (2) by 365; and

216.13 (4) the planned closure rate adjustment is the amount available in clause (1), divided  
216.14 by capacity days determined under clause (3).

216.15 (b) A planned closure rate adjustment under this section is effective on the first day  
216.16 of the month following completion of closure of the facility designated for closure in the  
216.17 application and becomes part of the nursing facility's total operating payment rate.

216.18 (c) Applicants may use the planned closure rate adjustment to allow for a property  
216.19 payment for a new nursing facility or an addition to an existing nursing facility or as an  
216.20 operating payment rate adjustment. Applications approved under this subdivision are  
216.21 exempt from other requirements for moratorium exceptions under section 144A.073,  
216.22 subdivisions 2 and 3.

216.23 (d) Upon the request of a closing facility, the commissioner must allow the facility a  
216.24 closure rate adjustment as provided under section 144A.161, subdivision 10.

216.25 (e) A facility that has received a planned closure rate adjustment may reassign it  
216.26 to another facility that is under the same ownership at any time within three years of its  
216.27 effective date. The amount of the adjustment shall be computed according to paragraph (a).

216.28 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,  
216.29 the commissioner shall recalculate planned closure rate adjustments for facilities that  
216.30 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per  
216.31 bed dollar amount. The recalculated planned closure rate adjustment shall be effective  
216.32 from the date the per bed dollar amount is increased.

216.33 (g) For planned closures approved after June 30, 2009, the commissioner of human  
216.34 services shall calculate the amount of the planned closure rate adjustment available under  
216.35 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).



217.1 (h) Beginning July 16, 2011, the commissioner shall no longer accept applications  
217.2 for planned closure rate adjustments under subdivision 3.

217.3 Sec. 30. Minnesota Statutes 2010, section 256B.441, subdivision 50a, is amended to  
217.4 read:

217.5 Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility  
217.6 located in close proximity to another nursing facility of the same facility group type but in  
217.7 a different peer group and that has higher limits for care-related or other operating costs,  
217.8 the commissioner shall adjust the limits in accordance with clauses (1) to (4):

217.9 (1) determine the difference between the limits;

217.10 (2) determine the distance between the two facilities, by the shortest driving route. If  
217.11 the distance exceeds 20 miles, no adjustment shall be made;

217.12 (3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a  
217.13 percentage; and

217.14 (4) increase the limits for the nursing facility with the lower limits by the value  
217.15 determined in clause (1) multiplied by the value determined in clause (3).

217.16 (b) Effective October 1, 2011, nursing facilities located no more than one-quarter  
217.17 mile from a peer group with higher limits under either subdivision 50 or 51, may receive  
217.18 an operating rate adjustment. The operating payment rates of a lower-limit peer group  
217.19 facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer  
217.20 group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer  
217.21 group facility. Peer groups are those defined in subdivision 30. The nearest facility must  
217.22 be determined by the most direct driving route.

217.23 Sec. 31. Minnesota Statutes 2010, section 256B.441, is amended by adding a  
217.24 subdivision to read:

217.25 Subd. 61. **Rate increase for low-rate facilities.** Effective October 1, 2011,  
217.26 operating payment rates of all nursing facilities that are reimbursed under this section or  
217.27 section 256B.434 shall be increased for a resource utilization group rate with a weight  
217.28 of 1.00 by up to 2.45 percent, but not to exceed for the same resource utilization group  
217.29 weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The  
217.30 percentage of the operating payment rate for each facility to be case-mix adjusted shall be  
217.31 equal to the percentage that is case-mix adjusted in that facility's operating payment rate  
217.32 on the preceding September 30.

217.33 Sec. 32. Minnesota Statutes 2010, section 256B.48, subdivision 1, is amended to read:

218.1 Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive  
218.2 medical assistance payments unless it refrains from all of the following:

218.3 (a) Charging private paying residents rates for similar services which exceed those  
218.4 which are approved by the state agency for medical assistance recipients as determined by  
218.5 the prospective desk audit rate, except under the following circumstances:

218.6 (1) the nursing facility may:

218.7 ~~(1)~~ (i) charge private paying residents a higher rate for a private room; and

218.8 ~~(2)~~ (ii) charge for special services which are not included in the daily rate if medical  
218.9 assistance residents are charged separately at the same rate for the same services in  
218.10 addition to the daily rate paid by the commissioner;

218.11 (2) effective July 1, 2011, through September 30, 2012, nursing facilities may  
218.12 charge private paying residents rates up to two percent higher than the allowable medical  
218.13 assistance payment rate determined by the commissioner for the RUGS group currently  
218.14 assigned to the resident; and

218.15 (3) effective for rate years beginning October 1, 2012, and after, nursing facilities  
218.16 may charge private paying residents rates greater than the allowable medical assistance  
218.17 payment rate determined by the commissioner for the RUGS group currently assigned  
218.18 to the resident by up to two percent more than the differential in effect on the prior  
218.19 September 30. Nothing in this section precludes a nursing facility from charging a rate  
218.20 allowable under the facility's single room election option under Minnesota Rules, part  
218.21 9549.0060, subpart 11, or the enhanced rates under section 256B.431, subdivision 32.

218.22 Services covered by the payment rate must be the same regardless of payment source.

218.23 Special services, if offered, must be available to all residents in all areas of the nursing  
218.24 facility and charged separately at the same rate. Residents are free to select or decline

218.25 special services. Special services must not include services which must be provided by  
218.26 the nursing facility in order to comply with licensure or certification standards and that

218.27 if not provided would result in a deficiency or violation by the nursing facility. Services

218.28 beyond those required to comply with licensure or certification standards must not be

218.29 charged separately as a special service if they were included in the payment rate for the

218.30 previous reporting year. A nursing facility that charges a private paying resident a rate in

218.31 violation of this ~~clause~~ paragraph is subject to an action by the state of Minnesota or any of

218.32 its subdivisions or agencies for civil damages. A private paying resident or the resident's

218.33 legal representative has a cause of action for civil damages against a nursing facility that

218.34 charges the resident rates in violation of this ~~clause~~ paragraph. The damages awarded shall

218.35 include three times the payments that result from the violation, together with costs and

218.36 disbursements, including reasonable ~~attorneys'~~ attorney fees or their equivalent. A private

219.1 paying resident or the resident's legal representative, the state, subdivision or agency, or a  
219.2 nursing facility may request a hearing to determine the allowed rate or rates at issue in  
219.3 the cause of action. Within 15 calendar days after receiving a request for such a hearing,  
219.4 the commissioner shall request assignment of an administrative law judge under sections  
219.5 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by  
219.6 the parties. The administrative law judge shall issue a report within 15 calendar days  
219.7 following the close of the hearing. The prohibition set forth in this ~~clause~~ paragraph shall  
219.8 not apply to facilities licensed as boarding care facilities which are not certified as skilled  
219.9 or intermediate care facilities level I or II for reimbursement through medical assistance.

219.10 (b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission  
219.11 to the facility, or from anyone acting in behalf of the applicant, as a condition of admission,  
219.12 expediting the admission, or as a requirement for the individual's continued stay, any fee,  
219.13 deposit, gift, money, donation, or other consideration not otherwise required as payment  
219.14 under the state plan. For residents on medical assistance, medical assistance payments  
219.15 according to the state plan must be accepted as payment in full for continued stay, except  
219.16 where otherwise provided for under statute;

219.17 (2) requiring an individual, or anyone acting in behalf of the individual, to loan  
219.18 any money to the nursing facility;

219.19 (3) requiring an individual, or anyone acting in behalf of the individual, to promise  
219.20 to leave all or part of the individual's estate to the facility; or

219.21 (4) requiring a third-party guarantee of payment to the facility as a condition of  
219.22 admission, expedited admission, or continued stay in the facility.

219.23 Nothing in this paragraph would prohibit discharge for nonpayment of services in  
219.24 accordance with state and federal regulations.

219.25 (c) Requiring any resident of the nursing facility to utilize a vendor of health care  
219.26 services chosen by the nursing facility. A nursing facility may require a resident to use  
219.27 pharmacies that utilize unit dose packing systems approved by the Minnesota Board of  
219.28 Pharmacy, and may require a resident to use pharmacies that are able to meet the federal  
219.29 regulations for safe and timely administration of medications such as systems with specific  
219.30 number of doses, prompt delivery of medications, or access to medications on a 24-hour  
219.31 basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict  
219.32 a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit  
219.33 dose drug packing.

219.34 (d) Providing differential treatment on the basis of status with regard to public  
219.35 assistance.

220.1 (e) Discriminating in admissions, services offered, or room assignment on the  
220.2 basis of status with regard to public assistance ~~or refusal to purchase special services.~~  
220.3 Discrimination in admissions ~~discrimination~~, services offered, or room assignment shall  
220.4 include, but is not limited to:

220.5 (1) basing admissions decisions upon ~~assurance by the applicant to the nursing~~  
220.6 ~~facility, or the applicant's guardian or conservator, that the applicant is neither eligible for~~  
220.7 ~~nor will seek~~ information or assurances regarding current or future eligibility for public  
220.8 assistance for payment of nursing facility care ~~costs~~; and

220.9 (2) engaging in preferential selection from waiting lists based on an applicant's  
220.10 ability to pay privately or an applicant's refusal to pay for a special service.

220.11 The collection and use by a nursing facility of financial information of any applicant  
220.12 pursuant to a preadmission screening program established by law shall not raise an  
220.13 inference that the nursing facility is utilizing that information for any purpose prohibited  
220.14 by this paragraph.

220.15 (f) Requiring any vendor of medical care as defined by section 256B.02, subdivision  
220.16 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any  
220.17 amount based on utilization or service levels or any portion of the vendor's fee to the  
220.18 nursing facility except as payment for renting or leasing space or equipment or purchasing  
220.19 support services from the nursing facility as limited by section 256B.433. All agreements  
220.20 must be disclosed to the commissioner upon request of the commissioner. Nursing  
220.21 facilities and vendors of ancillary services that are found to be in violation of this provision  
220.22 shall each be subject to an action by the state of Minnesota or any of its subdivisions or  
220.23 agencies for treble civil damages on the portion of the fee in excess of that allowed by  
220.24 this provision and section 256B.433. Damages awarded must include three times the  
220.25 excess payments together with costs and disbursements including reasonable attorney's  
220.26 fees or their equivalent.

220.27 (g) Refusing, for more than 24 hours, to accept a resident returning to the same  
220.28 bed or a bed certified for the same level of care, in accordance with a physician's order  
220.29 authorizing transfer, after receiving inpatient hospital services.

220.30 (h) For a period not to exceed 180 days, the commissioner may continue to make  
220.31 medical assistance payments to a nursing facility or boarding care home which is in  
220.32 violation of this section if extreme hardship to the residents would result. In these cases  
220.33 the commissioner shall issue an order requiring the nursing facility to correct the violation.  
220.34 The nursing facility shall have 20 days from its receipt of the order to correct the violation.  
220.35 If the violation is not corrected within the 20-day period the commissioner may reduce  
220.36 the payment rate to the nursing facility by up to 20 percent. The amount of the payment

221.1 rate reduction shall be related to the severity of the violation and shall remain in effect  
221.2 until the violation is corrected. The nursing facility or boarding care home may appeal the  
221.3 commissioner's action pursuant to the provisions of chapter 14 pertaining to contested  
221.4 cases. An appeal shall be considered timely if written notice of appeal is received by the  
221.5 commissioner within 20 days of notice of the commissioner's proposed action.

221.6 In the event that the commissioner determines that a nursing facility is not eligible  
221.7 for reimbursement for a resident who is eligible for medical assistance, the commissioner  
221.8 may authorize the nursing facility to receive reimbursement on a temporary basis until the  
221.9 resident can be relocated to a participating nursing facility.

221.10 Certified beds in facilities which do not allow medical assistance intake on July 1,  
221.11 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

221.12 Sec. 33. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

221.13 Subd. 13. **Case management.** (a) Each recipient of a home and community-based  
221.14 waiver under this section shall be provided case management services according to  
221.15 section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the  
221.16 federally approved waiver application. ~~The case management service activities provided~~  
221.17 ~~will include:~~

221.18 ~~(1) assessing the needs of the individual within 20 working days of a recipient's~~  
221.19 ~~request;~~

221.20 ~~(2) developing the written individual service plan within ten working days after the~~  
221.21 ~~assessment is completed;~~

221.22 ~~(3) informing the recipient or the recipient's legal guardian or conservator of service~~  
221.23 ~~options;~~

221.24 ~~(4) assisting the recipient in the identification of potential service providers;~~

221.25 ~~(5) assisting the recipient to access services;~~

221.26 ~~(6) coordinating, evaluating, and monitoring of the services identified in the service~~  
221.27 ~~plan;~~

221.28 ~~(7) completing the annual reviews of the service plan; and~~

221.29 ~~(8) informing the recipient or legal representative of the right to have assessments~~  
221.30 ~~completed and service plans developed within specified time periods, and to appeal county~~  
221.31 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~  
221.32 ~~nursing facility level of care.~~

221.33 (b) The case manager may delegate certain aspects of the case management service  
221.34 activities to another individual provided there is oversight by the case manager. The case

222.1 manager may not delegate those aspects which require professional judgment including  
222.2 assessments, reassessments, and care plan development.

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

222.4 Sec. 34. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

222.5 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's  
222.6 strengths, informal support systems, and need for services shall be completed within 20  
222.7 working days of the recipient's request as provided in section 256B.0911. Reassessment  
222.8 of each recipient's strengths, support systems, and need for services shall be conducted  
222.9 at least every 12 months and at other times when there has been a significant change in  
222.10 the recipient's functioning.

222.11 (b) There must be a determination that the client requires a hospital level of care or a  
222.12 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and  
222.13 subsequent assessments to initiate and maintain participation in the waiver program.

222.14 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as  
222.15 appropriate to determine nursing facility level of care for purposes of medical assistance  
222.16 payment for nursing facility services, only face-to-face assessments conducted according  
222.17 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care  
222.18 determination or a nursing facility level of care determination must be accepted for  
222.19 purposes of initial and ongoing access to waiver services payment.

222.20 (d) Persons with developmental disabilities who apply for services under the nursing  
222.21 facility level waiver programs shall be screened for the appropriate level of care according  
222.22 to section 256B.092.

222.23 (e) Recipients who are found eligible for home and community-based services under  
222.24 this section before their 65th birthday may remain eligible for these services after their  
222.25 65th birthday if they continue to meet all other eligibility factors.

222.26 (f) The commissioner shall develop criteria to identify recipients whose level of  
222.27 functioning is reasonably expected to improve and reassess these recipients to establish  
222.28 a baseline assessment. Recipients who meet these criteria must have a comprehensive  
222.29 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be  
222.30 reassessed every six months until there has been no significant change in the recipient's  
222.31 functioning for at least 12 months. After there has been no significant change in the  
222.32 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,  
222.33 informal support systems, and need for services shall be conducted at least every 12  
222.34 months and at other times when there has been a significant change in the recipient's

223.1 functioning. Counties, case managers, and service providers are responsible for conducting  
223.2 these reassessments and shall complete the reassessments out of existing funds.

223.3 **EFFECTIVE DATE.** This section is effective January 1, 2012, except for paragraph  
223.4 (f), which is effective July 1, 2013.

223.5 Sec. 35. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

223.6 Subd. 15. ~~Individualized service~~ Coordinated services and support plan;  
223.7 comprehensive transitional service plan; maintenance service plan. (a) Each recipient  
223.8 of home and community-based waived services shall be provided a copy of the written  
223.9 ~~service~~ coordinated services and support plan ~~which;~~ that complies with the requirements  
223.10 of section 256B.092, subdivisions 1b and 1e.

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

223.13 ~~(2) meets the assessed needs of the recipient;~~

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

223.15 ~~(4) promotes independence;~~

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

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

223.19 (b) In developing the comprehensive transitional service plan, the individual  
223.20 receiving services, the case manager, and the guardian, if applicable, will identify  
223.21 the transitional service plan fundamental service outcome and anticipated timeline to  
223.22 achieve this outcome. Within the first 20 days following a recipient's request for an  
223.23 assessment or reassessment, the transitional service planning team must be identified. A  
223.24 team leader must be identified who will be responsible for assigning responsibility and  
223.25 communicating with team members to ensure implementation of the transition plan and  
223.26 ongoing assessment and communication process. The team leader should be an individual,  
223.27 such as the case manager or guardian, who has the opportunity to follow the recipient to  
223.28 the next level of service.

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

224.1 natural community support, increased collaboration among agencies, and technological  
224.2 supports.

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

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

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

224.17 (d) Following one year of transitional services, the transitional services planning  
224.18 team will make a determination as to whether or not the individual receiving services  
224.19 requires the current level of continuous and consistent support in order to maintain the  
224.20 recipient's current level of functioning. Recipients who are determined to have not had  
224.21 a significant change in functioning for 12 months must move from a transitional to a  
224.22 maintenance service plan. Recipients on a maintenance service plan must be reassessed  
224.23 to determine if the recipient would benefit from a transitional service plan at least every  
224.24 12 months and at other times when there has been a significant change in the recipient's  
224.25 functioning. This assessment should consider any changes to technological or natural  
224.26 community supports.

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

224.35 **EFFECTIVE DATE.** This section is effective January 1, 2012, except for  
224.36 paragraphs (b), (c), and (d), which are effective July 1, 2013.



225.1 Sec. 36. Minnesota Statutes 2010, section 256B.5012, is amended by adding a  
225.2 subdivision to read:

225.3 Subd. 9. **ICF/MR rate increase.** Effective July 1, 2011, the commissioner shall  
225.4 increase the daily rate to \$138.23 at an intermediate care facility for the developmentally  
225.5 disabled located in Clearwater County and classified as a class A facility with 15 beds.

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

225.7 Sec. 37. Minnesota Statutes 2010, section 256B.5012, is amended by adding a  
225.8 subdivision to read:

225.9 Subd. 10. **ICF/MR rate adjustment.** For each facility reimbursed under this  
225.10 section, except for a facility located in Clearwater County and classified as a class A  
225.11 facility with 15 beds, the commissioner shall decrease operating payment rates equal  
225.12 to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each  
225.13 facility, the commissioner shall apply the rate reduction, based on occupied beds, using the  
225.14 percentage specified in this subdivision multiplied by the total payment rate, including the  
225.15 variable rate but excluding the property-related payment rate, in effect on the preceding  
225.16 date. The total rate reduction shall include the adjustment provided in section 256B.501,  
225.17 subdivision 12.

225.18 Sec. 38. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

225.19 Subd. 6. **Excluded time.** "Excluded time" means:

225.20 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter  
225.21 other than an emergency shelter, halfway house, foster home, semi-independent living  
225.22 domicile or services program, residential facility offering care, board and lodging facility  
225.23 or other institution for the hospitalization or care of human beings, as defined in section  
225.24 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,  
225.25 or correctional facility; or any facility based on an emergency hold under sections  
225.26 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

225.27 (b) any period an applicant spends on a placement basis in a training and habilitation  
225.28 program, including a rehabilitation facility or work or employment program as defined  
225.29 in section 268A.01; ~~or receiving personal care assistance services pursuant to section~~  
225.30 ~~256B.0659~~; semi-independent living services provided under section 252.275, and  
225.31 Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs  
225.32 and assisted living services; and

225.33 (c) any placement for a person with an indeterminate commitment, including  
225.34 independent living.

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

226.2 Sec. 39. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by  
226.3 Laws 2009, chapter 173, article 2, section 1, subdivision 8, and Laws 2010, First Special  
226.4 Session chapter 1, article 15, section 5, and article 25, section 16, is amended to read:

226.5 Subd. 8. **Continuing Care Grants**

226.6 The amounts that may be spent from the  
226.7 appropriation for each purpose are as follows:

226.8	<b>(a) Aging and Adult Services Grants</b>	13,499,000	15,805,000
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226.9 **Base Adjustment.** The general fund base is  
226.10 increased by \$5,751,000 in fiscal year 2012  
226.11 and \$6,705,000 in fiscal year 2013.

226.12 **Information and Assistance**

226.13 **Reimbursement.** Federal administrative  
226.14 reimbursement obtained from information  
226.15 and assistance services provided by the  
226.16 Senior LinkAge or Disability Linkage lines  
226.17 to people who are identified as eligible for  
226.18 medical assistance shall be appropriated to  
226.19 the commissioner for this activity.

226.20 **Community Service Development Grant**

226.21 **Reduction.** Funding for community service  
226.22 development grants must be reduced by  
226.23 \$260,000 for fiscal year 2010; \$284,000 in  
226.24 fiscal year 2011; \$43,000 in fiscal year 2012;  
226.25 and \$43,000 in fiscal year 2013. Base level  
226.26 funding shall be restored in fiscal year 2014.

226.27 **Community Service Development Grant**

226.28 **Community Initiative.** Funding for  
226.29 community service development grants shall  
226.30 be used to offset the cost of aging support  
226.31 grants. Base level funding shall be restored  
226.32 in fiscal year 2014.

227.1 **Senior Nutrition Use of Federal Funds.**

227.2 For fiscal year 2010, general fund grants  
 227.3 for home-delivered meals and congregate  
 227.4 dining shall be reduced by \$500,000. The  
 227.5 commissioner must replace these general  
 227.6 fund reductions with equal amounts from  
 227.7 federal funding for senior nutrition from the  
 227.8 American Recovery and Reinvestment Act  
 227.9 of 2009.

227.10	<b>(b) Alternative Care Grants</b>	50,234,000	48,576,000
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227.11 **Base Adjustment.** The general fund base is  
 227.12 decreased by \$3,598,000 in fiscal year 2012  
 227.13 and \$3,470,000 in fiscal year 2013.

227.14 **Alternative Care Transfer.** Any money  
 227.15 allocated to the alternative care program that  
 227.16 is not spent for the purposes indicated does  
 227.17 not cancel but must be transferred to the  
 227.18 medical assistance account.

227.19	<b>(c) Medical Assistance Grants; Long-Term</b>		
227.20	<b>Care Facilities.</b>	367,444,000	419,749,000

227.21	<b>(d) Medical Assistance Long-Term Care</b>		
227.22	<b>Waivers and Home Care Grants</b>	853,567,000	1,039,517,000

227.23 **Manage Growth in TBI and CADI**

227.24 **Waivers.** During the fiscal years beginning  
 227.25 on July 1, 2009, and July 1, 2010, the  
 227.26 commissioner shall allocate money for home  
 227.27 and community-based waiver programs  
 227.28 under Minnesota Statutes, section 256B.49,  
 227.29 to ensure a reduction in state spending that is  
 227.30 equivalent to limiting the caseload growth of  
 227.31 the TBI waiver to 12.5 allocations per month  
 227.32 each year of the biennium and the CADI  
 227.33 waiver to 95 allocations per month each year  
 227.34 of the biennium. Limits do not apply: (1)  
 227.35 when there is an approved plan for nursing

228.1 facility bed closures for individuals under  
228.2 age 65 who require relocation due to the  
228.3 bed closure; (2) to fiscal year 2009 waiver  
228.4 allocations delayed due to unallotment; or (3)  
228.5 to transfers authorized by the commissioner  
228.6 from the personal care assistance program  
228.7 of individuals having a home care rating  
228.8 of "CS," "MT," or "HL." Priorities for the  
228.9 allocation of funds must be for individuals  
228.10 anticipated to be discharged from institutional  
228.11 settings or who are at imminent risk of a  
228.12 placement in an institutional setting.

228.13 **Manage Growth in DD Waiver.** The  
228.14 commissioner shall manage the growth in  
228.15 the DD waiver by limiting the allocations  
228.16 included in the February 2009 forecast to 15  
228.17 additional diversion allocations each month  
228.18 for the calendar years that begin on January  
228.19 1, 2010, and January 1, 2011. Additional  
228.20 allocations must be made available for  
228.21 transfers authorized by the commissioner  
228.22 from the personal care program of individuals  
228.23 having a home care rating of "CS," "MT,"  
228.24 or "HL."

228.25 **Adjustment to Lead Agency Waiver**  
228.26 **Allocations.** Prior to the availability of the  
228.27 alternative license defined in Minnesota  
228.28 Statutes, section 245A.11, subdivision 8,  
228.29 the commissioner shall reduce lead agency  
228.30 waiver allocations for the purposes of  
228.31 implementing a moratorium on corporate  
228.32 foster care.

228.33 ~~**Alternatives to Personal Care Assistance**~~  
228.34 ~~**Services.** Base level funding of \$3,237,000~~  
228.35 ~~in fiscal year 2012 and \$4,856,000 in~~

229.1 ~~fiscal year 2013 is to implement alternative~~  
 229.2 ~~services to personal care assistance services~~  
 229.3 ~~for persons with mental health and other~~  
 229.4 ~~behavioral challenges who can benefit~~  
 229.5 ~~from other services that more appropriately~~  
 229.6 ~~meet their needs and assist them in living~~  
 229.7 ~~independently in the community. These~~  
 229.8 ~~services may include, but not be limited to, a~~  
 229.9 ~~1915(i) state plan option.~~

229.10 **(e) Mental Health Grants**

229.11	Appropriations by Fund		
229.12	General	77,739,000	77,739,000
229.13	Health Care Access	750,000	750,000
229.14	Lottery Prize	1,508,000	1,508,000

229.15 **Funding Usage.** Up to 75 percent of a fiscal  
 229.16 year's appropriation for adult mental health  
 229.17 grants may be used to fund allocations in that  
 229.18 portion of the fiscal year ending December  
 229.19 31.

229.20 **(f) Deaf and Hard-of-Hearing Grants** 1,930,000 1,917,000

229.21 **(g) Chemical Dependency Entitlement Grants** 111,303,000 122,822,000

229.22 **Payments for Substance Abuse Treatment.**

229.23 For placements beginning during fiscal years  
 229.24 2010 and 2011, county-negotiated rates and  
 229.25 provider claims to the consolidated chemical  
 229.26 dependency fund must not exceed the lesser  
 229.27 of:

- 229.28 (1) rates charged for these services on
- 229.29 January 1, 2009; or
- 229.30 (2) 160 percent of the average rate on January
- 229.31 1, 2009, for each group of vendors with
- 229.32 similar attributes.

229.33 Rates for fiscal years 2010 and 2011 must  
 229.34 not exceed 160 percent of the average rate on

230.1 January 1, 2009, for each group of vendors  
230.2 with similar attributes.

230.3 Effective July 1, 2010, rates that were above  
230.4 the average rate on January 1, 2009, are  
230.5 reduced by five percent from the rates in  
230.6 effect on June 1, 2010. Rates below the  
230.7 average rate on January 1, 2009, are reduced  
230.8 by 1.8 percent from the rates in effect on  
230.9 June 1, 2010. Services provided under  
230.10 this section by state-operated services are  
230.11 exempt from the rate reduction. For services  
230.12 provided in fiscal years 2012 and 2013, the  
230.13 statewide aggregate payment under the new  
230.14 rate methodology to be developed under  
230.15 Minnesota Statutes, section 254B.12, must  
230.16 not exceed the projected aggregate payment  
230.17 under the rates in effect for fiscal year 2011  
230.18 excluding the rate reduction for rates that  
230.19 were below the average on January 1, 2009,  
230.20 plus a state share increase of \$3,787,000 for  
230.21 fiscal year 2012 and \$5,023,000 for fiscal  
230.22 year 2013. Notwithstanding any provision  
230.23 to the contrary in this article, this provision  
230.24 expires on June 30, 2013.

230.25 **Chemical Dependency Special Revenue**  
230.26 **Account.** For fiscal year 2010, \$750,000  
230.27 must be transferred from the consolidated  
230.28 chemical dependency treatment fund  
230.29 administrative account and deposited into the  
230.30 general fund.

230.31 **County CD Share of MA Costs for**  
230.32 **ARRA Compliance.** Notwithstanding the  
230.33 provisions of Minnesota Statutes, chapter  
230.34 254B, for chemical dependency services  
230.35 provided during the period October 1, 2008,

231.1 to December 31, 2010, and reimbursed by  
 231.2 medical assistance at the enhanced federal  
 231.3 matching rate provided under the American  
 231.4 Recovery and Reinvestment Act of 2009, the  
 231.5 county share is 30 percent of the nonfederal  
 231.6 share. This provision is effective the day  
 231.7 following final enactment.

231.8	<b>(h) Chemical Dependency Nonentitlement</b>		
231.9	<b>Grants</b>	1,729,000	1,729,000

231.10	<b>(i) Other Continuing Care Grants</b>	19,201,000	17,528,000
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231.11 **Base Adjustment.** The general fund base is  
 231.12 increased by \$2,639,000 in fiscal year 2012  
 231.13 and increased by \$3,854,000 in fiscal year  
 231.14 2013.

231.15 **Technology Grants.** \$650,000 in fiscal  
 231.16 year 2010 and \$1,000,000 in fiscal year  
 231.17 2011 are for technology grants, case  
 231.18 consultation, evaluation, and consumer  
 231.19 information grants related to developing and  
 231.20 supporting alternatives to shift-staff foster  
 231.21 care residential service models.

231.22 **Other Continuing Care Grants; HIV**  
 231.23 **Grants.** Money appropriated for the HIV  
 231.24 drug and insurance grant program in fiscal  
 231.25 year 2010 may be used in either year of the  
 231.26 biennium.

231.27 **Quality Assurance Commission.** Effective  
 231.28 July 1, 2009, state funding for the quality  
 231.29 assurance commission under Minnesota  
 231.30 Statutes, section 256B.0951, is canceled.

231.31       Sec. 40. **ESTABLISHMENT OF RATES FOR SHARED HOME AND**  
 231.32 **COMMUNITY-BASED WAIVER SERVICES.**

231.33       By January 1, 2012, the commissioner shall establish rates to begin paying for  
 231.34 in-home services and personal supports under all of the home and community-based

232.1 waiver services programs consistent with the standards in Minnesota Statutes, section  
232.2 256B.4912, subdivision 2.

232.3       Sec. 41. **ESTABLISHMENT OF RATE FOR CASE MANAGEMENT**  
232.4 **SERVICES.**

232.5       By July 1, 2012, the commissioner shall establish the rate to be paid for case  
232.6 management services under Minnesota Statutes, sections 256B.0621, subdivision 2, clause  
232.7 (4), 256B.092, and 256B.49, consistent with the standards in Minnesota Statutes, section  
232.8 256B.4912, subdivision 2.

232.9       Sec. 42. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**  
232.10 **REDESIGN.**

232.11       By February 1, 2012, the commissioner of human services shall develop a legislative  
232.12 report with specific recommendations and language for proposed legislation to be effective  
232.13 July 1, 2012, for the following:

232.14       (1) definitions of service and consolidation of standards and rates to the extent  
232.15 appropriate for all types of medical assistance case management services, including  
232.16 targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625,  
232.17 subdivision 20; and 256B.0924; mental health case management services for children  
232.18 and adults, all types of home and community-based waiver case management, and case  
232.19 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be  
232.20 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

232.21       (2) recommendations on county of financial responsibility requirements and quality  
232.22 assurance measures for case management;

232.23       (3) identification of county administrative functions that may remain entwined in  
232.24 case management service delivery models; and

232.25       (4) implementation of a methodology to fully fund county case management  
232.26 administrative functions.

232.27       Sec. 43. **MY LIFE, MY CHOICES TASK FORCE.**

232.28       Subdivision 1. **Establishment.** The My Life, My Choices Task Force is established  
232.29 to create a system of supports and services for people with disabilities governed by the  
232.30 following principles:

232.31       (1) freedom to act as a consumer of services in the marketplace;

232.32       (2) freedom to choose to take as much risk as any other citizen;

232.33       (3) more choices in levels of service that may vary throughout life;



- 233.1 (4) opportunity to work with a trusted advocate and fiscal support entity to manage a  
233.2 personal budget and to be accountable for reporting spending and personal outcomes;  
233.3 (5) opportunity to live with minimal constraints instead of minimal freedoms; and  
233.4 (6) ability to consolidate funding streams into an individualized budget.

233.5 Subd. 2. **Membership.** The My Life, My Choices Task Force shall consist of:

- 233.6 (1) the lieutenant governor;  
233.7 (2) the commissioner of human services, or the commissioner's designee;  
233.8 (3) a representative of the Minnesota Chamber of Commerce;  
233.9 (4) a county representative appointed by the Association of Minnesota Counties;  
233.10 (5) seven members appointed by the governor as follows: one administrative law  
233.11 judge, one labor representative, two family members of people with disabilities, and three  
233.12 individual members with different disabilities;  
233.13 (6) two members appointed by the speaker of the house as follows: a representative  
233.14 of a disability advocacy organization, and a representative of a disability legal services  
233.15 advocacy organization; and  
233.16 (7) three members appointed by the majority leader of the senate, including two  
233.17 representatives from nonprofit organizations, one of which serves all 87 counties and  
233.18 one that serves persons with disabilities and employs fewer than 50 people, and a  
233.19 representative of a philanthropic organization.

233.20 Appointed nongovernmental members of the task force shall serve as staff for the  
233.21 task force and take on responsibilities of coordinating meetings, reporting on committee  
233.22 recommendations, and providing other staff support as needed to meet the responsibilities  
233.23 of the task force as described in subdivision 3. The chairs and ranking minority members  
233.24 of the legislative committees with jurisdiction over health and human services policy and  
233.25 finance shall serve as ex officio members.

233.26 Subd. 3. **Duties.** The task force shall make recommendations, including proposed  
233.27 legislation, and report to the legislative committees with jurisdiction over health and  
233.28 human services policy and finance by November 15, 2011, on creating a system of  
233.29 supports and services for people with disabilities by July 1, 2012, as governed by the  
233.30 principles under subdivision 1. In making recommendations and proposed legislation, the  
233.31 council shall work in conjunction with the Consumer-Directed Community Supports Task  
233.32 Force and shall include self-directed planning, individual budgeting, choice of trusted  
233.33 partner, self-directed purchasing of services and supports, reporting of outcomes, ability to  
233.34 share in any savings, and any additional rules or laws that may need to be waived.

234.1 Subd. 4. **Expense reimbursement.** The members of the task force shall not be  
234.2 reimbursed by the state for expenses related to the duties of the task force. The task force  
234.3 shall be independently staffed and coordinated by nongovernmental appointees who  
234.4 serve on the task force, and no state dollars shall be appropriated for expenses related to  
234.5 the task force under this section.

234.6 Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

234.8 Sec. 44. **DIRECTION TO OMBUDSMAN FOR LONG-TERM CARE.**

234.9 The Office of Ombudsman for Long-Term Care shall develop a work group to  
234.10 address issues about, but not limited to: housing with services fees, staffing, and quality  
234.11 assurance. The work group shall include, but not be limited to: consumers, relatives of  
234.12 consumers, advocates, and providers. The Office of Ombudsman for Long-Term Care  
234.13 shall present a report with recommendations related to housing with services fees, staffing,  
234.14 and quality assurance to the legislative committees with jurisdiction over health and  
234.15 human services policy and finance by January 15, 2012.

234.16 Sec. 45. **DIRECTION TO COUNTIES.**

234.17 Counties must inform individuals who have had a level of service reduction of  
234.18 their right to request an informal review conference with their case worker and any other  
234.19 relevant county staff.

234.20 Sec. 46. **NURSING FACILITY PILOT PROJECT.**

234.21 Subdivision 1. **Report.** The commissioner of human services, in consultation with  
234.22 the commissioner of health, stakeholders, and experts, shall provide to the legislature  
234.23 recommendations by November 15, 2011, on how to develop a project to demonstrate a  
234.24 new approach to caring for certain individuals in nursing facilities.

234.25 Subd. 2. **Contents of report.** The recommendations shall address the:

234.26 (1) nature of the demonstration in terms of timing, size, qualifications to participate,  
234.27 participation selection criteria and postdemonstration options for the demonstration and  
234.28 for participating facilities;

234.29 (2) nature of needed new form of licensure;

- 235.1 (3) characteristics of the individuals the new model is intended to serve and  
235.2 comparison of these characteristics with those individuals served by existing models of  
235.3 care;  
235.4 (4) quality standards for licensure addressing management, types and amounts of  
235.5 staffing, safety, infection control, care processes, quality improvement, and resident rights;  
235.6 (5) characteristics of inspection process;  
235.7 (6) funding for inspection process;  
235.8 (7) enforcement authorities;  
235.9 (8) role of Medicare;  
235.10 (9) participation in the elderly waiver program, including rate setting;  
235.11 (10) nature of any federal approval or waiver requirements and the method and  
235.12 timing of obtaining them;  
235.13 (11) consumer rights; and  
235.14 (12) methods and resources needed to evaluate the effectiveness of the model with  
235.15 regards to cost and quality.

## ARTICLE 7

### CHEMICAL AND MENTAL HEALTH

235.16  
235.17  
235.18 Section 1. Minnesota Statutes 2010, section 246B.10, is amended to read:

235.19 **246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.**

235.20 The civilly committed sex offender's county shall pay to the state a portion of the  
235.21 cost of care provided in the Minnesota sex offender program to a civilly committed sex  
235.22 offender who has legally settled in that county. A county's payment must be made from  
235.23 the county's own sources of revenue and payments must equal ~~ten~~ 25 percent of the cost of  
235.24 care, as determined by the commissioner, for each day or portion of a day, that the civilly  
235.25 committed sex offender spends at the facility. If payments received by the state under this  
235.26 chapter exceed ~~90~~ 75 percent of the cost of care, the county is responsible for paying the  
235.27 state the remaining amount. The county is not entitled to reimbursement from the civilly  
235.28 committed sex offender, the civilly committed sex offender's estate, or from the civilly  
235.29 committed sex offender's relatives, except as provided in section 246B.07.

235.30 **EFFECTIVE DATE.** This section is effective for all individuals who are civilly  
235.31 committed to the Minnesota sex offender program on or after August 1, 2011.

235.32 Sec. 2. Minnesota Statutes 2010, section 252.025, subdivision 7, is amended to read:

235.33 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop  
235.34 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who

236.1 have developmental disabilities and exhibit severe behaviors which present a risk to  
236.2 public safety. This program is statewide and must provide specialized residential services  
236.3 in Cambridge and an array of community-based services with sufficient levels of care  
236.4 and a sufficient number of specialists to ensure that individuals referred to the program  
236.5 receive the appropriate care. The individuals working in the community-based services  
236.6 under this section are state employees supervised by the commissioner of human services.  
236.7 No midcontract layoffs shall occur as a result of restructuring under this section, but  
236.8 layoffs may occur as a normal consequence of a low census or closure of the facility  
236.9 due to decreased census.

236.10 Sec. 3. Minnesota Statutes 2010, section 253B.212, is amended to read:

236.11 **253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS;**  
236.12 **WHITE EARTH BAND OF OJIBWE.**

236.13 Subdivision 1. **Cost of care; commitment by tribal court order; Red Lake**  
236.14 **Band of Chippewa Indians.** The commissioner of human services may contract with  
236.15 and receive payment from the Indian Health Service of the United States Department of  
236.16 Health and Human Services for the care and treatment of those members of the Red  
236.17 Lake Band of Chippewa Indians who have been committed by tribal court order to the  
236.18 Indian Health Service for care and treatment of mental illness, developmental disability, or  
236.19 chemical dependency. The contract shall provide that the Indian Health Service may not  
236.20 transfer any person for admission to a regional center unless the commitment procedure  
236.21 utilized by the tribal court provided due process protections similar to those afforded  
236.22 by sections 253B.05 to 253B.10.

236.23 **Subd. 1a. Cost of care; commitment by tribal court order; White Earth Band of**  
236.24 **Ojibwe Indians.** The commissioner of human services may contract with and receive  
236.25 payment from the Indian Health Service of the United States Department of Health and  
236.26 Human Services for the care and treatment of those members of the White Earth Band  
236.27 of Ojibwe Indians who have been committed by tribal court order to the Indian Health  
236.28 Service for care and treatment of mental illness, developmental disability, or chemical  
236.29 dependency. The tribe may also contract directly with the commissioner for treatment  
236.30 of those members of the White Earth Band who have been committed by tribal court  
236.31 order to the White Earth Department of Health for care and treatment of mental illness,  
236.32 developmental disability, or chemical dependency. The contract shall provide that the  
236.33 Indian Health Service and the White Earth Band shall not transfer any person for admission  
236.34 to a regional center unless the commitment procedure utilized by the tribal court provided  
236.35 due process protections similar to those afforded by sections 253B.05 to 253B.10.

237.1 Subd. 2. **Effect given to tribal commitment order.** When, under an agreement  
237.2 entered into pursuant to ~~subdivision 1~~ subdivisions 1 or 1a, the Indian Health Service  
237.3 applies to a regional center for admission of a person committed to the jurisdiction of the  
237.4 health service by the tribal court as a person who is mentally ill, developmentally disabled,  
237.5 or chemically dependent, the commissioner may treat the patient with the consent of  
237.6 the Indian Health Service.

237.7 A person admitted to a regional center pursuant to this section has all the rights  
237.8 accorded by section 253B.03. In addition, treatment reports, prepared in accordance with  
237.9 the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health  
237.10 Service within 60 days of commencement of the patient's stay at the facility. A subsequent  
237.11 treatment report shall be filed with the Indian Health Service within six months of the  
237.12 patient's admission to the facility or prior to discharge, whichever comes first. Provisional  
237.13 discharge or transfer of the patient may be authorized by the head of the treatment facility  
237.14 only with the consent of the Indian Health Service. Discharge from the facility to the  
237.15 Indian Health Service may be authorized by the head of the treatment facility after notice  
237.16 to and consultation with the Indian Health Service.

237.17 Sec. 4. Minnesota Statutes 2010, section 254B.03, subdivision 1, is amended to read:

237.18 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical  
237.19 dependency services to persons residing within its jurisdiction who meet criteria  
237.20 established by the commissioner for placement in a chemical dependency residential  
237.21 or nonresidential treatment service subject to the limitations on residential chemical  
237.22 dependency treatment in section 254B.04, subdivision 1. Chemical dependency money  
237.23 must be administered by the local agencies according to law and rules adopted by the  
237.24 commissioner under sections 14.001 to 14.69.

237.25 (b) In order to contain costs, the commissioner of human services shall select eligible  
237.26 vendors of chemical dependency services who can provide economical and appropriate  
237.27 treatment. Unless the local agency is a social services department directly administered by  
237.28 a county or human services board, the local agency shall not be an eligible vendor under  
237.29 section 254B.05. The commissioner may approve proposals from county boards to provide  
237.30 services in an economical manner or to control utilization, with safeguards to ensure that  
237.31 necessary services are provided. If a county implements a demonstration or experimental  
237.32 medical services funding plan, the commissioner shall transfer the money as appropriate.

237.33 (c) A culturally specific vendor that provides assessments under a variance under  
237.34 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to  
237.35 persons not covered by the variance.

238.1 Sec. 5. Minnesota Statutes 2010, section 254B.03, subdivision 4, is amended to read:

238.2 Subd. 4. **Division of costs.** Except for services provided by a county under  
238.3 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,  
238.4 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for  
238.5 ~~16.14~~ 22.95 percent of the cost of chemical dependency services, including those services  
238.6 provided to persons eligible for medical assistance under chapter 256B and general  
238.7 assistance medical care under chapter 256D. Counties may use the indigent hospitalization  
238.8 levy for treatment and hospital payments made under this section. ~~16.14~~ 22.95 percent  
238.9 of any state collections from private or third-party pay, less 15 percent for the cost of  
238.10 payment and collections, must be distributed to the county that paid for a portion of the  
238.11 treatment under this section.

238.12 **EFFECTIVE DATE.** This section is effective for claims processed beginning  
238.13 July 1, 2011.

238.14 Sec. 6. Minnesota Statutes 2010, section 254B.04, subdivision 1, is amended to read:

238.15 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal  
238.16 Regulations, title 25, part 20, persons eligible for medical assistance benefits under  
238.17 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet  
238.18 the income standards of section 256B.056, subdivision 4, and persons eligible for general  
238.19 assistance medical care under section 256D.03, subdivision 3, are entitled to chemical  
238.20 dependency fund services subject to the following limitations: (1) no more than three  
238.21 residential chemical dependency treatment episodes for the same person in a four-year  
238.22 period of time unless the person meets the criteria established by the commissioner of  
238.23 human services; and (2) no more than four residential chemical dependency treatment  
238.24 episodes in a lifetime unless the person meets the criteria established by the commissioner  
238.25 of human services. For purposes of this section, "episode" means a span of treatment  
238.26 without interruption of 30 days or more. State money appropriated for this paragraph must  
238.27 be placed in a separate account established for this purpose.

238.28 Persons with dependent children who are determined to be in need of chemical  
238.29 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or  
238.30 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the  
238.31 local agency to access needed treatment services. Treatment services must be appropriate  
238.32 for the individual or family, which may include long-term care treatment or treatment in a  
238.33 facility that allows the dependent children to stay in the treatment facility. The county  
238.34 shall pay for out-of-home placement costs, if applicable.

239.1 (b) A person not entitled to services under paragraph (a), but with family income  
239.2 that is less than 215 percent of the federal poverty guidelines for the applicable family  
239.3 size, shall be eligible to receive chemical dependency fund services within the limit  
239.4 of funds appropriated for this group for the fiscal year. If notified by the state agency  
239.5 of limited funds, a county must give preferential treatment to persons with dependent  
239.6 children who are in need of chemical dependency treatment pursuant to an assessment  
239.7 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision  
239.8 6, or 260C.212. A county may spend money from its own sources to serve persons under  
239.9 this paragraph. State money appropriated for this paragraph must be placed in a separate  
239.10 account established for this purpose.

239.11 (c) Persons whose income is between 215 percent and 412 percent of the federal  
239.12 poverty guidelines for the applicable family size shall be eligible for chemical dependency  
239.13 services on a sliding fee basis, within the limit of funds appropriated for this group for the  
239.14 fiscal year. Persons eligible under this paragraph must contribute to the cost of services  
239.15 according to the sliding fee scale established under subdivision 3. A county may spend  
239.16 money from its own sources to provide services to persons under this paragraph. State  
239.17 money appropriated for this paragraph must be placed in a separate account established  
239.18 for this purpose.

239.19 **EFFECTIVE DATE.** This section is effective for all chemical dependency  
239.20 residential treatment beginning on or after July 1, 2011.

239.21 Sec. 7. Minnesota Statutes 2010, section 254B.04, is amended by adding a subdivision  
239.22 to read:

239.23 **Subd. 2a. Eligibility for treatment in residential settings.** Notwithstanding  
239.24 provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's  
239.25 discretion in making placements to residential treatment settings, a person eligible for  
239.26 services under this section must score at level 4 on assessment dimensions related to  
239.27 relapse, continued use, and recovery environment in order to be assigned to services with  
239.28 a room and board component reimbursed under this section.

239.29 Sec. 8. Minnesota Statutes 2010, section 254B.06, subdivision 2, is amended to read:

239.30 **Subd. 2. Allocation of collections.** The commissioner shall allocate all federal  
239.31 financial participation collections to a special revenue account. The commissioner shall  
239.32 allocate ~~83.86~~ 77.05 percent of patient payments and third-party payments to the special  
239.33 revenue account and ~~16.14~~ 22.95 percent to the county financially responsible for the  
239.34 patient.

240.1 **EFFECTIVE DATE.** This section is effective for claims processed beginning  
240.2 July 1, 2011.

240.3 Sec. 9. Minnesota Statutes 2010, section 256B.0625, subdivision 41, is amended to  
240.4 read:

240.5 Subd. 41. **Residential services for children with severe emotional disturbance.**  
240.6 Medical assistance covers rehabilitative services in accordance with section 256B.0945  
240.7 that are provided by a county or an American Indian tribe through a residential facility,  
240.8 for children who have been diagnosed with severe emotional disturbance and have been  
240.9 determined to require the level of care provided in a residential facility.

240.10 **EFFECTIVE DATE.** This section is effective October 1, 2011.

240.11 Sec. 10. Minnesota Statutes 2010, section 256B.0945, subdivision 4, is amended to  
240.12 read:

240.13 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,  
240.14 payments to counties for residential services provided by a residential facility shall only  
240.15 be made of federal earnings for services provided under this section, and the nonfederal  
240.16 share of costs for services provided under this section shall be paid by the county from  
240.17 sources other than federal funds or funds used to match other federal funds. Payment to  
240.18 counties for services provided according to this section shall be a proportion of the per  
240.19 day contract rate that relates to rehabilitative mental health services and shall not include  
240.20 payment for costs or services that are billed to the IV-E program as room and board.

240.21 (b) Per diem rates paid to providers under this section by prepaid plans shall be  
240.22 the proportion of the per-day contract rate that relates to rehabilitative mental health  
240.23 services and shall not include payment for group foster care costs or services that are  
240.24 billed to the county of financial responsibility. Services provided in facilities located in  
240.25 bordering states are eligible for reimbursement on a fee-for-service basis only as described  
240.26 in paragraph (a) and are not covered under prepaid health plans.

240.27 (c) Payment for mental health rehabilitative services provided under this section by  
240.28 or under contract with an American Indian tribe or tribal organization or by agencies  
240.29 operated by or under contract with an American Indian tribe or tribal organization must  
240.30 be made according to section 256B.0625, subdivision 34, or other relevant federally  
240.31 approved rate-setting methodology.

240.32 (d) The commissioner shall set aside a portion not to exceed five percent of the  
240.33 federal funds earned for county expenditures under this section to cover the state costs of



241.1 administering this section. Any unexpended funds from the set-aside shall be distributed  
241.2 to the counties in proportion to their earnings under this section.

241.3 **EFFECTIVE DATE.** This section is effective October 1, 2011.

241.4 Sec. 11. **COMMUNITY MENTAL HEALTH SERVICES; USE OF**  
241.5 **BEHAVIORAL HEALTH HOSPITALS.**

241.6 The commissioner shall issue a written report to the chairs and ranking minority  
241.7 members of the house and senate committees with jurisdiction of health and human  
241.8 services by December 31, 2011, on how the community behavioral health hospital  
241.9 facilities will be fully utilized to meet the mental health needs of regions in which the  
241.10 hospitals are located. The commissioner must consult with the regional planning work  
241.11 groups for adult mental health and must include the recommendations of the work groups  
241.12 in the legislative report. The report must address future use of community behavioral  
241.13 health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65  
241.14 percent licensed bed occupancy rate, and using the facilities for another purpose that will  
241.15 meet the mental health needs of residents of the region. The regional planning work  
241.16 groups shall work with the commissioner to prioritize the needs of their regions. These  
241.17 priorities, by region, must be included in the commissioner's report to the legislature.

241.18 Sec. 12. **INTEGRATED DUAL DIAGNOSIS TREATMENT.**

241.19 (a) The commissioner shall require individuals who perform chemical dependency  
241.20 assessments or mental health diagnostic assessments to use screening tools approved  
241.21 by the commissioner in order to identify whether an individual who is the subject of  
241.22 the assessment screens positive for co-occurring mental health or chemical dependency  
241.23 disorders. Screening for co-occurring disorders must begin no later than December 31,  
241.24 2011.

241.25 (b) The commissioner shall adopt rules as necessary to implement this section. The  
241.26 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing  
241.27 a certification process for integrated dual disorder treatment providers and a system  
241.28 through which individuals receive integrated dual diagnosis treatment if assessed as having  
241.29 both a substance use disorder and either a serious mental illness or emotional disturbance.

241.30 (c) The commissioner shall apply for any federal waivers necessary to secure, to the  
241.31 extent allowed by law, federal financial participation for the provision of integrated dual  
241.32 diagnosis treatment to persons with co-occurring disorders.

241.33 Sec. 13. **REGIONAL TREATMENT CENTERS; EMPLOYEES; REPORT.**

242.1 The commissioner shall issue a report to the legislative committees with jurisdiction  
242.2 over health and human services finance no later than December 31, 2011, which provides  
242.3 the number of employees in management positions at the Anoka-Metro Regional  
242.4 Treatment Center and the Minnesota Security Hospital at St. Peter and the ratio of  
242.5 management to direct-care staff for each facility.

242.6 Sec. 14. **COMMISSIONER'S CRITERIA FOR RESIDENTIAL TREATMENT.**

242.7 The commissioner shall develop specific criteria to approve treatment for individuals  
242.8 who require residential chemical dependency treatment in excess of the maximum allowed  
242.9 in section 254B.04, subdivision 1, due to co-occurring disorders, including disorders  
242.10 related to cognition, traumatic brain injury, or documented disability. Criteria shall be  
242.11 developed for use no later than October 1, 2011.

242.12 Sec. 15. **REPEALER.**

242.13 Laws 2009, chapter 79, article 3, section 18, as amended by Laws 2010, First Special  
242.14 Session chapter 1, article 19, section 19, is repealed.

## 242.15 **ARTICLE 8**

### 242.16 **REDESIGNING SERVICE DELIVERY**

242.17 Section 1. Minnesota Statutes 2010, section 256.01, subdivision 14, is amended to read:

242.18 Subd. 14. **Child welfare reform pilots.** The commissioner of human services  
242.19 shall encourage local reforms in the delivery of child welfare services, within available  
242.20 appropriations, and is authorized to approve local pilot programs which focus on reforming  
242.21 the child protection and child welfare systems in Minnesota. Authority to approve pilots  
242.22 includes authority to waive existing state rules as needed to accomplish reform efforts.  
242.23 Notwithstanding section 626.556, subdivision 10, 10b, or 10d, the commissioner may  
242.24 authorize programs to use alternative methods of investigating and assessing reports of  
242.25 child maltreatment, provided that the programs comply with the provisions of section  
242.26 626.556 dealing with the rights of individuals who are subjects of reports or investigations,  
242.27 including notice and appeal rights and data practices requirements. Pilot programs must  
242.28 be required to address responsibility for safety and protection of children, be time limited,  
242.29 and include evaluation of the pilot program.

242.30 Sec. 2. Minnesota Statutes 2010, section 256.01, subdivision 14b, is amended to read:

242.31 Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of  
242.32 human services may authorize projects to test tribal delivery of child welfare services to

243.1 American Indian children and their parents and custodians living on the reservation.  
243.2 The commissioner has authority to solicit and determine which tribes may participate  
243.3 in a project. Grants may be issued to Minnesota Indian tribes to support the projects.  
243.4 The commissioner may waive existing state rules as needed to accomplish the projects.  
243.5 Notwithstanding section 626.556, the commissioner may authorize projects to use  
243.6 alternative methods of investigating and assessing reports of child maltreatment, provided  
243.7 that the projects comply with the provisions of section 626.556 dealing with the rights  
243.8 of individuals who are subjects of reports or investigations, including notice and appeal  
243.9 rights and data practices requirements. The commissioner may seek any federal approvals  
243.10 necessary to carry out the projects as well as seek and use any funds available to the  
243.11 commissioner, including use of federal funds, foundation funds, existing grant funds,  
243.12 and other funds. The commissioner is authorized to advance state funds as necessary to  
243.13 operate the projects. Federal reimbursement applicable to the projects is appropriated  
243.14 to the commissioner for the purposes of the projects. The projects must be required to  
243.15 address responsibility for safety, permanency, and well-being of children.

243.16 (b) For the purposes of this section, "American Indian child" means a person under  
243.17 18 years of age who is a tribal member or eligible for membership in one of the tribes  
243.18 chosen for a project under this subdivision and who is residing on the reservation of  
243.19 that tribe.

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

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

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

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

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

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

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

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

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

243.32 (2) family preservation;

243.33 (3) facilitative, supportive, and reunification services;

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

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

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

244.14 (f) Participating tribes may conduct children's mental health screenings under section  
244.15 245.4874, subdivision 1, paragraph (a), clause (14), for children who are eligible for the  
244.16 initiative and living on the reservation and who meet one of the following criteria:

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

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

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

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

244.23 (g) Participating tribes may establish a local child mortality review panel. In  
244.24 establishing a local child mortality review panel, the tribe agrees to conduct local child  
244.25 mortality reviews for child deaths or near-fatalities occurring on the reservation under  
244.26 subdivision 12. Tribes with established child mortality review panels shall have access  
244.27 to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c)  
244.28 to (e). The tribe shall provide written notice to the commissioner and affected counties  
244.29 when a local child mortality review panel has been established and shall provide data upon  
244.30 request of the commissioner for purposes of sharing nonpublic data with members of the  
244.31 state child mortality review panel in connection to an individual case.

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

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

245.8 Sec. 3. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision  
245.9 to read:

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

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

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

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

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

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

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

245.34 (4) the materials provided in an alternative format meets all other requirements of  
245.35 the commissioner regarding content, size of the typeface, and any required time frames

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

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

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

246.15 (d) A prepaid health plan may provide in an alternative format materials otherwise  
246.16 required to be available in writing under Code of Federal Regulations, title 42, section  
246.17 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions  
246.18 of paragraphs (b), (c), and (e), are met for persons who are eligible for enrollment in  
246.19 managed care.

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

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

246.32 Sec. 4. Minnesota Statutes 2010, section 256D.09, subdivision 6, is amended to read:

246.33 Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or  
246.34 family general assistance is paid to a recipient in excess of the payment due, it shall be

247.1 recoverable by the county agency. The agency shall give written notice to the recipient of  
247.2 its intention to recover the overpayment.

247.3 (b) Except as provided for interim assistance in section 256D.06, subdivision  
247.4 5, when an overpayment occurs, the county agency shall recover the overpayment  
247.5 from a current recipient by reducing the amount of aid payable to the assistance unit of  
247.6 which the recipient is a member, for one or more monthly assistance payments, until  
247.7 the overpayment is repaid. All county agencies in the state shall reduce the assistance  
247.8 payment by three percent of the assistance unit's standard of need in nonfraud cases and  
247.9 ten percent where fraud has occurred, or the amount of the monthly payment, whichever is  
247.10 less, for all overpayments.

247.11 (c) In cases when there is both an overpayment and underpayment, the county  
247.12 agency shall offset one against the other in correcting the payment.

247.13 (d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,  
247.14 in addition to the aid reductions provided in this subdivision, to include further voluntary  
247.15 reductions in the grant level agreed to in writing by the individual, until the total amount  
247.16 of the overpayment is repaid.

247.17 (e) The county agency shall make reasonable efforts to recover overpayments to  
247.18 persons no longer on assistance under standards adopted in rule by the commissioner  
247.19 of human services. The county agency need not attempt to recover overpayments of  
247.20 less than \$35 paid to an individual no longer on assistance if the individual does not  
247.21 receive assistance again within three years, unless the individual has been convicted of  
247.22 violating section 256.98.

247.23 (f) Establishment of an overpayment is limited to 12 months prior to the month of  
247.24 discovery due to agency error and six years prior to the month of discovery due to client  
247.25 error or an intentional program violation determined under section 256.046.

247.26 Sec. 5. Minnesota Statutes 2010, section 256D.49, subdivision 3, is amended to read:

247.27 Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When  
247.28 the county agency determines that an overpayment of the recipient's monthly payment  
247.29 of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment  
247.30 to the recipient. If the person is no longer receiving Minnesota supplemental aid, the  
247.31 county agency may request voluntary repayment or pursue civil recovery. If the person is  
247.32 receiving Minnesota supplemental aid, the county agency shall recover the overpayment  
247.33 by withholding an amount equal to three percent of the standard of assistance for the  
247.34 recipient or the total amount of the monthly grant, whichever is less.

248.1 (b) Establishment of an overpayment is limited to 12 months from the date of  
248.2 discovery due to agency error. Establishment of an overpayment is limited to six years  
248.3 prior to the month of discovery due to client error or an intentional program violation  
248.4 determined under section 256.046.

248.5 (c) For recipients receiving benefits via electronic benefit transfer, if the overpayment  
248.6 is a result of an automated teller machine (ATM) dispensing funds in error to the recipient,  
248.7 the agency may recover the ATM error by immediately withdrawing funds from the  
248.8 recipient's electronic benefit transfer account, up to the amount of the error.

248.9 (d) Residents of ~~nursing homes, regional treatment centers, and~~ licensed residential  
248.10 facilities with negotiated rates shall not have overpayments recovered from their personal  
248.11 needs allowance.

248.12 Sec. 6. Minnesota Statutes 2010, section 256J.38, subdivision 1, is amended to read:

248.13 Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant  
248.14 receives an overpayment due to agency, client, or ATM error, or due to assistance received  
248.15 while an appeal is pending and the participant or former participant is determined  
248.16 ineligible for assistance or for less assistance than was received, the county agency must  
248.17 recoup or recover the overpayment using the following methods:

- 248.18 (1) reconstruct each affected budget month and corresponding payment month;  
248.19 (2) use the policies and procedures that were in effect for the payment month; and  
248.20 (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the  
248.21 calculation of the overpayment when the unit has not reported within two calendar months  
248.22 following the end of the month in which the income was received.

248.23 (b) Establishment of an overpayment is limited to 12 months prior to the month of  
248.24 discovery due to agency error. Establishment of an overpayment is limited to six years  
248.25 prior to the month of discovery due to client error or an intentional program violation  
248.26 determined under section 256.046.

248.27 Sec. 7. Minnesota Statutes 2010, section 393.07, subdivision 10, is amended to read:

248.28 Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local  
248.29 social services agency shall establish and administer the food stamp program according  
248.30 to rules of the commissioner of human services, the supervision of the commissioner as  
248.31 specified in section 256.01, and all federal laws and regulations. The commissioner of  
248.32 human services shall monitor food stamp program delivery on an ongoing basis to ensure  
248.33 that each county complies with federal laws and regulations. Program requirements to be  
248.34 monitored include, but are not limited to, number of applications, number of approvals,



249.1 number of cases pending, length of time required to process each application and deliver  
249.2 benefits, number of applicants eligible for expedited issuance, length of time required  
249.3 to process and deliver expedited issuance, number of terminations and reasons for  
249.4 terminations, client profiles by age, household composition and income level and sources,  
249.5 and the use of phone certification and home visits. The commissioner shall determine the  
249.6 county-by-county and statewide participation rate.

249.7 (b) On July 1 of each year, the commissioner of human services shall determine a  
249.8 statewide and county-by-county food stamp program participation rate. The commissioner  
249.9 may designate a different agency to administer the food stamp program in a county if the  
249.10 agency administering the program fails to increase the food stamp program participation  
249.11 rate among families or eligible individuals, or comply with all federal laws and regulations  
249.12 governing the food stamp program. The commissioner shall review agency performance  
249.13 annually to determine compliance with this paragraph.

249.14 (c) A person who commits any of the following acts has violated section 256.98 or  
249.15 609.821, or both, and is subject to both the criminal and civil penalties provided under  
249.16 those sections:

249.17 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a  
249.18 willful statement or misrepresentation, or intentional concealment of a material fact, food  
249.19 stamps or vouchers issued according to sections 145.891 to 145.897 to which the person  
249.20 is not entitled or in an amount greater than that to which that person is entitled or which  
249.21 specify nutritional supplements to which that person is not entitled; or

249.22 (2) presents or causes to be presented, coupons or vouchers issued according to  
249.23 sections 145.891 to 145.897 for payment or redemption knowing them to have been  
249.24 received, transferred or used in a manner contrary to existing state or federal law; or

249.25 (3) willfully uses, possesses, or transfers food stamp coupons, authorization to  
249.26 purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner  
249.27 contrary to existing state or federal law, rules, or regulations; or

249.28 (4) buys or sells food stamp coupons, authorization to purchase cards, other  
249.29 assistance transaction devices, vouchers issued according to sections 145.891 to 145.897,  
249.30 or any food obtained through the redemption of vouchers issued according to sections  
249.31 145.891 to 145.897 for cash or consideration other than eligible food.

249.32 (d) A peace officer or welfare fraud investigator may confiscate food stamps,  
249.33 authorization to purchase cards, or other assistance transaction devices found in the  
249.34 possession of any person who is neither a recipient of the food stamp program nor  
249.35 otherwise authorized to possess and use such materials. Confiscated property shall be  
249.36 disposed of as the commissioner may direct and consistent with state and federal food

250.1 stamp law. The confiscated property must be retained for a period of not less than 30 days  
250.2 to allow any affected person to appeal the confiscation under section 256.045.

250.3 ~~(e) Food stamp overpayment claims which are due in whole or in part to client error~~  
250.4 ~~shall be established by the county agency for a period of six years from the date of any~~  
250.5 ~~resultant overpayment~~ Establishment of an overpayment is limited to 12 months prior to  
250.6 the month of discovery due to agency error. Establishment of an overpayment is limited  
250.7 to six years prior to the month of discovery due to client error or an intentional program  
250.8 violation determined under section 256.046.

250.9 (f) With regard to the federal tax revenue offset program only, recovery incentives  
250.10 authorized by the federal food and consumer service shall be retained at the rate of 50  
250.11 percent by the state agency and 50 percent by the certifying county agency.

250.12 (g) A peace officer, welfare fraud investigator, federal law enforcement official,  
250.13 or the commissioner of health may confiscate vouchers found in the possession of any  
250.14 person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise  
250.15 authorized to possess and use such vouchers. Confiscated property shall be disposed of  
250.16 as the commissioner of health may direct and consistent with state and federal law. The  
250.17 confiscated property must be retained for a period of not less than 30 days.

250.18 (h) The commissioner of human services may seek a waiver from the United States  
250.19 Department of Agriculture to allow the state to specify foods that may and may not be  
250.20 purchased in Minnesota with benefits funded by the federal Food Stamp Program. The  
250.21 commissioner shall consult with the members of the house of representatives and senate  
250.22 policy committees having jurisdiction over food support issues in developing the waiver.  
250.23 The commissioner, in consultation with the commissioners of health and education, shall  
250.24 develop a broad public health policy related to improved nutrition and health status. The  
250.25 commissioner must seek legislative approval prior to implementing the waiver.

250.26 Sec. 8. Minnesota Statutes 2010, section 402A.10, subdivision 4, is amended to read:

250.27 Subd. 4. **Essential human services or essential services.** "Essential human  
250.28 services" or "essential services" means assistance and services to recipients or potential  
250.29 recipients of public welfare and other services delivered by counties or tribes that are  
250.30 mandated in federal and state law that are to be available in all counties of the state.

250.31 Sec. 9. Minnesota Statutes 2010, section 402A.10, subdivision 5, is amended to read:

250.32 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single  
250.33 county, or group consortium of counties operating by execution of a joint powers  
250.34 agreement under section 471.59 or other contractual agreement, that has voluntarily

251.1 chosen by resolution of the county board of commissioners to participate in the redesign  
251.2 under this chapter or has been assigned by the commissioner pursuant to section 402A.18.  
251.3 A service delivery authority includes an Indian tribe or group of tribes that have voluntarily  
251.4 chosen by resolution of tribal government to participate in redesign under this chapter.

251.5 Sec. 10. Minnesota Statutes 2010, section 402A.15, is amended to read:

251.6 **402A.15 STEERING COMMITTEE ON PERFORMANCE AND OUTCOME**  
251.7 **REFORMS.**

251.8 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome  
251.9 Reforms shall develop a uniform process to establish and review performance and outcome  
251.10 standards for all essential human services based on the current level of resources available,  
251.11 and ~~to shall~~ develop appropriate reporting measures and a uniform accountability process  
251.12 for responding to a county's or ~~human~~ service delivery authority's failure to make adequate  
251.13 progress on achieving performance measures. The accountability process shall focus on  
251.14 the performance measures rather than inflexible implementation requirements.

251.15 (b) The steering committee shall:

251.16 (1) by November 1, 2009, establish an agreed-upon list of essential services;

251.17 (2) by February 15, 2010, develop and recommend to the legislature a uniform,  
251.18 graduated process, in addition to the remedies identified in section 402A.18, for responding  
251.19 to a county's failure to make adequate progress on achieving performance measures; and

251.20 (3) by December 15, 2012, for each essential service<sub>2</sub> make recommendations  
251.21 to the legislature regarding ~~(1)~~ (i) performance measures and goals based on those  
251.22 measures for each essential service, ~~(2)~~ and (ii) a system for reporting on the performance  
251.23 measures and goals, ~~and (3) appropriate resources, including funding, needed to achieve~~  
251.24 ~~those performance measures and goals. The resource recommendations shall take into~~  
251.25 ~~consideration program demand and the unique differences of local areas in geography and~~  
251.26 ~~the populations served. Priority shall be given to services with the greatest variation in~~  
251.27 ~~availability and greatest administrative demands.~~ By January 15 of each year starting  
251.28 January 15, 2011, the steering committee shall report its recommendations to the governor  
251.29 and legislative committees with jurisdiction over health and human services. As part of its  
251.30 report, the steering committee shall, as appropriate, recommend statutory provisions, rules  
251.31 and requirements, and reports that should be repealed or eliminated.

251.32 (c) As far as possible, the performance measures, reporting system, and funding  
251.33 shall be consistent across program areas. The development of performance measures shall  
251.34 consider the manner in which data will be collected and performance will be reported.  
251.35 The steering committee shall consider state and local administrative costs related to

252.1 collecting data and reporting outcomes when developing performance measures. ~~The~~  
252.2 ~~steering committee shall correlate the performance measures and goals to available levels~~  
252.3 ~~of resources, including state and local funding.~~ The steering committee shall also identify  
252.4 and incorporate federal performance measures in its recommendations for those program  
252.5 areas where federal funding is contingent on meeting federal performance standards. The  
252.6 steering committee shall take into consideration that the goal of implementing changes  
252.7 to program monitoring and reporting the progress toward achieving outcomes is to  
252.8 significantly minimize the cost of administrative requirements and to allow funds freed  
252.9 by reduced administrative expenditures to be used to provide additional services, allow  
252.10 flexibility in service design and management, and focus energies on achieving program  
252.11 and client outcomes.

252.12 (d) In making its recommendations, the steering committee shall consider input from  
252.13 the council established in section 402A.20. ~~The steering committee shall review the~~  
252.14 ~~measurable goals established in a memorandum of understanding entered into under~~  
252.15 ~~section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied~~  
252.16 ~~as statewide performance outcomes.~~

252.17 (e) The steering committee shall form work groups that include persons who provide  
252.18 or receive essential services and representatives of organizations who advocate on behalf  
252.19 of those persons.

252.20 (f) By December 15, 2009, the steering committee shall establish a three-year  
252.21 schedule for completion of its work. The schedule shall be published on the Department of  
252.22 Human Services Web site and reported to the legislative committees with jurisdiction over  
252.23 health and human services. In addition, the commissioner shall post quarterly updates on  
252.24 the progress of the steering committee on the Department of Human Services Web site.

252.25 Subd. 2. **Composition.** (a) The steering committee shall include:

252.26 (1) the commissioner of human services, or designee, and two additional  
252.27 representatives of the department;

252.28 (2) two county commissioners, representative of rural and urban counties, selected  
252.29 by the Association of Minnesota Counties;

252.30 (3) two county directors of human services, representative of rural and urban  
252.31 counties, selected by the Minnesota Association of County Social Service Administrators;  
252.32 and

252.33 (4) three clients or client advocates representing different populations receiving  
252.34 services from the Department of Human Services, who are appointed by the commissioner.

253.1 (b) The commissioner, or designee, and a county commissioner shall serve as  
253.2 cochairs of the committee. The committee shall be convened within 60 days of May  
253.3 15, 2009.

253.4 (c) State agency staff shall serve as informational resources and staff to the steering  
253.5 committee. Statewide county associations may assemble county program data as required.

253.6 ~~(d) To promote information sharing and coordination between the steering committee  
253.7 and council, one of the county representatives from paragraph (a), clause (2), and one of the  
253.8 county representatives from paragraph (a), clause (3), must also serve as a representative  
253.9 on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).~~

253.10 Sec. 11. Minnesota Statutes 2010, section 402A.18, is amended to read:

253.11 **402A.18 COMMISSIONER POWER TO REMEDY FAILURE TO MEET**  
253.12 **PERFORMANCE OUTCOMES.**

253.13 Subdivision 1. **Underperforming county; specific service.** If the commissioner  
253.14 determines that a county or service delivery authority is deficient in achieving minimum  
253.15 performance outcomes for a specific essential service, the commissioner may impose the  
253.16 following remedies and adjust state and federal program allocations accordingly:

253.17 (1) voluntary incorporation of the administration and operation of the specific  
253.18 essential service with an existing service delivery authority or another county. A  
253.19 service delivery authority or county incorporating an underperforming county shall  
253.20 not be financially liable for the costs associated with remedying performance outcome  
253.21 deficiencies;

253.22 (2) mandatory incorporation of the administration and operation of the specific  
253.23 essential service with an existing service delivery authority or another county. A  
253.24 service delivery authority or county incorporating an underperforming county shall  
253.25 not be financially liable for the costs associated with remedying performance outcome  
253.26 deficiencies; or

253.27 (3) transfer of authority for program administration and operation of the specific  
253.28 essential service to the commissioner.

253.29 Subd. 2. **Underperforming county; more than one-half of service services.** If  
253.30 the commissioner determines that a county or service delivery authority is deficient in  
253.31 achieving minimum performance outcomes for more than one-half of the defined essential  
253.32 service services, the commissioner may impose the following remedies:

253.33 (1) voluntary incorporation of the administration and operation of ~~the specific~~  
253.34 essential service services with an existing service delivery authority or another county.  
253.35 A service delivery authority or county incorporating an underperforming county shall

254.1 not be financially liable for the costs associated with remedying performance outcome  
254.2 deficiencies;

254.3 (2) mandatory incorporation of the administration and operation of ~~the specific~~  
254.4 ~~essential service~~ services with an existing service delivery authority or another county.

254.5 A service delivery authority or county incorporating an underperforming county shall  
254.6 not be financially liable for the costs associated with remedying performance outcome  
254.7 deficiencies; or

254.8 (3) transfer of authority for program administration and operation of ~~the specific~~  
254.9 ~~essential service~~ services to the commissioner.

254.10 Subd. 2a. **Financial responsibility of underperforming county.** A county subject  
254.11 to remedies under subdivision 1 or 2 shall provide to the entity assuming administration of  
254.12 the essential service or essential services the amount of nonfederal and nonstate funding  
254.13 needed to remedy performance outcome deficiencies.

254.14 Subd. 3. **Conditions prior to imposing remedies.** Before the commissioner may  
254.15 impose the remedies authorized under this section, the following conditions must be met:

254.16 (1) the county or service delivery authority determined by the commissioner  
254.17 to be deficient in achieving minimum performance outcomes has the opportunity, in  
254.18 coordination with the council, to develop a program outcome improvement plan. The  
254.19 program outcome improvement plan must be developed no later than six months from the  
254.20 date of the deficiency determination; and

254.21 (2) the council has conducted an assessment of the program outcome improvement  
254.22 plan to determine if the county or service delivery authority has made satisfactory  
254.23 progress toward performance outcomes and has made a recommendation about remedies  
254.24 to the commissioner. The ~~review~~ assessment and recommendation must be made to the  
254.25 commissioner within 12 months from the date of the deficiency determination.

254.26 Sec. 12. Minnesota Statutes 2010, section 402A.20, is amended to read:

254.27 **402A.20 COUNCIL.**

254.28 Subdivision 1. **Council.** (a) The State-County Results, Accountability, and Service  
254.29 Delivery Redesign Council is established. Appointed council members must be appointed  
254.30 by their respective agencies, associations, or governmental units by November 1, 2009.  
254.31 The council shall be cochaired by the commissioner of human services, or designee, and a  
254.32 county representative from paragraph (b), clause (4) or (5), appointed by the Association  
254.33 of Minnesota Counties. Recommendations of the council must be approved by a majority  
254.34 of the voting council members. The provisions of section 15.059 do not apply to this  
254.35 council, and this council does not expire.

255.1 (b) The council must consist of the following members:

255.2 (1) two legislators appointed by the speaker of the house, one from the minority  
255.3 and one from the majority;

255.4 (2) two legislators appointed by the Senate Rules Committee, one from the majority  
255.5 and one from the minority;

255.6 (3) the commissioner of human services, or designee, and three employees from  
255.7 the department;

255.8 (4) two county commissioners appointed by the Association of Minnesota Counties;

255.9 (5) two county representatives appointed by the Minnesota Association of County  
255.10 Social Service Administrators;

255.11 (6) one representative appointed by AFSCME as a nonvoting member; and

255.12 (7) one representative appointed by the Teamsters as a nonvoting member.

255.13 (c) Administrative support to the council may be provided by the Association of  
255.14 Minnesota Counties and affiliates.

255.15 (d) Member agencies and associations are responsible for initial and subsequent  
255.16 appointments to the council.

255.17 Subd. 2. **Council duties.** The council shall:

255.18 (1) provide review of the service delivery redesign process, including proposed  
255.19 memoranda of understanding to establish a service delivery authority to conduct and  
255.20 administer experimental projects to test new methods and procedures of delivering  
255.21 services;

255.22 ~~(2) certify, in accordance with section 402A.30, subdivision 4, the formation of~~  
255.23 ~~a service delivery authority, including the memorandum of understanding in section~~  
255.24 ~~402A.30, subdivision 2, paragraph (b);~~

255.25 ~~(3) ensure the consistency of the memorandum of understanding entered into~~  
255.26 ~~under section 402A.30, subdivision 2, paragraph (b), with the performance standards~~  
255.27 ~~recommended by the steering committee and enacted by the legislature;~~

255.28 ~~(4)~~ (2) ensure the consistency of the memorandum of understanding, to the extent  
255.29 appropriate, ~~or~~ with other memorandum of understanding entered into by other service  
255.30 delivery authorities;

255.31 (3) review and make recommendations on applications from a service delivery  
255.32 authority for waivers of statutory or rule program requirements that are needed for  
255.33 flexibility to determine the most cost-effective means of achieving specified measurable  
255.34 goals in a redesign of human services delivery;

255.35 ~~(5)~~ (4) establish a process to take public input on the ~~service delivery framework~~  
255.36 ~~specified in the memorandum of understanding in section 402A.30, subdivision 2,~~

256.1 ~~paragraph (b)~~ scope of essential services over which a service delivery authority has  
256.2 jurisdiction;

256.3 ~~(6)~~ (5) form work groups as necessary to carry out the duties of the council under the  
256.4 redesign;

256.5 ~~(7)~~ (6) serve as a forum for resolving conflicts among participating counties and  
256.6 tribes or between participating counties or tribes and the commissioner of human services,  
256.7 provided nothing in this section is intended to create a formal binding legal process;

256.8 ~~(8)~~ (7) engage in the program improvement process established in section 402A.18,  
256.9 subdivision 3; and

256.10 ~~(9)~~ (8) identify and recommend incentives for counties and tribes to participate in  
256.11 ~~human services~~ service delivery authorities.

256.12 Subd. 3. **Program evaluation.** By December 15, 2014, the council shall request  
256.13 consideration by the legislative auditor for a reevaluation under section 3.971, subdivision  
256.14 7, of those aspects of the program evaluation of human services administration reported  
256.15 in January 2007 affected by this chapter.

256.16 Sec. 13. **[402A.35] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

256.17 Subdivision 1. **Requirements for establishing a service delivery authority.**

256.18 (a) A county, tribe, or consortium of counties is eligible to establish a service delivery  
256.19 authority if:

256.20 (1) the county, tribe, or consortium of counties is:

256.21 (i) a single county with a population of 55,000 or more;

256.22 (ii) a consortium of counties with a total combined population of 55,000 or more;

256.23 (iii) a consortium of four or more counties in reasonable geographic proximity  
256.24 without regard to population; or

256.25 (iv) one or more tribes with a total combined population of 25,000 or more.

256.26 The council may recommend that the commissioner of human services exempt a  
256.27 single county, tribe, or consortium of counties from the minimum population standard if  
256.28 the county, tribe, or consortium of counties can demonstrate that it can otherwise meet  
256.29 the requirements of this chapter.

256.30 (b) A service delivery authority shall:

256.31 (1) comply with current state and federal law, including any existing federal or state  
256.32 performance measures and performance measures under section 402A.15 when they are

256.33 enacted into law, except where waivers are approved by the commissioner. Nothing

256.34 in this subdivision requires the establishment of performance measures under section



257.1 402A.15 prior to a service delivery authority participating in the service delivery redesign  
257.2 under this chapter;

257.3 (2) define the scope of essential services over which the service delivery authority  
257.4 has jurisdiction;

257.5 (3) designate a single administrative structure to oversee the delivery of those  
257.6 services included in a proposal for a redesigned service or services and identify a single  
257.7 administrative agent for purposes of contact and communication with the department;

257.8 (4) identify the waivers from statutory or rule program requirements that are needed  
257.9 to ensure greater local control and flexibility to determine the most cost-effective means of  
257.10 achieving specified measurable goals that the participating service delivery authority is  
257.11 expected to achieve;

257.12 (5) set forth a reasonable level of targeted reductions in overhead and administrative  
257.13 costs for each service delivery authority participating in the service delivery redesign;

257.14 (6) set forth the terms under which a county, tribe, or consortium of counties  
257.15 may withdraw from participation. In the case of withdrawal of any or all parties or  
257.16 the dissolution of the service delivery authority, the employees shall continue to be  
257.17 represented by the same exclusive representative or representatives and continue to be  
257.18 covered by the same collective bargaining union agreement until a new agreement is  
257.19 negotiated or the collective bargaining agreement term ends; and

257.20 (7) set forth a structure for managing the terms and conditions of employment of the  
257.21 employees as provided in section 402A.40.

257.22 (c) Once a county, tribe, or consortium of counties establishes a service delivery  
257.23 authority, no county, tribe, or consortium of counties that is a member of the service  
257.24 delivery authority may participate as a member of any other service delivery authority.

257.25 The service delivery authority may allow an additional county, a tribe, or a consortium of  
257.26 counties to join the service delivery authority subject to the approval of the council and  
257.27 the commissioner.

257.28 (d) Nothing in this chapter precludes local governments from using sections 465.81  
257.29 and 465.82 to establish procedures for local governments to merge, with the consent  
257.30 of the voters. Nothing in this chapter limits the authority of a county board or tribal  
257.31 council to enter into contractual agreements for services not covered by the provisions  
257.32 of a memorandum of understanding establishing a service delivery authority with other  
257.33 agencies or with other units of government.

257.34 Subd. 2. **Relief from statutory requirements.** (a) Unless otherwise identified in  
257.35 the memorandum of understanding, any county, tribe, or consortium of counties forming a  
257.36 service delivery authority is exempt from the provisions of sections 245.465; 245.4835;

258.1 245.4874; 245.492, subdivision 2; 245.4932; 256F.13; 256J.626, subdivision 2, paragraph  
258.2 (b); and 256M.30.

258.3 (b) This subdivision does not preclude any county, tribe, or consortium of counties  
258.4 forming a service delivery authority from requesting additional waivers from statutory and  
258.5 rule requirements to ensure greater local control and flexibility.

258.6 Subd. 3. **Duties.** The service delivery authority shall:

258.7 (1) within the scope of essential services set forth in the memorandum of  
258.8 understanding establishing the authority, carry out the responsibilities required of local  
258.9 agencies under chapter 393 and human services boards under chapter 402;

258.10 (2) manage the public resources devoted to human services and other public services  
258.11 delivered or purchased by the counties or tribes that are subsidized or regulated by the  
258.12 Department of Human Services under chapters 245 to 261;

258.13 (3) employ staff to assist in carrying out its duties;

258.14 (4) develop and maintain a continuity of operations plan to ensure the continued  
258.15 operation or resumption of essential human services functions in the event of any business  
258.16 interruption according to local, state, and federal emergency planning requirements;

258.17 (5) receive and expend funds received for the redesign process under the  
258.18 memorandum of understanding;

258.19 (6) plan and deliver services directly or through contract with other governmental,  
258.20 tribal, or nongovernmental providers;

258.21 (7) rent, purchase, sell, and otherwise dispose of real and personal property as  
258.22 necessary to carry out the redesign; and

258.23 (8) carry out any other service designated as a responsibility of a county.

258.24 Subd. 4. **Process for establishing a service delivery authority.** (a) The county,  
258.25 tribe, or consortium of counties meeting the requirements of section 402A.30 and  
258.26 proposing to establish a service delivery authority shall present to the council:

258.27 (1) in conjunction with the commissioner, a proposed memorandum of understanding  
258.28 meeting the requirements of subdivision 1, paragraph (b), and outlining:

258.29 (i) the details of the proposal;

258.30 (ii) the state, tribal, and local resources, which may include, but are not limited to,  
258.31 funding, administrative and technology support, and other requirements necessary for  
258.32 the service delivery authority; and

258.33 (iii) the relief available to the service delivery authority if the resource commitments  
258.34 identified in item (ii) are not met; and

259.1 (2) a board resolution from the board of commissioners of each participating county  
259.2 stating the county's intent to participate, or in the case of a tribe, a resolution from tribal  
259.3 government, stating the tribe's intent to participate.

259.4 (b) After the council has considered and recommended approval of a proposed  
259.5 memorandum of understanding, the commissioner may finalize and execute the  
259.6 memorandum of understanding.

259.7 Subd. 5. **Commissioner authority to seek waivers.** The commissioner may use the  
259.8 authority under section 256.01, subdivision 2, paragraph (l), to grant waivers identified as  
259.9 part of a proposed service delivery authority under subdivision 1, paragraph (b), clause  
259.10 (4), except that waivers granted under this section must be approved by the council under  
259.11 section 402A.20 rather than the Legislative Advisory Committee.

259.12 Sec. 14. **[402A.40] TRANSITION TO NEW BARGAINING UNIT STRUCTURE.**

259.13 Subdivision 1. **Application of section.** Notwithstanding the provisions of section  
259.14 179A.12 or any other law, this section governs, where contrary to other law, the initial  
259.15 certification and decertification, if any, of exclusive representatives for service delivery  
259.16 authorities. Employees of a service delivery authority are public employees under section  
259.17 179A.03, subdivision 14. Service delivery authorities are public employers under section  
259.18 179A.03, subdivision 15.

259.19 Subd. 2. **Existing majority.** The commissioner of the Minnesota Bureau of  
259.20 Mediation Services shall certify an employee organization for employees of a service  
259.21 delivery authority as exclusive representative for an appropriate unit upon a petition  
259.22 filed with the commissioner by the organization demonstrating that the petitioner is  
259.23 certified pursuant to section 179A.12 as the exclusive representative of a majority of the  
259.24 employees included within the unit as of that date. Two or more employee organizations  
259.25 that represent the employees in a unit may petition jointly under this subdivision, provided  
259.26 that any organization may withdraw from a joint certification in favor of the remaining  
259.27 organizations on 30 days' notice to the remaining organizations, the employer, and the  
259.28 commissioner, without affecting the rights and obligations of the remaining organizations  
259.29 or the employer. The commissioner shall make a determination on a timely petition within  
259.30 45 days of its receipt.

259.31 Subd. 3. **No existing majority.** (a) If no exclusive representative is certified under  
259.32 subdivision 2, the commissioner shall certify an employee organization as exclusive  
259.33 representative for an appropriate unit established upon a petition filed by the organization  
259.34 within the time period provided in subdivision 2 demonstrating that the petitioner is  
259.35 certified under section 179A.12 as the exclusive representative of fewer than a majority

260.1 of the employees included within the unit if no other employee organization so certified  
260.2 has filed a petition within the time period provided in subdivision 2 and a majority of the  
260.3 employees in the unit are represented by employee organizations under section 179A.12  
260.4 on the date of the petition. Two or more employee organizations, each of which represents  
260.5 employees included in the unit may petition jointly under this paragraph, provided that  
260.6 any organization may withdraw from a joint certification in favor of the remaining  
260.7 organizations on 30 days' notice to the remaining organizations, the employer, and the  
260.8 commissioner without affecting the rights and obligations of the remaining organizations  
260.9 or the employer. The commissioner shall make a determination on a timely petition within  
260.10 45 days of its receipt.

260.11 (b) If no exclusive representative is certified under paragraph (a) or subdivision 2,  
260.12 and an employee organization petitions the commissioner within 90 days of the creation of  
260.13 the service delivery authority demonstrating that a majority of the employees included  
260.14 within an appropriate unit wish to be represented by the petitioner, where this majority  
260.15 is evidenced by current dues deduction rights, signed statements from employees in  
260.16 counties within the service delivery authority that are not currently represented by any  
260.17 employee organization plainly indicating that the signatories wish to be represented for  
260.18 collective bargaining purposes by the petitioner rather than by any other organization,  
260.19 or a combination of those, the commissioner shall certify the petitioner as exclusive  
260.20 representative of the employees in the unit. The commissioner shall make a determination  
260.21 on a timely petition within 45 days of its receipt.

260.22 (c) If no exclusive representative is certified under paragraph (a) or (b) or subdivision  
260.23 2, and an employee organization petitions the commissioner subsequent to the creation  
260.24 of the service delivery authority demonstrating that at least 30 percent of the employees  
260.25 included within an appropriate unit wish to be represented by the petitioner, where this 30  
260.26 percent is evidenced by current dues deduction rights, signed statements from employees  
260.27 in counties within the service delivery authority that are not currently represented by any  
260.28 employee organization plainly indicating that the signatories wish to be represented for  
260.29 collective bargaining purposes by the petitioner rather than by any other organization, or a  
260.30 combination of those, the commissioner shall conduct a secret ballot election to determine  
260.31 the wishes of the majority. The election must be conducted within 45 days of receipt or  
260.32 final decision on any petitions filed pursuant to subdivision 2, whichever is later. The  
260.33 election is governed by section 179A.12, where not inconsistent with other provisions  
260.34 of this section.

261.1 Subd. 4. **Decertification.** The commissioner may not consider a petition for  
261.2 decertification of an exclusive representative certified under this section for one year after  
261.3 certification, unless section 179A.20, subdivision 6, applies.

261.4 Subd. 5. **Continuing contract.** (a) The terms and conditions of collective  
261.5 bargaining agreements covering the employees of service delivery authorities remain in  
261.6 effect until a successor agreement becomes effective or, if no employee organization  
261.7 petitions to represent the employees of the service delivery authority, until six months  
261.8 after the establishment of the service delivery authority.

261.9 (b) Any accrued leave, including but not limited to sick leave, vacation time,  
261.10 compensatory leave or paid time off, or severance pay benefits accumulated under policies  
261.11 of the previously employing county or a collective bargaining agreement between the  
261.12 previously employing county and an exclusive representative shall continue to apply in the  
261.13 newly created service delivery authority for the employees of the previously employing  
261.14 county. An employee who was eligible for the benefits of the Family and Medical Leave  
261.15 Act at the previously employing county shall continue to be eligible at the newly created  
261.16 service delivery authority.

261.17 (c) If it is necessary, prior to the negotiation of a new collective bargaining  
261.18 agreement, to lay off an employee of a service delivery authority and if two or more  
261.19 employees previously performed the work, seniority based on continuous length of  
261.20 service with a service delivery authority member county shall be the determining factor  
261.21 in determining which qualified employee shall be offered the job by the service delivery  
261.22 authority. An employee whose work is being transferred to the service delivery authority  
261.23 shall have the option of being laid off.

261.24 Subd. 6. **Contract and representation responsibilities.** (a) The exclusive  
261.25 representatives of units of employees certified prior to the creation of the service delivery  
261.26 authority remain responsible for administration of their contracts and for other contractual  
261.27 duties and have the right to dues and fair share fee deduction and other contractual  
261.28 privileges and rights until a contract is agreed upon with the service delivery authority.  
261.29 Exclusive representatives of service delivery authority employees certified after the  
261.30 creation of the service delivery authority are immediately upon certification responsible  
261.31 for bargaining on behalf of employees within the unit. They are also responsible for  
261.32 administering grievances arising under previous contracts covering employees included  
261.33 within the unit that remain unresolved upon agreement with the service delivery authority  
261.34 on a contract. Where the employer does not object, these responsibilities may be varied by  
261.35 agreement between the outgoing and incoming exclusive representatives. All other rights  
261.36 and duties of representation begin upon the creation of a service delivery authority, except

262.1 that exclusive representatives certified upon or after the creation of the service delivery  
262.2 authority shall immediately, upon certification, have the right to all employer information  
262.3 and all forms of access to employees within the bargaining unit which would be permitted  
262.4 to the current contract holder, including the rights in section 179A.07, subdivision 6. This  
262.5 section does not affect an existing collective bargaining contract. Incoming exclusive  
262.6 representatives are immediately, upon certification, responsible for bargaining on behalf of  
262.7 all previously unrepresented employees assigned to their units.

262.8 (b) Nothing in this section prevents an exclusive representative certified after  
262.9 the effective dates of these provisions from assessing fair share or dues deductions  
262.10 immediately upon certification if the employees were unrepresented for collective  
262.11 bargaining purposes before that certification.

262.12 **Sec. 15. COUNTY ELECTRONIC VERIFICATION PROCEDURES.**

262.13 The commissioner of human services shall define which public assistance program  
262.14 requirements may be electronically verified for the purposes of determining eligibility,  
262.15 and shall also define procedures for electronic verification. The commissioner of human  
262.16 services shall report back to the chairs and ranking minority members of the legislative  
262.17 committees with jurisdiction over these issues by January 15, 2012, with draft legislation  
262.18 to implement the procedures if legislation is necessary for purposes of implementation.

262.19 **Sec. 16. ALIGNMENT OF PROGRAM POLICY AND PROCEDURES.**

262.20 The commissioner of human services, in consultation with counties and other key  
262.21 stakeholders, shall analyze and develop recommendations to align program policy and  
262.22 procedures across all public assistance programs to simplify and streamline program  
262.23 eligibility and access. The commissioner shall report back to the chairs and ranking  
262.24 minority members of the legislative committees with jurisdiction over these issues by  
262.25 January 15, 2013, with draft legislation to implement the recommendations.

262.26 **Sec. 17. ALTERNATIVE STRATEGIES FOR CERTAIN**  
262.27 **REDETERMINATIONS.**

262.28 The commissioner of human services shall develop and implement by January 15,  
262.29 2012, a simplified process to redetermine eligibility for recipient populations in the medical  
262.30 assistance, Minnesota supplemental aid, food support, and group residential housing  
262.31 programs who are eligible based upon disability, age, or chronic medical conditions, and  
262.32 who are expected to experience minimal change in income or assets from month to month.  
262.33 The commissioner shall apply for any federal waivers needed to implement this section.

263.1       Sec. 18. **SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT**  
263.2 **PROCESS.**

263.3       (a) The commissioner of human services shall issue a request for information for an  
263.4 integrated service delivery system for health care programs, food support, cash assistance,  
263.5 and child care. The commissioner shall determine, in consultation with partners in  
263.6 paragraph (c), if the products meet departments' and counties' functions. The request for  
263.7 information may incorporate a performance-based vendor financing option in which the  
263.8 vendor shares the risk of the project's success. The health care system must be developed  
263.9 in phases with the capacity to integrate food support, cash assistance, and child care  
263.10 programs as funds are available. The request for information must require that the system:

263.11       (1) streamline eligibility determinations and case processing to support statewide  
263.12 eligibility processing;

263.13       (2) enable interested persons to determine eligibility for each program, and to apply  
263.14 for programs online in a manner that the applicant will be asked only those questions  
263.15 relevant to the programs for which the person is applying;

263.16       (3) leverage technology that has been operational in other state environments with  
263.17 similar requirements; and

263.18       (4) include Web-based application, worker application processing support, and the  
263.19 opportunity for expansion.

263.20       (b) The commissioner shall issue a final report, including the implementation plan,  
263.21 to the chairs and ranking minority members of the legislative committees with jurisdiction  
263.22 over health and human services no later than October 31, 2011.

263.23       (c) The commissioner shall partner with counties, a service delivery authority  
263.24 established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology,  
263.25 other state agencies, and service partners to develop an integrated service delivery  
263.26 framework, which will simplify and streamline human services eligibility and enrollment  
263.27 processes. The primary objectives for the simplification effort include significantly  
263.28 improved eligibility processing productivity resulting in reduced time for eligibility  
263.29 determination and enrollment, increased customer service for applicants and recipients of  
263.30 services, increased program integrity, and greater administrative flexibility.

263.31       (d) The commissioner, along with a county representative appointed by the  
263.32 Association of Minnesota Counties, shall report specific implementation progress to the  
263.33 legislature annually beginning May 15, 2012.

263.34       (e) The commissioner shall work with the Minnesota Association of County Social  
263.35 Service Administrators and the Office of Enterprise Technology to develop collaborative  
263.36 task forces, as necessary, to support implementation of the service delivery components

264.1 under this paragraph. The commissioner must evaluate, develop, and include as part  
264.2 of the integrated eligibility and enrollment service delivery framework, the following  
264.3 minimum components:

264.4 (1) screening tools for applicants to determine potential eligibility as part of an  
264.5 online application process;

264.6 (2) the capacity to use databases to electronically verify application and renewal  
264.7 data as required by law;

264.8 (3) online accounts accessible by applicants and enrollees;

264.9 (4) an interactive voice response system, available statewide, that provides case  
264.10 information for applicants, enrollees, and authorized third parties;

264.11 (5) an electronic document management system that provides electronic transfer of  
264.12 all documents required for eligibility and enrollment processes; and

264.13 (6) a centralized customer contact center that applicants, enrollees, and authorized  
264.14 third parties can use statewide to receive program information, application assistance,  
264.15 and case information, report changes, make cost-sharing payments, and conduct other  
264.16 eligibility and enrollment transactions.

264.17 (f) Subject to a legislative appropriation, the commissioner of human services shall  
264.18 issue a request for proposal for the appropriate phase of an integrated service delivery  
264.19 system for health care programs, food support, cash assistance, and child care.

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

264.21 Sec. 19. **WHITE EARTH BAND OF OJIBWE HUMAN SERVICES PROJECT.**

264.22 (a) The commissioner of human services, in consultation with the White Earth Band  
264.23 of Ojibwe, shall transfer legal responsibility to the tribe for providing human services to  
264.24 tribal members and their families who reside on or off the reservation in Mahnomen  
264.25 County. The transfer shall include:

264.26 (1) financing, including federal and state funds, grants, and foundation funds; and

264.27 (2) services to eligible tribal members and families defined as it applies to state  
264.28 programs being transferred to the tribe.

264.29 (b) The determination as to which programs will be transferred to the tribe and  
264.30 the timing of the transfer of the programs shall be made by a consensus decision of the  
264.31 governing body of the tribe and the commissioner. The commissioner shall waive existing  
264.32 rules and seek all federal approvals and waivers as needed to carry out the transfer.

264.33 (c) When the commissioner approves transfer of programs and the tribe assumes  
264.34 responsibility under this section, Mahnomen County is relieved of responsibility for  
264.35 providing program services to tribal members and their families who live on or off the



265.1 reservation while the tribal project is in effect and funded, except that a family member  
265.2 who is not a White Earth member may choose to receive services through the tribe or the  
265.3 county. The commissioner shall have authority to redirect funds provided to Mahnomen  
265.4 County for these services, including administrative expenses, to the White Earth Band  
265.5 of Ojibwe Indians.

265.6 (d) Upon the successful transfer of legal responsibility for providing human services  
265.7 for tribal members and their families who reside on and off the reservation in Mahnomen  
265.8 County, the commissioner and the White Earth Band of Ojibwe shall develop a plan to  
265.9 transfer legal responsibility for providing human services for tribal members and their  
265.10 families who reside on or off reservation in Clearwater and Becker Counties.

265.11 (e) No later than January 15, 2012, the commissioner shall submit a written  
265.12 report detailing the transfer progress to the chairs and ranking minority members of the  
265.13 legislative committees with jurisdiction over health and human services. If legislation is  
265.14 needed to fully complete the transfer of legal responsibility for providing human services,  
265.15 the commissioner shall submit proposed legislation along with the written report.

265.16 Sec. 20. **REPEALER.**

265.17 (a) Minnesota Statutes 2010, sections 402A.30; and 402A.45, are repealed.

265.18 (b) Minnesota Rules, part 9500.1243, subpart 3, is repealed.

## 265.19 **ARTICLE 9**

### 265.20 **HUMAN SERVICES FORECAST ADJUSTMENTS**

265.21 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT**  
265.22 **APPROPRIATIONS.**

265.23 The sums shown are added to, or if shown in parentheses, are subtracted from the  
265.24 appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter  
265.25 173, article 2; Laws 2010, First Special Session chapter 1, articles 15, 23, and 25; and  
265.26 Laws 2010, Second Special Session chapter 1, article 3, to the commissioner of human  
265.27 services and for the purposes specified in this article. The appropriations are from the  
265.28 general fund or another named fund and are available for the fiscal year indicated for  
265.29 each purpose. The figure "2011" used in this article means that the appropriation or  
265.30 appropriations listed are available for the fiscal year ending June 30, 2011.

265.31 Sec. 2. **COMMISSIONER OF HUMAN**  
265.32 **SERVICES**

265.33 Subdivision 1. **Total Appropriation** **\$ (235,463,000)**

266.1	<u>Appropriations by Fund</u>	
266.2		<u>2011</u>
266.3	<u>General</u>	<u>(381,869,000)</u>
266.4	<u>Health Care Access</u>	<u>169,514,000</u>
266.5	<u>Federal TANF</u>	<u>(23,108,000)</u>
266.6	<u>The amounts that may be spent for each</u>	
266.7	<u>purpose are specified in the following</u>	
266.8	<u>subdivisions.</u>	
266.9	<b><u>Subd. 2. Revenue and Pass-through</u></b>	<b><u>732,000</u></b>
266.10	<u>This appropriation is from the federal TANF</u>	
266.11	<u>fund.</u>	
266.12	<b><u>Subd. 3. Children and Economic Assistance</u></b>	
266.13	<b><u>Grants</u></b>	
266.14	<u>Appropriations by Fund</u>	
266.15	<u>General</u>	<u>(7,098,000)</u>
266.16	<u>Federal TANF</u>	<u>(23,840,000)</u>
266.17	<b><u>(a) MFIP/DWP Grants</u></b>	
266.18	<u>Appropriations by Fund</u>	
266.19	<u>General</u>	<u>18,715,000</u>
266.20	<u>Federal TANF</u>	<u>(23,840,000)</u>
266.21	<b><u>(b) MFIP Child Care Assistance Grants</u></b>	<b><u>(24,394,000)</u></b>
266.22	<b><u>(c) General Assistance Grants</u></b>	<b><u>(664,000)</u></b>
266.23	<b><u>(d) Minnesota Supplemental Aid Grants</u></b>	<b><u>793,000</u></b>
266.24	<b><u>(e) Group Residential Housing Grants</u></b>	<b><u>(1,548,000)</u></b>
266.25	<b><u>Subd. 4. Basic Health Care Grants</u></b>	
266.26	<u>Appropriations by Fund</u>	
266.27	<u>General</u>	<u>(335,050,000)</u>
266.28	<u>Health Care Access</u>	<u>169,514,000</u>
266.29	<b><u>(a) MinnesotaCare Grants</u></b>	<b><u>169,514,000</u></b>
266.30	<u>This appropriation is from the health care</u>	
266.31	<u>access fund.</u>	
266.32	<b><u>(b) Medical Assistance Basic Health Care -</u></b>	
266.33	<b><u>Families and Children</u></b>	<b><u>(49,368,000)</u></b>

267.1	<u>(c) Medical Assistance Basic Health Care -</u>		
267.2	<u>Elderly and Disabled</u>		<u>(43,258,000)</u>
267.3	<u>(d) Medical Assistance Basic Health Care -</u>		
267.4	<u>Adults without Children</u>		<u>(242,424,000)</u>
267.5	<u>Subd. 5. Continuing Care Grants</u>		<u>(39,721,000)</u>
267.6	<u>(a) Medical Assistance Long-Term Care</u>		
267.7	<u>Facilities</u>		<u>(14,627,000)</u>
267.8	<u>(b) Medical Assistance Long-Term Care</u>		
267.9	<u>Waivers</u>		<u>(44,718,000)</u>
267.10	<u>(c) Chemical Dependency Entitlement Grants</u>		<u>19,624,000</u>

267.11 Sec. 3. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6,  
 267.12 is amended to read:

267.13 **Subd. 6. Health Care Grants**

267.14	<b>(a) MinnesotaCare Grants</b>	998,000	<b>(13,376,000)</b>
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267.15 This appropriation is from the health care  
 267.16 access fund.

267.17 **Health Care Access Fund Transfer to**  
 267.18 **General Fund.** The commissioner of  
 267.19 management and budget shall transfer the  
 267.20 following amounts in the following years  
 267.21 from the health care access fund to the  
 267.22 general fund: ~~\$998,000~~ \$0 in fiscal year  
 267.23 2010; ~~\$176,704,000~~ \$59,901,000 in fiscal  
 267.24 year 2011; \$141,041,000 in fiscal year 2012;  
 267.25 and \$286,150,000 in fiscal year 2013. If at  
 267.26 any time the governor issues an executive  
 267.27 order not to participate in early medical  
 267.28 assistance expansion, no funds shall be  
 267.29 transferred from the health care access  
 267.30 fund to the general fund until early medical  
 267.31 assistance expansion takes effect. This  
 267.32 paragraph is effective the day following final  
 267.33 enactment.

268.1 **MinnesotaCare Ratable Reduction.**  
 268.2 Effective for services rendered on or after  
 268.3 July 1, 2010, to December 31, 2013,  
 268.4 MinnesotaCare payments to managed care  
 268.5 plans under Minnesota Statutes, section  
 268.6 256L.12, for single adults and households  
 268.7 without children whose income is greater  
 268.8 than 75 percent of federal poverty guidelines  
 268.9 shall be reduced by 15 percent. Effective  
 268.10 for services provided from July 1, 2010, to  
 268.11 June 30, 2011, this reduction shall apply to  
 268.12 all services. Effective for services provided  
 268.13 from July 1, 2011, to December 31, 2013, this  
 268.14 reduction shall apply to all services except  
 268.15 inpatient hospital services. Notwithstanding  
 268.16 any contrary provision of this article, this  
 268.17 paragraph shall expire on December 31,  
 268.18 2013.

268.19	<b>(b) Medical Assistance Basic Health Care</b>		
268.20	<b>Grants - Families and Children</b>	-0-	295,512,000

268.21 **Critical Access Dental.** Of the general  
 268.22 fund appropriation, \$731,000 in fiscal year  
 268.23 2011 is to the commissioner for critical  
 268.24 access dental provider reimbursement  
 268.25 payments under Minnesota Statutes, section  
 268.26 256B.76 subdivision 4. This is a onetime  
 268.27 appropriation.

268.28 **Nonadministrative Rate Reduction.** For  
 268.29 services rendered on or after July 1, 2010,  
 268.30 to December 31, 2013, the commissioner  
 268.31 shall reduce contract rates paid to managed  
 268.32 care plans under Minnesota Statutes,  
 268.33 sections 256B.69 and 256L.12, and to  
 268.34 county-based purchasing plans under  
 268.35 Minnesota Statutes, section 256B.692, by  
 268.36 three percent of the contract rate attributable

269.1 to nonadministrative services in effect on  
 269.2 June 30, 2010. Notwithstanding any contrary  
 269.3 provision in this article, this rider expires on  
 269.4 December 31, 2013.

269.5 **(c) Medical Assistance Basic Health Care**  
 269.6 **Grants - Elderly and Disabled** -0- (30,265,000)

269.7 ~~(75,389,000)~~  
 269.8 **(d) General Assistance Medical Care Grants** -0- (59,583,000)

269.9 The reduction to general assistance medical  
 269.10 care grants is contingent upon the effective  
 269.11 date in Laws 2010, First Special Session  
 269.12 chapter 1, article 16, section 48. The  
 269.13 reduction shall be reestimated based upon  
 269.14 the actual effective date of the law. The  
 269.15 commissioner of management and budget  
 269.16 shall make adjustments in fiscal year  
 269.17 2011 to general assistance medical care  
 269.18 appropriations to conform to the total  
 269.19 expected expenditure reductions specified in  
 269.20 this section.

269.21 **(e) Other Health Care Grants** -0- (7,000,000)

269.22 **Cobra Carryforward.** Unexpended funds  
 269.23 appropriated in fiscal year 2010 for COBRA  
 269.24 grants under Laws 2009, chapter 79, article  
 269.25 5, section 78, do not cancel and are available  
 269.26 to the commissioner for fiscal year 2011  
 269.27 COBRA grant expenditures. Up to \$111,000  
 269.28 of the fiscal year 2011 appropriation for  
 269.29 COBRA grants provided in Laws 2009,  
 269.30 chapter 79, article 13, section 3, subdivision  
 269.31 6, may be used by the commissioner for costs  
 269.32 related to administration of the COBRA  
 269.33 grants.

269.34 Sec. 4. **EFFECTIVE DATE.**

270.1 This article is effective the day following final enactment.

270.2 **ARTICLE 10**

270.3 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

270.4 Section 1. **SUMMARY OF APPROPRIATIONS.**

270.5 The amounts shown in this section summarize direct appropriations, by fund, made  
 270.6 in this article.

	<u>2012</u>	<u>2013</u>	<u>Total</u>
270.8 <u>General</u>	\$ 5,564,457,000	\$ 5,407,093,000	\$ 10,971,550,000
270.9 <u>State Government Special</u>			
270.10 <u>Revenue</u>	63,700,000	63,475,000	127,175,000
270.11 <u>Health Care Access</u>	317,467,000	306,733,000	624,200,000
270.12 <u>Federal TANF</u>	286,744,000	258,466,000	545,210,000
270.13 <u>Lottery Prize Fund</u>	1,665,000	1,665,000	3,330,000
270.14 <b><u>Total</u></b>	<b>\$ 6,234,032,000</b>	<b>\$ 6,037,432,000</b>	<b>\$ 12,271,464,000</b>

270.15 Sec. 2. **HUMAN SERVICES APPROPRIATIONS.**

270.16 The sums shown in the columns marked "Appropriations" are appropriated to the  
 270.17 agencies and for the purposes specified in this article. The appropriations are from the  
 270.18 general fund, or another named fund, and are available for the fiscal years indicated  
 270.19 for each purpose. The figures "2012" and "2013" used in this article mean that the  
 270.20 appropriations listed under them are available for the fiscal year ending June 30, 2012, or  
 270.21 June 30, 2013, respectively. "The first year" is fiscal year 2012. "The second year" is fiscal  
 270.22 year 2013. "The biennium" is fiscal years 2012 and 2013.

**APPROPRIATIONS**  
**Available for the Year**  
**Ending June 30**  
2012                      2013

270.27 Sec. 3. **COMMISSIONER OF HUMAN**  
 270.28 **SERVICES**

270.29 Subdivision 1. **Total Appropriation**                      \$ 6,078,510,000 \$ 5,891,475,000

Appropriations by Fund

	<u>2012</u>	<u>2013</u>
270.31 <u>General</u>	5,489,816,000	5,337,566,000
270.32 <u>State Government</u>		
270.33 <u>Special Revenue</u>	565,000	565,000
270.34 <u>Health Care Access</u>	306,086,000	299,578,000
270.35 <u>Federal TANF</u>	280,378,000	252,101,000
270.36 <u>Lottery Prize Fund</u>	1,665,000	1,665,000

271.1 **Receipts for Systems Projects.**  
271.2 Appropriations and federal receipts for  
271.3 information systems projects for MAXIS,  
271.4 PRISM, MMIS, and SSIS must be deposited  
271.5 in the state systems account authorized in  
271.6 Minnesota Statutes, section 256.014. Money  
271.7 appropriated for computer projects approved  
271.8 by the Minnesota Office of Enterprise  
271.9 Technology, funded by the legislature,  
271.10 and approved by the commissioner  
271.11 of management and budget, may be  
271.12 transferred from one project to another  
271.13 and from development to operations as the  
271.14 commissioner of human services considers  
271.15 necessary. Any unexpended balance in  
271.16 the appropriation for these projects does  
271.17 not cancel but is available for ongoing  
271.18 development and operations.

271.19 **Nonfederal Share Transfers.** The  
271.20 nonfederal share of activities for which  
271.21 federal administrative reimbursement is  
271.22 appropriated to the commissioner may be  
271.23 transferred to the special revenue fund.

271.24 **TANF Maintenance of Effort.**  
271.25 (a) In order to meet the basic maintenance  
271.26 of effort (MOE) requirements of the TANF  
271.27 block grant specified under Code of Federal  
271.28 Regulations, title 45, section 263.1, the  
271.29 commissioner may only report nonfederal  
271.30 money expended for allowable activities  
271.31 listed in the following clauses as TANF/MOE  
271.32 expenditures:

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

- 272.1 (2) the child care assistance programs  
272.2 under Minnesota Statutes, sections 119B.03  
272.3 and 119B.05, and county child care  
272.4 administrative costs under Minnesota  
272.5 Statutes, section 119B.15;
- 272.6 (3) state and county MFIP administrative  
272.7 costs under Minnesota Statutes, chapters  
272.8 256J and 256K;
- 272.9 (4) state, county, and tribal MFIP  
272.10 employment services under Minnesota  
272.11 Statutes, chapters 256J and 256K;
- 272.12 (5) qualifying working family credit  
272.13 expenditures under Minnesota Statutes,  
272.14 section 290.0671; and
- 272.15 (6) qualifying Minnesota education credit  
272.16 expenditures under Minnesota Statutes,  
272.17 section 290.0674.
- 272.18 (b) The commissioner shall ensure that  
272.19 sufficient qualified nonfederal expenditures  
272.20 are made each year to meet the state's  
272.21 TANF/MOE requirements. For the activities  
272.22 listed in paragraph (a), clauses (2) to  
272.23 (6), the commissioner may only report  
272.24 expenditures that are excluded from the  
272.25 definition of assistance under Code of  
272.26 Federal Regulations, title 45, section 260.31.
- 272.27 (c) For fiscal years beginning with state fiscal  
272.28 year 2003, the commissioner shall assure  
272.29 that the maintenance of effort used by the  
272.30 commissioner of management and budget  
272.31 for the February and November forecasts  
272.32 required under Minnesota Statutes, section  
272.33 16A.103, contains expenditures under  
272.34 paragraph (a), clause (1), equal to at least 16



273.1 percent of the total required under Code of  
273.2 Federal Regulations, title 45, section 263.1.

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

273.9 (e) For the federal fiscal years beginning on  
273.10 or after October 1, 2007, the commissioner  
273.11 may not claim an amount of TANF/MOE in  
273.12 excess of the 75 percent standard in Code  
273.13 of Federal Regulations, title 45, section  
273.14 263.1(a)(2), except:

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

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

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

273.32 For the purposes of clauses (1) to (3),  
273.33 the commissioner may supplement the  
273.34 MOE claim with working family credit

274.1 expenditures or other qualified expenditures  
274.2 to the extent such expenditures are otherwise  
274.3 available after considering the expenditures  
274.4 allowed in this subdivision.

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

274.8 **Working Family Credit Expenditures**  
274.9 **as TANF/MOE.** The commissioner may  
274.10 claim as TANF maintenance of effort up to  
274.11 \$6,707,000 per year of working family credit  
274.12 expenditures for fiscal years 2012 and 2013.

274.13 **Working Family Credit Expenditures**  
274.14 **to be Claimed for TANF/MOE.** The  
274.15 commissioner may count the following  
274.16 amounts of working family credit  
274.17 expenditures as TANF/MOE:

274.18 (1) fiscal year 2012, \$37,517,000;

274.19 (2) fiscal year 2013, \$28,171,000;

274.20 (3) fiscal year 2014, \$34,097,000; and

274.21 (4) fiscal year 2015, \$34,100,000.

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

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

274.30 (1) fiscal year 2012, \$25,020,000;

274.31 (2) fiscal year 2013, \$12,020,000;

274.32 (3) fiscal year 2014, \$15,818,000; and

275.1 (4) fiscal year 2015, \$15,818,000.

275.2 (b) The commissioner shall authorize the  
275.3 transfer of sufficient TANF funds to the  
275.4 federal child care and development fund to  
275.5 meet this appropriation and shall ensure that  
275.6 all transferred funds are expended according  
275.7 to federal child care and development fund  
275.8 regulations.

275.9 **Food Stamps Employment and Training**  
275.10 **Funds.** (a) Notwithstanding Minnesota  
275.11 Statutes, sections 256D.051, subdivisions 1a,  
275.12 6b, and 6c, and 256J.626, federal food stamps  
275.13 employment and training funds received  
275.14 as reimbursement for child care assistance  
275.15 program expenditures must be deposited in  
275.16 the general fund. The amount of funds must  
275.17 be limited to \$500,000 per year in fiscal  
275.18 years 2012 through 2015, contingent upon  
275.19 approval by the federal Food and Nutrition  
275.20 Service.

275.21 (b) Consistent with the receipt of these  
275.22 federal funds, the commissioner may  
275.23 adjust the level of working family credit  
275.24 expenditures claimed as TANF maintenance  
275.25 of effort. Notwithstanding any contrary  
275.26 provision in this article, this rider expires  
275.27 June 30, 2015.

275.28 **ARRA Food Support Benefit Increases.**  
275.29 The funds provided for food support benefit  
275.30 increases under the Supplemental Nutrition  
275.31 Assistance Program provisions of the  
275.32 American Recovery and Reinvestment Act  
275.33 (ARRA) of 2009 must be used for benefit  
275.34 increases beginning July 1, 2009.

276.1 **Supplemental Security Interim Assistance**  
 276.2 **Reimbursement Funds.** \$2,800,000 of  
 276.3 uncommitted revenue available to the  
 276.4 commissioner of human services for SSI  
 276.5 advocacy and outreach services must be  
 276.6 transferred to and deposited into the general  
 276.7 fund by October 1, 2011.

276.8 **Transfer.** By June 30, 2012, the  
 276.9 commissioner of management and budget  
 276.10 must transfer \$49,694,000 from the health  
 276.11 care access fund to the general fund. By June  
 276.12 30, 2013, the commissioner of management  
 276.13 and budget must transfer \$5,000,000 from the  
 276.14 health care access fund to the general fund.

276.15 **Subd. 2. Central Office Operations**

276.16 The amounts that may be spent from this  
 276.17 appropriation for each purpose are as follows:

276.18 **(a) Operations**

276.19	<u>Appropriations by Fund</u>	
276.20 <u>General</u>	<u>72,547,000</u>	<u>71,077,000</u>
276.21 <u>Health Care Access</u>	<u>11,508,000</u>	<u>11,508,000</u>
276.22 <u>State Government</u>		
276.23 <u>Special Revenue</u>	<u>440,000</u>	<u>440,000</u>
276.24 <u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>

276.25 **DHS Receipt Center Accounting.** The  
 276.26 commissioner is authorized to transfer  
 276.27 appropriations to, and account for DHS  
 276.28 receipt center operations in, the special  
 276.29 revenue fund.

276.30 **Administrative Recovery; Set-Aside.** The  
 276.31 commissioner may invoice local entities  
 276.32 through the SWIFT accounting system as an  
 276.33 alternative means to recover the actual cost  
 276.34 of administering the following provisions:

277.1 (1) Minnesota Statutes, section 125A.744,  
 277.2 subdivision 3;

277.3 (2) Minnesota Statutes, section 245.495,  
 277.4 paragraph (b);

277.5 (3) Minnesota Statutes, section 256B.0625,  
 277.6 subdivision 20, paragraph (k);

277.7 (4) Minnesota Statutes, section 256B.0924,  
 277.8 subdivision 6, paragraph (g);

277.9 (5) Minnesota Statutes, section 256B.0945,  
 277.10 subdivision 4, paragraph (d); and

277.11 (6) Minnesota Statutes, section 256F.10,  
 277.12 subdivision 6, paragraph (b).

277.13 **Payments for Cost Settlements.** The  
 277.14 commissioner is authorized to use amounts  
 277.15 repaid to the general assistance medical care  
 277.16 program under Minnesota Statutes 2009  
 277.17 Supplement, section 256D.03, subdivision  
 277.18 3, to pay cost settlements for claims for  
 277.19 services provided prior to June 1, 2010.

277.20 Notwithstanding any contrary provision in  
 277.21 this article, this provision does not expire.

277.22 **Base Adjustment.** The general fund base  
 277.23 for fiscal year 2014 shall be increased by  
 277.24 \$68,000 and decreased by \$11,000 in fiscal  
 277.25 year 2015.

277.26 **(b) Children and Families**

277.27	<u>Appropriations by Fund</u>		
277.28	<u>General</u>	<u>9,457,000</u>	<u>9,337,000</u>
277.29	<u>Federal TANF</u>	<u>2,160,000</u>	<u>2,160,000</u>

277.30 **Financial Institution Data Match and**

277.31 **Payment of Fees.** The commissioner is  
 277.32 authorized to allocate up to \$310,000 each  
 277.33 year in fiscal years 2012 and 2013 from the

278.1 PRISM special revenue account to make  
 278.2 payments to financial institutions in exchange  
 278.3 for performing data matches between account  
 278.4 information held by financial institutions  
 278.5 and the public authority's database of child  
 278.6 support obligors as authorized by Minnesota  
 278.7 Statutes, section 13B.06, subdivision 7.

278.8 **Base Adjustment.** The general fund base  
 278.9 is decreased by \$47,000 in fiscal years 2014  
 278.10 and 2015.

278.11 **(c) Health Care**

278.12		<u>Appropriations by Fund</u>	
278.13	<u>General</u>	<u>16,376,000</u>	<u>16,278,000</u>
278.14	<u>Health Care Access</u>	<u>22,623,000</u>	<u>26,926,000</u>

278.15 **Minnesota Senior Health Options**

278.16 **Reimbursement.** Federal administrative  
 278.17 reimbursement resulting from the Minnesota  
 278.18 senior health options project is appropriated  
 278.19 to the commissioner for this activity.

278.20 **Utilization Review.** Federal administrative  
 278.21 reimbursement resulting from prior  
 278.22 authorization and inpatient admission  
 278.23 certification by a professional review  
 278.24 organization shall be dedicated to the  
 278.25 commissioner for these purposes. A portion  
 278.26 of these funds must be used for activities to  
 278.27 decrease unnecessary pharmaceutical costs  
 278.28 in medical assistance.

278.29 **Base Adjustment.** The general fund base  
 278.30 shall be decreased by \$2,000 in fiscal year  
 278.31 2014 and \$114,000 in fiscal year 2015.

278.32 The health care access fund base is decreased  
 278.33 by \$411,000 in fiscal year 2014 and \$880,000  
 278.34 in fiscal year 2015.

279.1 **(d) Continuing Care**

279.2	<u>Appropriations by Fund</u>		
279.3	<u>General</u>	<u>18,078,000</u>	<u>17,864,000</u>
279.4	<u>State Government</u>		
279.5	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

279.6 **Region 10 Administrative Expenses.**

279.7 \$100,000 is appropriated each fiscal  
 279.8 year, beginning in fiscal year 2012, for  
 279.9 the administration of the State Quality  
 279.10 Improvement and Licensing System under  
 279.11 Minnesota Statutes, section 256B.0961.

279.12 **Base Adjustment.** The general fund base is  
 279.13 decreased by \$662,000 in fiscal year 2014  
 279.14 and \$762,000 in fiscal year 2015.

279.15 **(e) Chemical and Mental Health**

279.16	<u>Appropriations by Fund</u>		
279.17	<u>General</u>	<u>4,194,000</u>	<u>4,194,000</u>
279.18	<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>

279.19 **Subd. 3. Forecasted Programs**

279.20 The amounts that may be spent from this  
 279.21 appropriation for each purpose are as follows:

279.22 **(a) MFIP/DWP Grants**

279.23	<u>Appropriations by Fund</u>		
279.24	<u>General</u>	<u>83,986,000</u>	<u>88,187,000</u>
279.25	<u>Federal TANF</u>	<u>84,425,000</u>	<u>75,417,000</u>

279.26 **(b) MFIP Child Care Assistance Grants** 39,012,000 44,805,000

279.27 **(c) General Assistance Grants and Adult**  
 279.28 **Assistance** 48,774,000 44,003,000

279.29 **General Assistance Standard.** The  
 279.30 commissioner shall set the monthly standard  
 279.31 of assistance for general assistance units  
 279.32 consisting of an adult recipient who is  
 279.33 childless and unmarried or living apart  
 279.34 from parents or a legal guardian at \$203.

280.1 The commissioner may reduce this amount  
 280.2 according to Laws 1997, chapter 85, article  
 280.3 3, section 54. This paragraph expires  
 280.4 September 30, 2012.

280.5 **Emergency General Assistance.** The  
 280.6 amount appropriated for emergency general  
 280.7 assistance funds is limited to no more  
 280.8 than \$7,089,812 in fiscal year 2012 and  
 280.9 \$1,682,453 in fiscal year 2013. Funds  
 280.10 to counties shall be allocated by the  
 280.11 commissioner using the allocation method  
 280.12 specified in Minnesota Statutes, section  
 280.13 256D.06. This paragraph expires September  
 280.14 30, 2012.

280.15 **Base Adjustment.** The general fund base  
 280.16 for adult assistance is \$44,512,000 in fiscal  
 280.17 years 2014 and 2015.

280.18 <b><u>(d) Minnesota Supplemental Aid Grants</u></b>	<u>34,460,000</u>	<u>33,532,000</u>
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280.19 **Emergency Minnesota Supplemental**  
 280.20 **Aid Funds.** The amount appropriated for  
 280.21 emergency Minnesota supplemental aid  
 280.22 funds is limited to no more than \$367,000  
 280.23 in fiscal year 2012. Funds to counties shall  
 280.24 be allocated by the commissioner using the  
 280.25 allocation method specified in Minnesota  
 280.26 Statutes, section 256D.46. This paragraph  
 280.27 expires September 30, 2012.

280.28 <b><u>(e) Group Residential Housing Grants</u></b>	<u>121,080,000</u>	<u>129,238,000</u>
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280.29 <b><u>(f) MinnesotaCare Grants</u></b>	<u>271,430,000</u>	<u>260,619,000</u>
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280.30 This appropriation is from the health care  
 280.31 access fund.

280.32 <b><u>(g) GAMC Grants</u></b>	<u>174,150,000</u>	<u>232,200,000</u>
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281.1 **General Assistance Medical Care**

281.2 **Payments.** For general assistance medical  
281.3 care payments under Minnesota Statutes,  
281.4 section 256D.031:

281.5 \$120,150,000 in fiscal year 2012 and  
281.6 \$160,200,000 in fiscal year 2013 are for  
281.7 payments to coordinated care delivery  
281.8 systems under Minnesota Statutes, section  
281.9 256D.031, subdivision 7; and

281.10 \$54,000,000 in fiscal year 2012 and  
281.11 \$72,000,000 in fiscal year 2013 are for  
281.12 payments for prescription drugs under  
281.13 Minnesota Statutes, section 256D.031,  
281.14 subdivision 9.

281.15 Any amount under paragraph (g) that is not  
281.16 spent in the first year does not cancel and is  
281.17 available for payments in the second year.

281.18 The commissioner may transfer any  
281.19 unexpended amount under Minnesota  
281.20 Statutes, section 256D.031, subdivision 9,  
281.21 after the final allocation in fiscal year 2011 to  
281.22 make payments under Minnesota Statutes,  
281.23 section 256D.031, subdivision 7.

281.24 **(h) Medical Assistance Grants** 4,175,592,000 3,938,873,000

281.25 **Managed Care Incentive Payments.** The  
281.26 commissioner shall not make managed care  
281.27 incentive payments for expanding preventive  
281.28 services. This provision does not expire.

281.29 **Capitation Payment Delay.** The  
281.30 commissioner shall delay 71 percent of the  
281.31 medical assistance capitation payment for  
281.32 families with children to managed care plans  
281.33 and county-based purchasing plans due in  
281.34 May of 2013 until July of 2013.

282.1 **Reduction of Rates for Congregate**

282.2 **Living for Individuals with Lower Needs.**

282.3 Beginning October 1, 2011, lead agencies  
282.4 must reduce rates in effect on January 1,  
282.5 2011, by ten percent for individuals with  
282.6 lower needs living in foster care settings  
282.7 where the license holder does not share the  
282.8 residence with recipients on the CADI, DD,  
282.9 and TBI waivers and customized living  
282.10 settings for CADI and TBI. Lead agencies  
282.11 must adjust contracts within 60 days of the  
282.12 effective date.

282.13 **Reduction of Lead Agency Waiver**

282.14 **Allocations to Implement Rate Reductions**

282.15 **for Congregate Living for Individuals**

282.16 **with Lower Needs.** Beginning October 1,  
282.17 2011, the commissioner shall reduce lead  
282.18 agency waiver allocations to implement the  
282.19 reduction of rates for individuals with lower  
282.20 needs living in foster care settings where the  
282.21 license holder does not share the residence  
282.22 with recipients on the CADI, DD, and TBI  
282.23 waivers and customized living settings for  
282.24 CADI and TBI.

282.25 **Manage Elderly Waiver Growth.**

282.26 Beginning July 1, 2011, and ending on June  
282.27 30, 2013, the commissioner shall manage  
282.28 the elderly waiver so that the number of  
282.29 people does not exceed the number on June  
282.30 30, 2011.

282.31 **Reduce customized living and 24-hour**

282.32 **customized living component rates.**

282.33 Effective July 1, 2011, the commissioner  
282.34 shall reduce elderly waiver customized living  
282.35 and 24-hour customized living component

283.1 service spending by ten percent through  
283.2 reductions in component rates and service  
283.3 rate limits. The commissioner shall adjust  
283.4 the elderly waiver capitation payment  
283.5 rates for managed care organizations paid  
283.6 under Minnesota Statutes, section 256B.69,  
283.7 subdivisions 6a and 23, to reflect reductions  
283.8 in component spending for customized living  
283.9 services and 24-hour customized living  
283.10 services under Minnesota Statutes, section  
283.11 256B.0915, subdivisions 3e and 3h, for the  
283.12 contract period beginning January 1, 2012.  
283.13 To implement the reduction specified in  
283.14 this provision, capitation rates paid by the  
283.15 commissioner to managed care organizations  
283.16 under Minnesota Statutes, section 256B.69,  
283.17 shall reflect a 20 percent reduction for the  
283.18 specified services for the period January 1,  
283.19 2012, to June 30, 2012, and a ten percent  
283.20 reduction for those services on or after July  
283.21 1, 2012.

283.22 **Limit Growth in the Developmental**  
283.23 **Disability Waiver.** For the biennium  
283.24 beginning July 1, 2011, the commissioner  
283.25 shall limit the developmental disability  
283.26 waiver to the number of recipients served  
283.27 in March 2010. If necessary to achieve  
283.28 this level, the commissioner shall not  
283.29 refill waiver openings until the number of  
283.30 waiver recipients reaches the March 2010  
283.31 level. Once the March 2010 enrollment  
283.32 level is reached, the commissioner shall  
283.33 refill vacated openings to maintain the  
283.34 March 2010 enrollment level. To the  
283.35 extent possible, waiver allocations shall  
283.36 be available to individuals who meet the

284.1 priorities for accessing waiver services  
284.2 described in Minnesota Statutes, section  
284.3 256B.092, subdivision 12. The limits do not  
284.4 include conversions from intermediate care  
284.5 facilities for persons with developmental  
284.6 disabilities. When implementing the waiver  
284.7 enrollment limits under this provision, it  
284.8 is an absolute defense to an appeal under  
284.9 Minnesota Statutes, section 256.045, if  
284.10 the commissioner or lead agency proves  
284.11 that it followed the established written  
284.12 procedures and criteria and determined that  
284.13 home and community-based services could  
284.14 not be provided to the person within the  
284.15 appropriations or lead agency's allocation of  
284.16 home and community-based services money.

284.17 **Limit Growth in the Community**  
284.18 **Alternatives for Disabled Individuals**  
284.19 **Waiver.** For the biennium beginning  
284.20 July 1, 2011, the commissioner shall limit  
284.21 the community alternatives for disabled  
284.22 individuals waiver to the number of  
284.23 recipients served in March 2010. If necessary  
284.24 to achieve this level, the commissioner shall  
284.25 not refill waiver openings until the number  
284.26 of waiver recipients reaches the March 2010  
284.27 level. Once the March 2010 enrollment  
284.28 level is reached, the commissioner shall  
284.29 refill vacated openings to maintain the  
284.30 March 2010 enrollment level. To the  
284.31 extent possible, waiver allocations shall  
284.32 be available to individuals who meet the  
284.33 priorities for accessing waiver services  
284.34 described in Minnesota Statutes, section  
284.35 256B.49, subdivision 11a. The limits include  
284.36 conversions and diversions, unless the

285.1 commissioner has approved a plan to convert  
285.2 funding due to the closure or downsizing  
285.3 of a residential facility or nursing facility  
285.4 to serve directly affected individuals on  
285.5 the community alternatives for disabled  
285.6 individuals waiver. When implementing  
285.7 the waiver enrollment limits under this  
285.8 provision, it is an absolute defense to an  
285.9 appeal under Minnesota Statutes, section  
285.10 256.045, if the commissioner or lead agency  
285.11 proves that it followed the established written  
285.12 procedures and criteria and determined that  
285.13 home and community-based services could  
285.14 not be provided to the person within the  
285.15 appropriations or lead agency's allocation of  
285.16 home and community-based services money.

285.17 **Limit Growth in the Waiver for**  
285.18 **Individuals with Traumatic Brain Injury.**  
285.19 For the biennium beginning July 1, 2011, the  
285.20 commissioner shall limit the traumatic brain  
285.21 injury waiver to the number of recipients  
285.22 served in March 2010. If necessary to  
285.23 achieve this level, the commissioner shall  
285.24 not refill waiver openings until the number  
285.25 of waiver recipients reaches the March 2010  
285.26 level. Once the March 2010 enrollment  
285.27 level is reached, the commissioner shall  
285.28 refill vacated openings to maintain the  
285.29 March 2010 enrollment level. To the  
285.30 extent possible, waiver allocations shall  
285.31 be available to individuals who meet the  
285.32 priorities for accessing waiver services  
285.33 described in Minnesota Statutes, section  
285.34 256B.49, subdivision 11a. The limits include  
285.35 conversions and diversions, unless the  
285.36 commissioner has approved a plan to convert

286.1 funding due to the closure or downsizing of a  
 286.2 residential facility or nursing facility to serve  
 286.3 directly affected individuals on the traumatic  
 286.4 brain injury waiver. When implementing  
 286.5 the waiver enrollment limits under this  
 286.6 provision, it is an absolute defense to an  
 286.7 appeal under Minnesota Statutes, section  
 286.8 256.045, if the commissioner or lead agency  
 286.9 proves that it followed the established written  
 286.10 procedures and criteria and determined that  
 286.11 home and community-based services could  
 286.12 not be provided to the person within the  
 286.13 appropriations or lead agency's allocation of  
 286.14 home and community-based services money.

286.15 **Personal Care Assistance Relative**  
 286.16 **Care.** The commissioner shall adjust the  
 286.17 capitation payment rates for managed care  
 286.18 organizations paid under Minnesota Statutes,  
 286.19 section 256B.69, to reflect the rate reductions  
 286.20 for personal care assistance provided by  
 286.21 a relative pursuant to Minnesota Statutes,  
 286.22 section 256B.0659, subdivision 11.

286.23	<b><u>(i) Alternative Care Grants</u></b>	<u>45,727,000</u>	<u>47,877,000</u>
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286.24 **Alternative Care Transfer.** Any money  
 286.25 allocated to the alternative care program that  
 286.26 is not spent for the purposes indicated does  
 286.27 not cancel but shall be transferred to the  
 286.28 medical assistance account.

286.29	<b><u>(j) Chemical Dependency Entitlement Grants</u></b>	<u>108,568,000</u>	<u>123,095,000</u>
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286.30 **Subd. 4. Grant Programs**

286.31 The amounts that may be spent from this  
 286.32 appropriation for each purpose are as follows:

286.33 **(a) Support Services Grants**

287.1	<u>Appropriations by Fund</u>		
287.2	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
287.3	<u>Federal TANF</u>	<u>100,525,000</u>	<u>94,611,000</u>

287.4 **MFIP Consolidated Fund Grants.** The  
 287.5 TANF fund base is reduced by \$10,000,000  
 287.6 each year beginning in fiscal year 2012.

287.7 **Subsidized Employment Funding Through**  
 287.8 **ARRA.** The commissioner is authorized to  
 287.9 apply for TANF emergency fund grants for  
 287.10 subsidized employment activities. Growth  
 287.11 in expenditures for subsidized employment  
 287.12 within the supported work program and the  
 287.13 MFIP consolidated fund over the amount  
 287.14 expended in the calendar year quarters in  
 287.15 the TANF emergency fund base year shall  
 287.16 be used to leverage the TANF emergency  
 287.17 fund grants for subsidized employment and  
 287.18 to fund supported work. The commissioner  
 287.19 shall develop procedures to maximize  
 287.20 reimbursement of these expenditures over the  
 287.21 TANF emergency fund base year quarters,  
 287.22 and may contract directly with employers  
 287.23 and providers to maximize these TANF  
 287.24 emergency fund grants.

287.25	<b><u>(b) Basic Sliding Fee Child Care Assistance</u></b>		
287.26	<b><u>Grants</u></b>	<u>36,067,000</u>	<u>37,342,000</u>

287.27 **Base Adjustment.** The general fund base is  
 287.28 decreased by \$1,490,000 in fiscal year 2014  
 287.29 and \$867,000 in fiscal year 2015.

287.30 **Child Care and Development Fund**  
 287.31 **Unexpended Balance.** In addition to  
 287.32 the amount provided in this section, the  
 287.33 commissioner shall expend \$5,000,000  
 287.34 in fiscal year 2012 from the federal child  
 287.35 care and development fund unexpended

288.1 balance for basic sliding fee child care under  
 288.2 Minnesota Statutes, section 119B.03. The  
 288.3 commissioner shall ensure that all child  
 288.4 care and development funds are expended  
 288.5 according to the federal child care and  
 288.6 development fund regulations.

288.7 **(c) Child Care Development Grants** 232,000 232,000

288.8 **Base Adjustment.** The general fund base is  
 288.9 increased by \$1,255,000 in fiscal years 2014  
 288.10 and 2015.

288.11 **(d) Child Support Enforcement Grants** 50,000 50,000

288.12 **Federal Child Support Demonstration**  
 288.13 **Grants.** Federal administrative  
 288.14 reimbursement resulting from the federal  
 288.15 child support grant expenditures authorized  
 288.16 under section 1115a of the Social Security  
 288.17 Act is appropriated to the commissioner for  
 288.18 this activity.

288.19 **(e) Children's Services Grants**

288.20	<u>Appropriations by Fund</u>		
288.21	<u>General</u>	<u>45,654,000</u>	<u>45,654,000</u>
288.22	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

288.23 **Adoption Assistance and Relative Custody**  
 288.24 **Assistance Payments.** \$1,661,000 each  
 288.25 year is for continuation of current payments  
 288.26 for adoption assistance and relative custody  
 288.27 assistance.

288.28 **Adoption Assistance and Relative Custody**  
 288.29 **Assistance Transfer.** The commissioner  
 288.30 may transfer unencumbered appropriation  
 288.31 balances for adoption assistance and relative  
 288.32 custody assistance between fiscal years and  
 288.33 between programs.



289.1 **Privatized Adoption Grants.** Federal  
 289.2 reimbursement for privatized adoption grant  
 289.3 and foster care recruitment grant expenditures  
 289.4 is appropriated to the commissioner for  
 289.5 adoption grants and foster care and adoption  
 289.6 administrative purposes.

289.7 **Adoption Assistance Incentive Grants.**  
 289.8 Federal funds available during fiscal year  
 289.9 2012 and fiscal year 2013 for adoption  
 289.10 incentive grants are appropriated to the  
 289.11 commissioner for these purposes.

289.12 **Base Adjustment.** The general fund base is  
 289.13 increased by \$1,134,000 in fiscal years 2014  
 289.14 and 2015.

289.15 **(f) Children and Community Services Grants** 54,301,000 52,301,000

289.16 **(g) Children and Economic Support Grants**

289.17	<u>Appropriations by Fund</u>		
289.18	<u>General</u>	<u>15,770,000</u>	<u>15,772,000</u>
289.19	<u>Federal TANF</u>	<u>700,000</u>	<u>0</u>

289.20 **Long-Term Homeless Services.** \$700,000  
 289.21 is appropriated from the federal TANF  
 289.22 fund for the biennium beginning July  
 289.23 1, 2011, to the commissioner of human  
 289.24 services for long-term homeless services  
 289.25 for low-income homeless families under  
 289.26 Minnesota Statutes, section 256K.26. This  
 289.27 is a onetime appropriation and is not added  
 289.28 to the base.

289.29 **Base Adjustment.** The general fund base is  
 289.30 increased by \$42,000 in fiscal year 2014 and  
 289.31 \$43,000 in fiscal year 2015.

289.32 **(h) Health Care Grants** 150,000 150,000

289.33 This appropriation is from the health care  
 289.34 access fund.

290.1 **Surplus Appropriation Canceled.** Of the  
 290.2 health care access fund appropriation in  
 290.3 Laws 2009, chapter 79, article 13, section 3,  
 290.4 subdivision 6, paragraph (e), for the COBRA  
 290.5 premium state subsidy program, \$11,750,000  
 290.6 must be canceled in fiscal year 2011. This  
 290.7 provision is effective the day following final  
 290.8 enactment.

290.9 <b><u>(i) Aging and Adult Services Grants</u></b>	<u>18,734,000</u>	<u>18,910,000</u>
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290.10 **Aging Grants Reduction.** Effective July  
 290.11 1, 2011, funding for grants made under  
 290.12 Minnesota Statutes, sections 256.9754 and  
 290.13 256B.0917, subdivision 13, is reduced by  
 290.14 \$3,600,000 for each year of the biennium.  
 290.15 These reductions are onetime and do  
 290.16 not affect base funding for the 2014-2015  
 290.17 biennium. Grants made during the 2012-2013  
 290.18 biennium under Minnesota Statutes, section  
 290.19 256B.9754, must not be used for new  
 290.20 construction or building renovation.

290.21 **Base Level Adjustment.** The general fund  
 290.22 base is increased by \$3,600,000 in fiscal year  
 290.23 2014 and increased by \$3,600,000 in fiscal  
 290.24 year 2015.

290.25 <b><u>(j) Deaf and Hard-of-Hearing Grants</u></b>	<u>1,936,000</u>	<u>1,767,000</u>
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290.26 <b><u>(k) Disabilities Grants</u></b>	<u>15,438,000</u>	<u>18,432,000</u>
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290.27 **HIV Grants.** The general fund appropriation  
 290.28 for the HIV drug and insurance grant  
 290.29 program shall be reduced by \$2,425,000 in  
 290.30 fiscal year 2012 and increased by \$2,425,000  
 290.31 in fiscal year 2014. These adjustments are  
 290.32 onetime and shall not be applied to the base.  
 290.33 Notwithstanding any contrary provision, this  
 290.34 provision expires June 30, 2014. Money

291.1 appropriated for the HIV drug and insurance  
 291.2 grant program in fiscal year 2014 may be  
 291.3 used in either year of the biennium.

291.4 **Region 10.** Any unspent allocation for  
 291.5 Region 10 Quality Assurance from the  
 291.6 biennium beginning on July 1, 2009, may be  
 291.7 carried over into the biennium beginning on  
 291.8 July 1, 2011.

291.9 **Base Level Adjustment.** The general fund  
 291.10 base is increased by \$2,425,000 in fiscal year  
 291.11 2014 only.

291.12 **Local Planning Grants for Creating**  
 291.13 **Alternatives to Congregate Living for**  
 291.14 **Individuals with Lower Needs.** The  
 291.15 commissioner shall make available a total  
 291.16 of \$250,000 per year in local planning  
 291.17 grants, beginning July 1, 2011, to assist  
 291.18 lead agencies and provider organizations in  
 291.19 developing alternatives to congregate living  
 291.20 within the available level of resources for the  
 291.21 home and community-based services waivers  
 291.22 for persons with disabilities.

291.23 **(l) Adult Mental Health Grants**

291.24	<u>Appropriations by Fund</u>		
291.25	<u>General</u>	<u>69,957,000</u>	<u>69,957,000</u>
291.26	<u>Health Care Access</u>	<u>375,000</u>	<u>375,000</u>
291.27	<u>Lottery Prize Fund</u>	<u>1,508,000</u>	<u>1,508,000</u>

291.28 **Funding Usage.** Up to 75 percent of a fiscal  
 291.29 year's appropriation for adult mental health  
 291.30 grants may be used to fund allocations in that  
 291.31 portion of the fiscal year ending December  
 291.32 31.

291.33 **Base Adjustment.** The general fund base is  
 291.34 increased by \$813,000 in fiscal years 2014

292.1	<u>and 2015. The health care access fund base</u>		
292.2	<u>is increased by \$375,000 in fiscal years 2014</u>		
292.3	<u>and 2015.</u>		
292.4	<b><u>(m) Children's Mental Health Grants</u></b>	<u>14,251,000</u>	<u>14,251,000</u>
292.5	<b><u>Funding Usage.</u></b> <u>Up to 75 percent of a fiscal</u>		
292.6	<u>year's appropriation for children's mental</u>		
292.7	<u>health grants may be used to fund allocations</u>		
292.8	<u>in that portion of the fiscal year ending</u>		
292.9	<u>December 31.</u>		
292.10	<b><u>Base Adjustment.</u></b> <u>The general fund base is</u>		
292.11	<u>increased by \$2,431,000 in fiscal years 2014</u>		
292.12	<u>and 2015.</u>		
292.13	<b><u>(n) Chemical Dependency Nonentitlement</u></b>		
292.14	<b><u>Grants</u></b>	<u>1,336,000</u>	<u>1,336,000</u>
292.15	<b><u>Subd. 5. State-Operated Services</u></b>		
292.16	<b><u>Transfer Authority Related to</u></b>		
292.17	<b><u>State-Operated Services.</u></b> <u>Money</u>		
292.18	<u>appropriated for state-operated services</u>		
292.19	<u>may be transferred between fiscal years</u>		
292.20	<u>of the biennium with the approval of the</u>		
292.21	<u>commissioner of management and budget.</u>		
292.22	<b><u>(a) State-Operated Services Mental Health</u></b>	<u>115,286,000</u>	<u>115,135,000</u>
292.23	<u>The commissioner shall close the Community</u>		
292.24	<u>Behavioral Health Hospital-Willmar on or</u>		
292.25	<u>before June 30, 2011. The commissioner</u>		
292.26	<u>shall relocate the Child and Adolescent</u>		
292.27	<u>Behavioral Health Hospital located in</u>		
292.28	<u>the former Willmar Regional Treatment</u>		
292.29	<u>Center to the facility previously housing</u>		
292.30	<u>the Community Behavioral Health</u>		
292.31	<u>Hospital-Willmar.</u>		
292.32	<b><u>(b) Minnesota Security Hospital</u></b>	<u>69,582,000</u>	<u>69,582,000</u>
292.33	<b><u>Subd. 6. Sex Offender Program</u></b>	<u>70,416,000</u>	<u>67,570,000</u>

293.1 **Transfer Authority Related to Minnesota**

293.2 **Sex Offender Program. Money**

293.3 appropriated for the Minnesota sex offender

293.4 program may be transferred between fiscal

293.5 years of the biennium with the approval

293.6 of the commissioner of management and

293.7 budget.

293.8 **Minnesota Sex Offender Program**

293.9 **Reduction.** The fiscal year 2011 general

293.10 fund appropriation for Minnesota sex

293.11 offender services under Laws 2009, chapter

293.12 79, article 13, section 3, subdivision 10,

293.13 paragraph (b), is reduced by \$3,000,000.

293.14 This paragraph is effective the day following

293.15 final enactment.

293.16 **Subd. 7. Technical Activities**

92,206,000

79,551,000

293.17 This appropriation is from the federal TANF

293.18 fund.

293.19 **Base Level Adjustment.** The TANF fund

293.20 base is increased by \$4,155,000 in fiscal year

293.21 2014 and increased by \$4,582,000 in fiscal

293.22 year 2015.

293.23 **Sec. 4. COMMISSIONER OF HEALTH**

293.24 **Subdivision 1. Total Appropriation**

**\$**

**132,589,000**

**\$**

**123,237,000**

293.25 Appropriations by Fund

293.26 2012 2013

293.27 General 69,455,000 64,341,000

293.28 State Government

293.29 Special Revenue 45,387,000 45,376,000

293.30 Health Care Access 11,381,000 7,155,000

293.31 Federal TANF 6,366,000 6,365,000

293.32 The amounts that may be spent for each

293.33 purpose are specified in the following

293.34 subdivisions.

294.1 Subd. 2. Community and Family Health  
 294.2 Promotion

294.3	<u>Appropriations by Fund</u>		
294.4	<u>General</u>	<u>43,539,000</u>	<u>38,799,000</u>
294.5	<u>State Government</u>		
294.6	<u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>
294.7	<u>Health Care Access</u>	<u>1,719,000</u>	<u>1,719,000</u>
294.8	<u>Federal TANF</u>	<u>6,366,000</u>	<u>6,365,000</u>

294.9 TANF Appropriations. (1) \$578,000 of the  
 294.10 TANF funds is appropriated each year to the  
 294.11 commissioner for family planning grants  
 294.12 under Minnesota Statutes, section 145.925.

294.13 (2) \$1,790,000 of the TANF funds is  
 294.14 appropriated each year to the commissioner  
 294.15 for home visiting and nutritional services  
 294.16 listed under Minnesota Statutes, section  
 294.17 145.882, subdivision 7, clauses (6) and (7).

294.18 Funds must be distributed to community  
 294.19 health boards according to Minnesota  
 294.20 Statutes, section 145A.131, subdivision 1.

294.21 (3) \$1,000,000 of the TANF funds is  
 294.22 appropriated each year to the commissioner  
 294.23 for decreasing infant mortality rates under  
 294.24 Minnesota Statutes, section 145.928,  
 294.25 subdivision 7.

294.26 (4) \$2,998,000 of the TANF funds is  
 294.27 appropriated each year to the commissioner  
 294.28 for the family home visiting grant program  
 294.29 according to Minnesota Statutes, section  
 294.30 145A.17. \$2,000,000 of the funding must  
 294.31 be distributed to community health boards  
 294.32 according to Minnesota Statutes, section  
 294.33 145A.131, subdivision 1. \$998,000 of  
 294.34 the funding must be distributed to tribal  
 294.35 governments based on Minnesota Statutes,  
 294.36 section 145A.14, subdivision 2a.

295.1 (5) The commissioner may use up to 7.06  
 295.2 percent of the funds appropriated each fiscal  
 295.3 year to conduct the ongoing evaluations  
 295.4 required under Minnesota Statutes, section  
 295.5 145A.17, subdivision 7, and training and  
 295.6 technical assistance as required under  
 295.7 Minnesota Statutes, section 145A.17,  
 295.8 subdivisions 4 and 5.

295.9 **TANF Carryforward.** Any unexpended  
 295.10 balance of the TANF appropriation in the  
 295.11 first year of the biennium does not cancel but  
 295.12 is available for the second year.

295.13 **Base Level Adjustment.** The general fund  
 295.14 base is decreased by \$5,000 in fiscal years  
 295.15 2014 and 2015.

295.16 **Subd. 3. Policy Quality and Compliance**

295.17		<u>Appropriations by Fund</u>	
295.18	<u>General</u>	<u>10,395,000</u>	<u>10,023,000</u>
295.19	<u>State Government</u>		
295.20	<u>Special Revenue</u>	<u>14,026,000</u>	<u>14,083,000</u>
295.21	<u>Health Care Access</u>	<u>9,662,000</u>	<u>5,436,000</u>

295.22 **Medical Education and Research**

295.23 **Costs (MERC) Fund Transfers.** The  
 295.24 commissioner of management and budget  
 295.25 shall transfer \$9,800,000 from the MERC  
 295.26 fund to the general fund by October 1, 2011.

295.27 **White Earth Clinic.** Of the general fund  
 295.28 appropriation, \$500,000 in the first year and  
 295.29 \$200,000 in the second year is for a grant  
 295.30 to the White Earth Band of Ojibwe Indians.  
 295.31 If the White Earth Band of Ojibwe Indians  
 295.32 accepts this grant, funds must be used for  
 295.33 the White Earth Clinic under Minnesota  
 295.34 Statutes, section 145.9271. The base for this

296.1 program is \$200,000 for each of fiscal years  
296.2 2014 and 2015.

296.3 **Comprehensive Advanced Life Support.**

296.4 Of the general fund appropriation, \$31,000  
296.5 each year is added to the base of the  
296.6 comprehensive advanced life support  
296.7 (CALs) program under Minnesota Statutes,  
296.8 section 144.6062.

296.9 **Unused Federal Match Funds.** Of the  
296.10 funds appropriated in Laws 2009, chapter  
296.11 79, article 13, section 4, subdivision 3, for  
296.12 state matching funds for the federal Health  
296.13 Information Technology for Economic and  
296.14 Clinical Health Act, \$2,800,000 is transferred  
296.15 to the health care access fund by October 1,  
296.16 2011.

296.17 **Loan Forgiveness.** \$1,014,000 is  
296.18 appropriated from the health care access  
296.19 fund in fiscal year 2012 for the department to  
296.20 fulfill existing obligations of loan forgiveness  
296.21 agreements. This funding is available  
296.22 through fiscal year 2014. In addition, prior  
296.23 year funds appropriated for loan forgiveness  
296.24 and required to fulfill existing obligations do  
296.25 not expire and are available until expended.

296.26 **Administrative Reports.** Of the general  
296.27 fund appropriation, \$82,000 in fiscal year  
296.28 2012 and \$10,000 in fiscal year 2013  
296.29 are for transfer to the commissioner of  
296.30 management and budget for the reduction of  
296.31 the administrative report study.

296.32 **Base Level Adjustment.** The state  
296.33 government special revenue fund base shall  
296.34 be reduced by \$141,000 in fiscal years 2014



297.1	<u>and 2015. The health care access base shall</u>		
297.2	<u>be increased by \$600,000 in fiscal year 2014.</u>		
297.3	<b><u>Subd. 4. Health Protection</u></b>		
297.4	<u>Appropriations by Fund</u>		
297.5	<u>General</u>	<u>9,370,000</u>	<u>9,370,000</u>
297.6	<u>State Government</u>		
297.7	<u>Special Revenue</u>	<u>30,328,000</u>	<u>30,260,000</u>
297.8	<b><u>Subd. 5. Administrative Support Services</u></b>	<u>6,151,000</u>	<u>6,149,000</u>
297.9	<b><u>Sec. 5. COUNCIL ON DISABILITY</u></b>	<b><u>\$ 524,000</u></b>	<b><u>\$ 524,000</u></b>
297.10	<b><u>Sec. 6. OMBUDSMAN FOR MENTAL</u></b>		
297.11	<b><u>HEALTH AND DEVELOPMENTAL</u></b>		
297.12	<b><u>DISABILITIES</u></b>	<b><u>\$ 1,655,000</u></b>	<b><u>\$ 1,655,000</u></b>
297.13	<u>Funds appropriated for fiscal year 2011 are</u>		
297.14	<u>available until expended.</u>		
297.15	<b><u>Sec. 7. OMBUDSPERSON FOR FAMILIES</u></b>	<b><u>\$ 265,000</u></b>	<b><u>\$ 265,000</u></b>
297.16	<b><u>Sec. 8. HEALTH-RELATED BOARDS</u></b>		
297.17	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$ 17,748,000</u></b>	<b><u>\$ 17,534,000</u></b>
297.18	<u>This appropriation is from the state</u>		
297.19	<u>government special revenue fund. The</u>		
297.20	<u>amounts that may be spent for each purpose</u>		
297.21	<u>are specified in the following subdivisions.</u>		
297.22	<b><u>Subd. 2. Board of Chiropractic Examiners</u></b>	<u>469,000</u>	<u>469,000</u>
297.23	<b><u>Subd. 3. Board of Dentistry</u></b>	<u>1,829,000</u>	<u>1,814,000</u>
297.24	<b><u>Health Professional Services Program. Of</u></b>		
297.25	<u>this appropriation, \$704,000 in fiscal year</u>		
297.26	<u>2012 and \$704,000 in fiscal year 2013 from</u>		
297.27	<u>the state government special revenue fund are</u>		
297.28	<u>for the health professional services program.</u>		
297.29	<b><u>Subd. 4. Board of Dietetic and Nutrition</u></b>		
297.30	<b><u>Practice</u></b>	<u>110,000</u>	<u>110,000</u>
297.31	<b><u>Subd. 5. Board of Marriage and Family</u></b>		
297.32	<b><u>Therapy</u></b>	<u>192,000</u>	<u>167,000</u>

298.1 **Rulemaking.** Of this appropriation, \$25,000  
 298.2 in fiscal year 2012 is for rulemaking. This is  
 298.3 a onetime appropriation.

298.4	<b><u>Subd. 6. Board of Medical Practice</u></b>	<u>3,866,000</u>	<u>3,866,000</u>
298.5	<b><u>Subd. 7. Board of Nursing</u></b>	<u>3,694,000</u>	<u>3,551,000</u>
298.6	<b><u>Subd. 8. Board of Nursing Home</u></b>		
298.7	<b><u>Administrators</u></b>	<u>2,153,000</u>	<u>2,145,000</u>

298.8 **Rulemaking.** Of this appropriation, \$44,000  
 298.9 in fiscal year 2012 is for rulemaking. This is  
 298.10 a onetime appropriation.

298.11 **Electronic Licensing System Adaptors.**  
 298.12 Of this appropriation, \$761,000 in fiscal  
 298.13 year 2013 from the state government special  
 298.14 revenue fund is to the administrative services  
 298.15 unit to cover the costs to connect to the  
 298.16 e-licensing system. Minnesota Statutes,  
 298.17 section 16E.22. Base level funding for this  
 298.18 activity in fiscal year 2014 shall be \$100,000.  
 298.19 Base level funding for this activity in fiscal  
 298.20 year 2015 shall be \$50,000.

298.21 **Development and Implementation of a**  
 298.22 **Disciplinary, Regulatory, Licensing and**  
 298.23 **Information Management System.** Of this  
 298.24 appropriation, \$800,000 in fiscal year 2012  
 298.25 and \$300,000 in fiscal year 2013 are for the  
 298.26 development of a shared system. Base level  
 298.27 funding for this activity in fiscal year 2014  
 298.28 shall be \$50,000.

298.29 **Administrative Services Unit - Operating**  
 298.30 **Costs.** Of this appropriation, \$526,000  
 298.31 in fiscal year 2012 and \$526,000 in  
 298.32 fiscal year 2013 are for operating costs  
 298.33 of the administrative services unit. The  
 298.34 administrative services unit may receive

299.1 and expend reimbursements for services  
299.2 performed by other agencies.

299.3 **Administrative Services Unit - Retirement**

299.4 **Costs.** Of this appropriation in fiscal year  
299.5 2012, \$225,000 is for onetime retirement  
299.6 costs in the health-related boards. This  
299.7 funding may be transferred to the health  
299.8 boards incurring those costs for their  
299.9 payment. These funds are available either  
299.10 year of the biennium.

299.11 **Administrative Services Unit - Volunteer**

299.12 **Health Care Provider Program.** Of this  
299.13 appropriation, \$150,000 in fiscal year 2012  
299.14 and \$150,000 in fiscal year 2013 are to pay  
299.15 for medical professional liability coverage  
299.16 required under Minnesota Statutes, section  
299.17 214.40.

299.18 **Administrative Services Unit - Contested**

299.19 **Cases and Other Legal Proceedings.** Of  
299.20 this appropriation, \$200,000 in fiscal year  
299.21 2012 and \$200,000 in fiscal year 2013 are  
299.22 for costs of contested case hearings and other  
299.23 unanticipated costs of legal proceedings  
299.24 involving health-related boards funded  
299.25 under this section. Upon certification of a  
299.26 health-related board to the administrative  
299.27 services unit that the costs will be incurred  
299.28 and that there is insufficient money available  
299.29 to pay for the costs out of money currently  
299.30 available to that board, the administrative  
299.31 services unit is authorized to transfer money  
299.32 from this appropriation to the board for  
299.33 payment of those costs with the approval  
299.34 of the commissioner of management and  
299.35 budget. This appropriation does not cancel.

300.1 Any unencumbered and unspent balances  
 300.2 remain available for these expenditures in  
 300.3 subsequent fiscal years.

300.4 **Base Adjustment.** The State Government  
 300.5 Special Revenue Fund base is decreased by  
 300.6 \$911,000 in fiscal year 2014 and \$1,011,000  
 300.7 in fiscal year 2015.

300.8 Subd. 9. **Board of Optometry** 106,000 106,000

300.9 Subd. 10. **Board of Pharmacy** 2,341,000 2,344,000

300.10 **Prescription Electronic Reporting.** Of  
 300.11 this appropriation, \$356,000 in fiscal year  
 300.12 2012 and \$356,000 in fiscal year 2013 from  
 300.13 the state government special revenue fund  
 300.14 are to the board to operate the prescription  
 300.15 electronic reporting system in Minnesota  
 300.16 Statutes, section 152.126. Base level funding  
 300.17 for this activity in fiscal year 2014 shall be  
 300.18 \$356,000.

300.19 Subd. 11. **Board of Physical Therapy** 389,000 345,000

300.20 **Rulemaking.** Of this appropriation, \$44,000  
 300.21 in fiscal year 2012 is for rulemaking. This is  
 300.22 a onetime appropriation.

300.23 Subd. 12. **Board of Podiatry** 75,000 75,000

300.24 Subd. 13. **Board of Psychology** 846,000 846,000

300.25 Subd. 14. **Board of Social Work** 1,036,000 1,053,000

300.26 Subd. 15. **Board of Veterinary Medicine** 228,000 229,000

300.27 Subd. 16. **Board of Behavioral Health and**  
 300.28 **Therapy** 414,000 414,000

300.29 **Sec. 9. EMERGENCY MEDICAL SERVICES**  
 300.30 **REGULATORY BOARD** **\$ 2,742,000** **\$ 2,742,000**

300.31 **Regional Grants.** \$585,000 in fiscal year  
 300.32 2012 and \$585,000 in fiscal year 2013 are

301.1 for regional emergency medical services  
301.2 programs, to be distributed equally to the  
301.3 eight emergency medical service regions.  
301.4 Notwithstanding Minnesota Statutes, section  
301.5 144E.50, 100 percent of the appropriation  
301.6 shall be granted to the emergency medical  
301.7 service regions.

301.8 **Cooper/Sams Volunteer Ambulance**  
301.9 **Program.** \$700,000 in fiscal year 2012 and  
301.10 \$700,000 in fiscal year 2013 are for the  
301.11 Cooper/Sams volunteer ambulance program  
301.12 under Minnesota Statutes, section 144E.40.

301.13 (a) Of this amount, \$611,000 in fiscal year  
301.14 2012 and \$611,000 in fiscal year 2013  
301.15 are for the ambulance service personnel  
301.16 longevity award and incentive program,  
301.17 under Minnesota Statutes, section 144E.40.

301.18 (b) Of this amount, \$89,000 in fiscal year  
301.19 2012 and \$89,000 in fiscal year 2013 are  
301.20 for the operations of the ambulance service  
301.21 personnel longevity award and incentive  
301.22 program, under Minnesota Statutes, section  
301.23 144E.40.

301.24 **Ambulance Training Grant.** \$361,000 in  
301.25 fiscal year 2012 and \$361,000 in fiscal year  
301.26 2013 are for training grants.

301.27 **EMSRB Board Operations.** \$1,096,000 in  
301.28 fiscal year 2012 and \$1,096,000 in fiscal year  
301.29 2013 are for operations.

301.30 Sec. 10. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision  
301.31 to read:

301.32 Subd. 33. **Federal administrative reimbursement dedicated.** Federal  
301.33 administrative reimbursement resulting from the following activities is appropriated to the  
301.34 commissioner for the designated purposes:

302.1 (1) reimbursement for the Minnesota senior health options project; and  
 302.2 (2) reimbursement related to prior authorization and inpatient admission certification  
 302.3 by a professional review organization. A portion of these funds must be used for activities  
 302.4 to decrease unnecessary pharmaceutical costs in medical assistance.

302.5 Sec. 11. Laws 2010, First Special Session chapter 1, article 15, section 3, subdivision  
 302.6 6, is amended to read:

302.7 Subd. 6. **Continuing Care Grants**

302.8 (a) **Aging and Adult Services Grants** (3,600,000) (3,600,000)

302.9 **Community Service/Service Development**  
 302.10 **Grants Reduction.** Effective retroactively  
 302.11 from July 1, 2009, funding for grants made  
 302.12 under Minnesota Statutes, sections 256.9754  
 302.13 and 256B.0917, subdivision 13, is reduced by  
 302.14 ~~\$5,807,000~~ \$3,600,000 for each year of the  
 302.15 biennium. Grants made during the biennium  
 302.16 under Minnesota Statutes, section 256.9754,  
 302.17 shall not be used for new construction or  
 302.18 building renovation.

302.19 **Aging Grants Delay.** Aging grants must be  
 302.20 reduced by \$917,000 in fiscal year 2011 and  
 302.21 increased by \$917,000 in fiscal year 2012.  
 302.22 These adjustments are onetime and must not  
 302.23 be applied to the base. This provision expires  
 302.24 June 30, 2012.

302.25 (b) **Medical Assistance Long-Term Care**  
 302.26 **Facilities Grants** (3,827,000) (2,745,000)

302.27 **ICF/MR Variable Rates Suspension.**  
 302.28 Effective retroactively from July 1, 2009,  
 302.29 to June 30, 2010, no new variable rates  
 302.30 shall be authorized for intermediate care  
 302.31 facilities for persons with developmental  
 302.32 disabilities under Minnesota Statutes, section  
 302.33 256B.5013, subdivision 1.

303.1	<b>ICF/MR Occupancy Rate Adjustment</b>		
303.2	<b>Suspension.</b> Effective retroactively from		
303.3	July 1, 2009, to June 30, 2011, approval		
303.4	of new applications for occupancy rate		
303.5	adjustments for unoccupied short-term		
303.6	beds under Minnesota Statutes, section		
303.7	256B.5013, subdivision 7, is suspended.		
303.8	<b>(c) Medical Assistance Long-Term Care</b>	(2,318,000)	(5,807,000)
303.9	<b>Waivers and Home Care Grants</b>		
303.10	<b>Developmental Disability Waiver Acuity</b>		
303.11	<b>Factor.</b> Effective retroactively from January		
303.12	1, 2010, the January 1, 2010, one percent		
303.13	growth factor in the developmental disability		
303.14	waiver allocations under Minnesota Statutes,		
303.15	section 256B.092, subdivisions 4 and 5,		
303.16	that is attributable to changes in acuity;		
303.17	<u>is suspended to June 30, 2011 eliminated.</u>		
303.18	<u>Effective January 1, 2012, the one percent</u>		
303.19	<u>growth factor in the developmental</u>		
303.20	<u>disability waiver allocations is eliminated.</u>		
303.21	<u>Notwithstanding any law to the contrary, this</u>		
303.22	<u>provision does not expire.</u>		
303.23	<b>(d) Adult Mental Health Grants</b>	(5,000,000)	-0-
303.24	<b>(e) Chemical Dependency Entitlement Grants</b>	(3,622,000)	(3,622,000)
303.25	<b>(f) Chemical Dependency Nonentitlement</b>		
303.26	<b>Grants</b>	(393,000)	(393,000)
303.27			<del>(2,500,000)</del>
303.28	<b>(g) Other Continuing Care Grants</b>	-0-	<u>(1,414,000)</u>
303.29	<b>Other Continuing Care Grants Delay.</b>		
303.30	Other continuing care grants must be reduced		
303.31	by \$1,414,000 in fiscal year 2011 and		
303.32	increased by \$1,414,000 in fiscal year 2012.		
303.33	These adjustments are onetime and must not		
303.34	be applied to the base. This provision expires		
303.35	June 30, 2012.		

304.1 **(h) Deaf and Hard-of-Hearing Grants** -0- (169,000)

304.2 **Deaf and Hard-of-Hearing Grants Delay.**

304.3 Effective retroactively from July 1, 2010,

304.4 deaf and hard-of-hearing grants must be

304.5 reduced by \$169,000 in fiscal year 2011 and

304.6 increased by \$169,000 in fiscal year 2012.

304.7 These adjustments are onetime and must not

304.8 be applied to the base. This provision expires

304.9 June 30, 2012.

304.10 Sec. 12. **TRANSFERS.**

304.11 Subdivision 1. **Grants.** The commissioner of human services, with the approval  
304.12 of the commissioner of management and budget, and after notification of the chairs of  
304.13 the senate health and human services budget and policy committee and the house of  
304.14 representatives health and human services finance committee, may transfer unencumbered  
304.15 appropriation balances for the biennium ending June 30, 2013, within fiscal years among  
304.16 the MFIP; general assistance; general assistance medical care under Minnesota Statutes,  
304.17 section 256D.03, subdivision 3; medical assistance; MFIP child care assistance under  
304.18 Minnesota Statutes, section 119B.05; Minnesota supplemental aid; MinnesotaCare,  
304.19 and group residential housing programs, and the entitlement portion of the chemical  
304.20 dependency consolidated treatment fund, and between fiscal years of the biennium.

304.21 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative  
304.22 money may be transferred within the Departments of Health and Human Services as the  
304.23 commissioners consider necessary, with the advance approval of the commissioner of  
304.24 management and budget. The commissioner shall inform the chairs of the senate health  
304.25 and human services budget and policy committee and the house of representatives health  
304.26 and human services finance committee quarterly about transfers made under this provision.

304.27 Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

304.28 The commissioners of health and human services shall not use indirect cost  
304.29 allocations to pay for the operational costs of any program for which they are responsible.

304.30 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

304.31 All uncodified language contained in this article expires on June 30, 2013, unless a  
304.32 different expiration date is explicit.



305.1 Sec. 15. **EFFECTIVE DATE.**

305.2 The provisions in this article are effective July 1, 2011, unless a different effective  
305.3 date is specified."

305.4 Delete the title and insert:

305.5 "A bill for an act  
305.6 relating to state government; establishing the health and human services  
305.7 budget; making changes to children and family services, Department of Health,  
305.8 miscellaneous provisions, health licensing fees, health care, and continuing  
305.9 care; redesigning service delivery; making changes to chemical and mental  
305.10 health; modifying fee schedules; modifying program eligibility requirements;  
305.11 authorizing rulemaking; imposing criminal penalties; requiring reports;  
305.12 appropriating money for the Departments of Health and Human Services and  
305.13 other health-related boards and councils; making forecast adjustments; amending  
305.14 Minnesota Statutes 2010, sections 8.31, subdivisions 1, 3a; 62D.08, subdivision  
305.15 7; 62E.08, subdivision 1; 62E.14, by adding a subdivision; 62J.04, subdivisions  
305.16 3, 9; 62J.17, subdivision 4a; 62J.495, by adding a subdivision; 62J.692; 62Q.32;  
305.17 62U.04, subdivisions 3, 9; 62U.06, subdivision 2; 119B.011, subdivision 13;  
305.18 119B.035, subdivision 4; 119B.09, subdivision 10, by adding subdivisions;  
305.19 119B.125, by adding a subdivision; 119B.13, subdivisions 1, 1a, 7; 144.1501,  
305.20 subdivision 1; 144.396, subdivisions 5, 6; 144.98, subdivisions 2a, 7, by adding  
305.21 subdivisions; 144A.102; 144A.61, by adding a subdivision; 144E.123; 145.925,  
305.22 subdivisions 1, 2; 145.928, subdivisions 7, 8; 145A.17, subdivision 3; 148.07,  
305.23 subdivision 1; 148.108, by adding a subdivision; 148.191, subdivision 2;  
305.24 148.212, subdivision 1; 148.231; 148B.17; 148B.33, subdivision 2; 148B.52;  
305.25 150A.091, subdivisions 2, 3, 4, 5, 8, by adding a subdivision; 151.07; 151.101;  
305.26 151.102, by adding a subdivision; 151.12; 151.13, subdivision 1; 151.19; 151.25;  
305.27 151.47, subdivision 1; 151.48; 152.12, subdivision 3; 157.15, by adding a  
305.28 subdivision; 157.20, by adding a subdivision; 245A.14, subdivision 4; 245C.03,  
305.29 by adding a subdivision; 245C.10, by adding a subdivision; 246B.10; 252.025,  
305.30 subdivision 7; 252.27, subdivision 2a; 253B.212; 254B.03, subdivisions 1, 4;  
305.31 254B.04, subdivision 1, by adding a subdivision; 254B.06, subdivision 2; 256.01,  
305.32 subdivisions 2b, 14, 14b, 24, 29, by adding a subdivision; 256.969, subdivision  
305.33 2b; 256B.04, subdivisions 14a, 18, by adding a subdivision; 256B.05, by  
305.34 adding a subdivision; 256B.056, subdivisions 3, 4; 256B.057, subdivision 9;  
305.35 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8b, 8c, 8e, 13e, 13h,  
305.36 17, 17a, 18, 31a, 41, by adding subdivisions; 256B.0631, subdivisions 1, 2,  
305.37 3; 256B.0644; 256B.0659, subdivisions 11, 28; 256B.0751, subdivision 4, by  
305.38 adding a subdivision; 256B.0911, subdivisions 1a, 3a; 256B.0913, subdivision  
305.39 4; 256B.0915, subdivisions 3a, 3b, 3e, 3h, 10; 256B.0916, subdivision 6a;  
305.40 256B.092, subdivisions 1b, 1e, 1g, 3, 8; 256B.0943, by adding a subdivision;  
305.41 256B.0945, subdivision 4; 256B.14, by adding a subdivision; 256B.431,  
305.42 subdivisions 2r, 32; 256B.434, subdivision 4; 256B.437, subdivision 6;  
305.43 256B.441, subdivision 50a, by adding a subdivision; 256B.48, subdivision  
305.44 1; 256B.49, subdivisions 13, 14, 15; 256B.5012, by adding subdivisions;  
305.45 256B.69, subdivisions 5a, 5c, 28, by adding subdivisions; 256B.76, subdivision  
305.46 4; 256D.02, subdivision 12a; 256D.03, subdivision 3; 256D.031, subdivisions  
305.47 1, 6, 7, 9, 10; 256D.05, subdivision 1; 256D.06, subdivision 2; 256D.09,  
305.48 subdivision 6; 256D.44, subdivision 5; 256D.46, subdivision 1; 256D.47;  
305.49 256D.49, subdivision 3; 256E.35, subdivisions 5, 6; 256G.02, subdivision  
305.50 6; 256I.03, by adding a subdivision; 256I.04, subdivisions 1, 2b; 256I.05,  
305.51 subdivision 1a; 256J.12, subdivisions 1a, 2; 256J.20, subdivision 3; 256J.37, by  
305.52 adding a subdivision; 256J.38, subdivision 1; 256J.49, subdivision 13; 256J.53,  
305.53 subdivision 2; 256L.01, subdivision 4a; 256L.02, subdivision 3; 256L.03,  
305.54 subdivision 5; 256L.04, subdivisions 1, 7, 10; 256L.05, subdivisions 2, 3a, by  
305.55 adding a subdivision; 256L.07, subdivision 1; 256L.11, subdivision 7; 256L.12,

306.1 subdivision 9; 256L.15, subdivision 1a; 260C.157, subdivision 3; 260D.01;  
306.2 297F.10, subdivision 1; 326B.175; 393.07, subdivisions 10, 10a; 402A.10,  
306.3 subdivisions 4, 5; 402A.15; 402A.18; 402A.20; 518A.51; Laws 2009, chapter  
306.4 79, article 13, section 3, subdivision 8, as amended; Laws 2010, First Special  
306.5 Session chapter 1, article 15, section 3, subdivision 6; article 25, section 3,  
306.6 subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 1;  
306.7 15; 62E; 62J; 62U; 145; 148; 151; 214; 256; 256B; 256L; 326B; 402A; proposing  
306.8 coding for new law as Minnesota Statutes, chapter 256N; repealing Minnesota  
306.9 Statutes 2010, sections 62J.07, subdivisions 1, 2, 3; 62J.17, subdivisions 1, 3,  
306.10 5a, 6a, 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 144.1464;  
306.11 144.147; 144.1499; 256.979, subdivisions 5, 6, 7, 10; 256.9791; 256.9862,  
306.12 subdivision 2; 256B.055, subdivision 15; 256B.057, subdivision 2c; 256B.0756;  
306.13 256D.01, subdivisions 1, 1a, 1b, 1e, 2; 256D.03, subdivisions 1, 2, 2a; 256D.05,  
306.14 subdivisions 1, 2, 4, 5, 6, 7, 8; 256D.0513; 256D.06, subdivisions 1, 1b, 2, 5, 7, 8;  
306.15 256D.09, subdivisions 1, 2, 2a, 2b, 5, 6; 256D.10; 256D.13; 256D.15; 256D.16;  
306.16 256D.35, subdivision 8b; 256D.46; 256L.07, subdivision 7; 402A.30; 402A.45;  
306.17 Laws 2008, chapter 358, article 3, sections 8; 9; Laws 2009, chapter 79, article 3,  
306.18 section 18, as amended; article 5, sections 55, as amended; 56; 57; 60; 61; 62; 63;  
306.19 64; 65; 66; 68; 69; 79; Minnesota Rules, parts 3400.0130, subpart 8; 4651.0100,  
306.20 subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21,  
306.21 22, 23; 4651.0110, subparts 2, 2a, 3, 4, 5; 4651.0120; 4651.0130; 4651.0140;  
306.22 4651.0150; 9500.1243, subpart 3; 9500.1261, subparts 3, items D, E, 4, 5."

307.1 We request the adoption of this report and repassage of the bill.

307.2 Senate Conferees:

307.3 .....  
307.4 David W. Hann Michelle R. Benson

307.5 .....  
307.6 Gretchen Hoffman Scott J. Newman

307.7 .....  
307.8 Sean Nienow

307.9 House Conferees:

307.10 .....  
307.11 Jim Abeler Steve Gottwalt

307.12 .....  
307.13 Mary Kiffmeyer Kathy Lohmer

307.14 .....  
307.15 Thomas Huntley